

## **MHPAEA Summary Form**

### **MHPAEA Summary Form Instructions**

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

The MHPAEA Summary Form includes the MHPAEA Data Report.

Carriers must use the terms defined in COMAR 31.10.51 and the *Instructions for MHPAEA NQTL Analysis Report and Data Report* to complete the summary form.

Preferred Provider Organization (PPO)

PPO-HSAF Health Savings Acct - Family

## MHPAEA Summary Form

### MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), Cigna Health and Life Insurance Company must make sure that there is “parity” between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

Cigna Health and Life Insurance Company has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have any questions on this summary, please contact Customer Service at 1 (800) 997-1654.

If you have questions on your specific health plan, please call

Behavioral Health Benefits

1 (800) 433-5768

24 hours a day, 365 days a year

Medical, Dental, Vision

1 (800) 244-6224

24 hours a day, 365 days a year

TTY/TDD Service (For callers who are deaf or hard of hearing)

Dial 711 and follow the prompts

24 hours a day, 365 days a year

### Overview:

We have identified the five health benefit plans with the highest enrollment for each product we offer in the individual, small, and large group markets, as applicable. These plans contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on benefits paid. What these NQTL’s are and how the health plans achieve parity are discussed below.

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**1. Definition of Medical Necessity**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Medically Necessary/Medical Necessity</b> Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:</p> <ul style="list-style-type: none"> <li>• required to diagnose or treat an illness, injury, disease or its symptoms;</li> <li>• in accordance with generally accepted standards of medical practice;</li> <li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li> <li>• not primarily for the convenience of the patient, Physician or other health care provider; and</li> <li>• rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.</li> </ul> <p>Preventive care services described in this certificate are considered to be Medically Necessary.</p>	<p><b>Medically Necessary/Medical Necessity</b> Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:</p> <ul style="list-style-type: none"> <li>• required to diagnose or treat an illness, injury, disease or its symptoms;</li> <li>• in accordance with generally accepted standards of medical practice;</li> <li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li> <li>• not primarily for the convenience of the patient, Physician or other health care provider; and</li> <li>• rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.</li> </ul> <p>Preventive care services described in this certificate are considered to be Medically Necessary.</p>

B. Identify the factors used in the development of the limitation(s);

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all medical health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG or</p>	<p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG,</p>

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<p>are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee (“MTAC”) reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all M/S benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.</p>	<p>the American Society of Addiction Medicine (“ASAM”) or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee (“MTAC”) reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.</p>
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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's</p>	<p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's</p>

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<p>Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p> <p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the "Behavioral Health" clinicians listed in the "Coverage Policy SME" tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna's Medical</p>	<p>Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p> <p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the "Behavioral Health" clinicians listed in the "Coverage Policy SME" tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna's Medical</p>
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<p>Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48):</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b><i>Medical Necessity Appeals</i></b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQTL for the Medical Necessity Appeals.</p>	<p>Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48) ):</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b><i>Medical Necessity Appeals</i></b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQTL for the Medical Necessity Appeals.</p>
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**Internal Appeals.** Cigna follows the same a single-level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs a single level appeal, whether expedited or standard.

Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.

**External Appeals.** Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer's designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.

All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding

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<p>on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>	<p>is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Cigna Health Management, Inc., an affiliate of CHLIC performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC and both national and regional vendors to perform UM. All entities adhere to Cigna’s policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p>	<p>Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health” formerly Cigna Behavioral Health) an affiliate of CHLIC, performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for CHLIC.</p> <p>Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"> <li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li> <li>• in accordance with generally accepted standards of medical practice;</li> <li>• clinically appropriate in terms of type, frequency, extent, site and</li> </ul>

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<ul style="list-style-type: none"> <li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li> <li>• in accordance with generally accepted standards of medical practice;</li> <li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li> <li>• not primarily for the convenience of the patient, Physician or other health care provider;</li> <li>• not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and</li> <li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</li> </ul> <p>Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.”</p>	<ul style="list-style-type: none"> <li>duration;</li> <li>• not primarily for the convenience of the patient, Physician or other health care provider;</li> <li>• not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</li> <li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</li> </ul> <p>Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.”</p>
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- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

A review of Cigna's written policies and processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. Cigna's Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. Cigna applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Compliance is further demonstrated through Cigna's uniform definition of Medical Necessity for M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.

### ***Peer to Peer Review Variation***

With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Cigna ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.

Cigna's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and Cigna's Clinical Coverage policies and plan documents approved for use in care management determinations. Cigna's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and Cigna's Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer.

The Peer-to-Peer review is available for any coverage request for which Cigna anticipates issuing a denial Cigna incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Cigna clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Cigna Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Cigna Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Cigna clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request.

If Cigna's pro-active, *volunteer* Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial

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without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. Cigna's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provider resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to Cigna.

Cigna has not identified any additional discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is *more* advantageous to the administration of MH/SUD benefits than M/S benefits such as the pro-active behavioral health peer-to-peer review process outlined herein. The Peer-to-Peer analysis is addressed in the "in operation" section of this submission set forth below.

Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the medical management suite of NQTLs, including Medical Necessity and Appeals, Prior Authorization and Concurrent Review. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna's application of the medical necessity

NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits for the Cigna book of business including all commercial data Medical Necessity denial rates.

Cigna utilizes appeals data to review the number of utilization review decisions across the book-of-business. Appeals data is delineated by pre and post services and includes prior authorization and concurrent review, overturned for the same time period relating to the utilization management data metrics included in Cigna's book of business data. Data reflected overall comparable overturn rates across benefit classifications.

While the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims for the Cigna book of business. This appeal rate, coupled with the utilization management data reflecting higher Medical Necessity denial rates for M/S claims than for MH/SUD claims is representative of Cigna's proactive approach to peer-to-peer review. Approximately 37% of all pre-service MH/SUD peer-to-peer reviews inclusive of read only reviews, which includes a Medical Director review of the medical file without discussion when a peer-to-peer is scheduled but the requesting provider does not attend, in Cigna's book-of-business data resulted in approvals that may have otherwise have resulted in a medical necessity denial.

Additionally, Cigna conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and

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decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company’s most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.

The number of utilization review decisions across the Cigna book of business data, reflects comparable average denial rates based upon Medical Necessity across all benefit classifications for utilization management programs including prior authorization, concurrent review and retrospective review with medical necessity denials for M/S services on average higher than medical necessity denials of MH/SUD services. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.

Cigna concludes the Medical Necessity NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the ‘as written’ comparative analysis Cigna reviewed applicable policies, processes and procedures to ensure comparability of the application of Medical Necessity to M/S and MH/SUD services which revealed the application of Medical Necessity to be applied to MH/SUD services no more stringently than M/S Services. In performing the operational analysis of the application of UM, Cigna reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.

**2. Prior Authorization Review Process**

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Direct Access to Obstetricians and Gynecologists</b>                      You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for</p>	

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<p>making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit <a href="http://www.myCigna.com">www.myCigna.com</a> or contact customer service at the phone number listed on the back of your ID card.</p>	
<p><b>Pre-Admission Certification/Continued Stay Review for Hospital Confinement</b>          Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:</p> <ul style="list-style-type: none"> <li>• as a registered bed patient, except for 48/96 hour maternity stays;</li> <li>• for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;</li> <li>• for Mental Health or Substance Abuse Residential Treatment Services.</li> </ul> <p>You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. The Review Organization will make all initial determinations on whether to authorize or certify a non-emergency course of treatment within two working days of receipt of the information necessary to make their decision; and promptly notify the attending health care provider and patient of that determination. If the Review Organization does not have sufficient information to make a determination within three calendar days of the initial request for health care services, the Review Organization will notify the health care provider that additional information must be provided. For an inpatient or residential crisis services admission for the treatment of a mental, emotional, or substance abuse disorder, the Review Organization will make all determinations on whether to authorize or certify an inpatient admission or an admission for residential crisis services within two hours after receipt of the information necessary to make the</p>	<p><b>Pre-Admission Certification/Continued Stay Review for Hospital Confinement</b>          Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:</p> <ul style="list-style-type: none"> <li>• as a registered bed patient, except for 48/96 hour maternity stays;</li> <li>• for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;</li> <li>• for Mental Health or Substance Abuse Residential Treatment Services.</li> </ul> <p>You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. The Review Organization will make all initial determinations on whether to authorize or certify a non-emergency course of treatment within two working days of receipt of the information necessary to make their decision; and promptly notify the attending health care provider and patient of that determination. If the Review Organization does not have sufficient information to make a determination within three calendar days of the initial request for health care services, the Review Organization will notify the health care provider that additional information must be provided. For an inpatient or residential crisis services admission for the treatment of a mental, emotional, or substance abuse disorder, the Review Organization will make all determinations on whether to authorize or certify an inpatient admission or an admission for residential crisis services within two hours after receipt of the information necessary to make the</p>

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<p>determination, and promptly notify the health care provider of that determination.</p> <p>Written notice of an adverse decision will be sent to you and to the attending health care provider within five working days after the adverse decision has been made.</p> <p>Covered Expenses incurred will not include the first \$500 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, by the end of the first scheduled work day after the date of admission, or as soon as reasonably possible.</p> <p>Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:</p> <ul style="list-style-type: none"><li>• Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and</li><li>• any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.</li></ul> <p>All determinations for an extended stay in a health care facility or additional health care services will be made within one working day of receipt of the information necessary to make that determination. The attending health care provider will be notified promptly of the determination.</p> <p>In the case of an emergency admission, you should contact the Review Organization by the end of the first scheduled work day after the admission or as soon as reasonably possible. The Review Organization will not render an adverse decision for an emergency admission solely because the Hospital did not notify the Review Organization of the emergency admission within 24 hours or by the end of the first</p>	<p>determination, and promptly notify the health care provider of that determination.</p> <p>Written notice of an adverse decision will be sent to you and to the attending health care provider within five working days after the adverse decision has been made.</p> <p>Covered Expenses incurred will not include the first \$500 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, by the end of the first scheduled work day after the date of admission, or as soon as reasonably possible.</p> <p>Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:</p> <ul style="list-style-type: none"><li>• Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and</li><li>• any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.</li></ul> <p>All determinations for an extended stay in a health care facility or additional health care services will be made within one working day of receipt of the information necessary to make that determination. The attending health care provider will be notified promptly of the determination.</p> <p>In the case of an emergency admission, you should contact the Review Organization by the end of the first scheduled work day after the admission or as soon as reasonably possible. The Review Organization will not render an adverse decision for an emergency admission solely because the Hospital did not notify the Review Organization of the emergency admission within 24 hours or by the end of the first</p>
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<p>scheduled work day after the admission if the patient's medical condition prevented the Hospital from determining the patient's insurance status and the Review Organization's emergency admission notification requirements. The Review Organization will not render an adverse decision during the first 24 hours after a patient's admission when: the admission is based on a determination that the patient is in imminent danger to self or others; the determination was made by the patient's Physician or Psychologist in conjunction with a member of the facility's medical staff; and the facility immediately notifies the Review Organization of the patient's admission and the reasons for the admission. The Review Organization will not render an adverse decision for up to 72 hours for a Hospital admission determined to be Medically Necessary for the patient's treating Physician when: the admission is an involuntary psychiatric admission; and the Hospital immediately notifies the Review Organization of the patient's admission and the reasons for the admission. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.</p> <p>In the case of an admission due to pregnancy, a call by you to the Review Organization prior to the end of the third month of pregnancy will allow the Review Organization an opportunity to obtain information from you that could determine whether a referral to Cigna's maternity-related case management programs is indicated.</p> <p>If there is an adverse determination in regard to any of the above determinations, the Review Organization will provide an opportunity for the health care provider to seek a reconsideration by telephone on an expedited basis not to exceed 24 hours.</p> <p>If a course of treatment has been preauthorized or approved for a patient, the Review Organization will not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to the patient.</p>	<p>scheduled work day after the admission if the patient's medical condition prevented the Hospital from determining the patient's insurance status and the Review Organization's emergency admission notification requirements. The Review Organization will not render an adverse decision during the first 24 hours after a patient's admission when: the admission is based on a determination that the patient is in imminent danger to self or others; the determination was made by the patient's Physician or Psychologist in conjunction with a member of the facility's medical staff; and the facility immediately notifies the Review Organization of the patient's admission and the reasons for the admission. The Review Organization will not render an adverse decision for up to 72 hours for a Hospital admission determined to be Medically Necessary for the patient's treating Physician when: the admission is an involuntary psychiatric admission; and the Hospital immediately notifies the Review Organization of the patient's admission and the reasons for the admission. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.</p> <p>In the case of an admission due to pregnancy, a call by you to the Review Organization prior to the end of the third month of pregnancy will allow the Review Organization an opportunity to obtain information from you that could determine whether a referral to Cigna's maternity-related case management programs is indicated.</p> <p>If there is an adverse determination in regard to any of the above determinations, the Review Organization will provide an opportunity for the health care provider to seek a reconsideration by telephone on an expedited basis not to exceed 24 hours.</p> <p>If a course of treatment has been preauthorized or approved for a patient, the Review Organization will not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to the patient.</p>
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<p>PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. A representative of the Review Organization is reasonably accessible to patients and health care providers in Maryland 7 days a week, 24 hours a day.</p> <p>In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.</p> <p>In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.</p>	<p>PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. A representative of the Review Organization is reasonably accessible to patients and health care providers in Maryland 7 days a week, 24 hours a day.</p> <p>In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.</p> <p>In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.</p>
<p><b>Prior Authorization/Pre-Authorized</b></p> <p>The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization in order for certain services and benefits to be covered under this policy. Prior Authorization is not required for Emergency Services.</p> <p>Services that require Prior Authorization include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• inpatient Hospital services, except for 48/96 hour maternity stays;</li> <li>• inpatient services at any participating Other Health Care Facility;</li> <li>• residential treatment;</li> <li>• non-emergency ambulance; or</li> <li>• transplant services.</li> </ul>	<p><b>Prior Authorization/Pre-Authorized</b></p> <p>The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization in order for certain services and benefits to be covered under this policy. Prior Authorization is not required for Emergency Services.</p> <p>Services that require Prior Authorization include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• inpatient Hospital services, except for 48/96 hour maternity stays;</li> <li>• inpatient services at any participating Other Health Care Facility;</li> <li>• residential treatment;</li> <li>• non-emergency ambulance; or</li> <li>• transplant services.</li> </ul>

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B. Identify the factors used in the development of the limitation(s);

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p><b>Factors</b>                      Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service.</p>	<p><b>Inpatient, In-Network and Out-of-Network Services Requiring Prior Authorization</b></p> <p><b>Factors</b>                      Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service.</p>
<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p>Not Applicable</p>	<p><b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p>Not Applicable</p>

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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p><b>Sources</b></p> <ul style="list-style-type: none"> <li>• Internal claims data</li> <li>• UM program operating costs</li> <li>• UM authorization data</li> <li>• Expert Medical Review</li> <li>• Nationally recognized evidence-based guidelines</li> </ul>	<p><b>Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p><b>Sources</b></p> <ul style="list-style-type: none"> <li>• Internal claims data</li> <li>• UM program operating costs</li> <li>• UM authorization data</li> <li>• Expert Medical Review</li> <li>• Nationally recognized evidence-based guidelines</li> </ul>
<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>

D. Identify the methods and analysis used in the development of the limitation(s); and

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b></p> <p>All non-emergent M/S inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR) including Inpatient, In-Network and Inpatient, Out-of-Network benefits. Cigna has no additional Prior Authorization</p>	<p><b>Inpatient, In-Network and Out-of-Network Services Requiring Prior Authorization</b></p> <p>All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR)) including Inpatient, In-Network and Inpatient, Out-of-Network benefits. Cigna has no additional Prior Authorization</p>

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<p>requirements applied to Out-of-Network M/S benefits than it does to that applied to Inpatient, In-Network M/S benefits.</p> <p><b>Process</b>          For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. If the request cannot be authorized using an approved algorithm, the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p>	<p>requirements applied to Out-of-Network MH/SUD benefits than it does to that applied to Inpatient, In-Network MH/SUD benefits.</p> <p><b>Process</b>          For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. . If the request cannot be authorized using an approved algorithm, t the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p>
<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>

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E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

**Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization**

Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.

A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.

First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.

Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.

Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness of application of prior authorization is comparable across MH/SUD and M/S benefits.

Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization).

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An “in operation” review of Cigna’s application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business data. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Cigna also reviewed the ROIs for both MH/SUD and M/S non-emergent inpatient admissions. For the purposes of the ROI calculation, the estimated costs to perform a coverage review, which is informed by costs/expenses for personnel salaries and time to review. Cigna reviewed the ROI for both M/S and MH/SUD non-emergent inpatient admissions. M/S services for non-emergent inpatient admissions calculated at 9:1 for 2019, 8:0 for 2020 and 10:1 for partial year 2021 and ROIs for MH/SUD services for non-emergent inpatient admissions calculated at 2.93:1 for 2019, 2.05:1 for 2020 and 2.03:1 for partial year 2021 respectively. These calculations are consistent with the factor/evidentiary standard outlined in Steps 2 and 3, namely that the application of prior authorization to inpatient M/S benefits produces a positive savings for both MH/SUD and M/S benefits, as measured in the aggregate across the Cigna-administered book-of-business. To be clear, if the number preceding the colon is greater than 1 (e.g., 2.93), then the application of prior authorization produces a positive ROI and thus meets the evidentiary standard for application of the same to MH/SUD or M/S inpatient benefits.

The process by which services are considered for application of Prior Authorization is comparable in writing and in operation across MH/SUD and M/S benefits, as evidenced by Cigna’s assessment of several components of the prior authorization determination process in the overall context of its utilization management programs.

**Outpatient Office Visits, In-Network Outpatient Office Visits, Out-of-Network**

Not Applicable

**All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization**

Not Applicable

**3. Concurrent Review Process**

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
<b>Concurrent Determinations</b>	<b>Concurrent Determinations</b>

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<p>When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.</p>	<p>When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.</p>
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B. Identify the factors used in the development of the limitation(s);

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Inpatient, In-Network Inpatient, Out-of-Network</b></p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p>	<p><b>Inpatient, In-Network Inpatient, Out-of-Network</b></p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p>

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<ul style="list-style-type: none"> <li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li> <li>• Expected timeframe for clinical response/outcomes based on literature</li> <li>• Efficacy of the treatment modality</li> <li>• Progress toward goals of therapy</li> <li>• Discharge / transition planning</li> </ul>	<ul style="list-style-type: none"> <li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li> <li>• Expected timeframe for clinical response/outcomes based on literature</li> <li>• Efficacy of the treatment modality</li> <li>• Progress toward goals of therapy</li> <li>• Discharge / transition planning</li> </ul>
<p><b>Outpatient Office Visits, In-Network</b>  <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network</b>  <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>All Other Outpatient Services, In-Network</b>  <b>All Other Outpatient Services, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>All Other Outpatient Services, In-Network</b>  <b>All Other Outpatient Services, Out-of-Network</b></p> <p>Not Applicable</p>

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Inpatient, In-Network</b>  <b>Inpatient, Out-of-Network</b></p> <p><b>Sources</b></p> <ul style="list-style-type: none"> <li>• Industry accepted procedures codes developed by: <ul style="list-style-type: none"> <li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li> <li>○ American Hospital Association (AHA) publication of revenue codes</li> <li>○ American Formulary Association (AFA) publication of codes</li> <li>○ Centers for Medicare and Medicaid Services (CMS)</li> </ul> </li> </ul>	<p><b>Inpatient, In-Network</b>  <b>Inpatient, Out-of-Network</b></p> <p><b>Sources</b></p> <ul style="list-style-type: none"> <li>• Industry accepted procedures codes developed by: <ul style="list-style-type: none"> <li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li> <li>○ American Hospital Association (AHA) publication of revenue codes</li> <li>○ American Formulary Association (AFA) publication of codes</li> <li>○ Centers for Medicare and Medicaid Services (CMS)</li> </ul> </li> </ul>

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<p>publication of codes</p> <ul style="list-style-type: none"> <li>• Internal claims data</li> <li>• UM program operating costs</li> <li>• UM authorization data</li> <li>• Expert Medical Review of Clinical Criteria</li> <li>• Nationally recognized evidence-based guidelines</li> </ul> <p><b>Evidentiary Standards</b>  The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all M/S services. The administration is identical.</p> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols).</p>	<p>publication of codes</p> <ul style="list-style-type: none"> <li>• Internal claims data</li> <li>• UM program operating costs</li> <li>• UM authorization data</li> <li>• Expert Medical Review of Clinical Criteria</li> <li>• Nationally recognized evidence-based guidelines</li> </ul> <p><b>Evidentiary Standards</b>  The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S and MH/SUD services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all MH/SUD and M/S services. The administration is identical.</p>
<p><b>Outpatient Office Visits, In-Network</b>  <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network</b>  <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>All Other Outpatient Services, In-Network</b>  <b>All Other Outpatient Services, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>All Other Outpatient Services, In-Network</b>  <b>All Other Outpatient Services, Out-of-Network</b></p> <p>Not Applicable</p>

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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Inpatient, In-Network Inpatient, Out-of-Network</b></p> <p>Concurrent Review is applied to all non-emergent M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider.</p>	<p><b>Inpatient, In-Network Inpatient, Out-of-Network</b></p> <p><b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.</p>

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<p>Cigna uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a Cigna medical, or co-branded coverage policy.</p>	
<p><b>Outpatient Office Visits, In-Network</b> <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>	<p><b>Outpatient Office Visits, In-Network</b> <b>Outpatient Office Visits, Out-of-Network</b></p> <p>Not Applicable</p>
<p><b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review</b></p> <p>Not Applicable</p>	<p><b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review</b></p> <p>Not Applicable</p>

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

<p><b>Inpatient, In-Network</b> <b>Inpatient, Out-of-Network</b></p> <p>Cigna applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for Concurrent Review.</p> <p><b><i>DRG Variation</i></b></p> <p>Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. The lack of correlation between the length of stay and the plan’s obligation to pay benefits for the same means that assessing the ongoing medical necessity of a continued facility stay for coverage/benefit purposes is unnecessary for such period of time.</p>
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The case rate/DRG payment functions as payment in full for any and all services rendered to the individual for the pre-authorized course of treatment for the length of time covered by the case rate/DRG payment and over which the individual remains in the facility. The plan’s liability for payment of benefits for services, and the individuals’ cost-sharing obligation, does not increase or decrease depending on how long the individual remains in the facility receiving the pre-authorized treatment in question, unless the individual’s stay extends beyond the time period that the DRG/case rate payment covers.

DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Concurrent Review by Cigna is clinically appropriate and permissible for psychiatric hospitalizations as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Differences in utilization management of inpatient behavioral health is not a more stringent application because DRG-based fees have not been established for psychiatric hospitalizations.

An “in operation” review of Cigna’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Inpatient, In-Network” classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. On average, denial rates for concurrent medical necessity review of In-Network Inpatient and Out-of-Network MH/SUD benefits were lower than M/S services.

A review of appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the out-of-network outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out of Network, Out Patient, showed comparable appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination.

Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

**Outpatient Office Visits, In-Network**  
**Outpatient Office Visits, Out-of-Network**

Not Applicable

**All Other Outpatient Services, In-Network**  
**All Other Outpatient Services, Out-of-Network**

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Not Applicable

**4. Retrospective Review Process**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><u>General Limitations</u> No payment will be made for expenses incurred for you or any one of your Dependents:</p> <ul style="list-style-type: none"> <li>expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specifically provided in the “Covered Expenses” section.</li> </ul>	<p><u>General Limitations</u> No payment will be made for expenses incurred for you or any one of your Dependents:</p> <ul style="list-style-type: none"> <li>expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specifically provided in the “Covered Expenses” section.</li> </ul>

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Factors</b> When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of</p>	<p><b>Factors</b> When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of</p>

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<p>evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>
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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Evidentiary Standards</b> When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p>	<p><b>Evidentiary Standards</b> When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p>

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<ul style="list-style-type: none"> <li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:             <ul style="list-style-type: none"> <li>○ Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li> <li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li> <li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:             <ul style="list-style-type: none"> <li>○ Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li> <li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li> <li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li> </ul> </li> </ul>
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and MH/SUD benefits.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law.</p>	<p>All non-emergent MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and /SUD benefits.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law.</p>

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Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows:

**“Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.”

Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the

Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows:

**“Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.”

Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the

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Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.	Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.
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E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

**As written:** Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for developing coverage criteria.

Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

**In operation:** Cigna has conducted a review of its application of the Retrospective Review NQTL, specifically approvals and denial information, which revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

The comparative analysis performed for application of Retrospective Review to inpatient and outpatient benefits evidences compliance with the MHPAEA NQTL requirement, in writing and in operation. Cigna's analysis of the process and policies governing the application of Retrospective Review across MH/SUD and M/S benefits, as well as the process by which MH/SUD and M/S services are selected for application of Retrospective Review, evidences comparability and equivalent stringency, in writing and in operation. The written process, the trigger for application of Retrospective Review, and the medical necessity standard used to review services subject to Retrospective Review, comparable across MH/SUD and M/S benefits, but the assessment of denial rates across a sample of Cigna-administered benefit plans do not reveal any potential "warning signs" warranting further assessment and/or changes to how the Retrospective Review NQTL is designed or applied to MH/SUD benefits.

The factor and its accompanying evidentiary standard used to determine whether Retrospective Review will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits. Cigna does not use

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different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the list of services subject to Retrospective Review.

Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject Retrospective Review as written and in operation, as well as its medical necessity review processes, are no more stringent for MH/SUD services than for M/S services within the same classification of benefits.

**5. Emergency Services**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable	Not Applicable

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable.  Emergency M/S services are not subject to prior authorization or Concurrent Review.	Not Applicable.  Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable.	Not Applicable.

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Emergency M/S services are not subject to prior authorization or Concurrent Review.	Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.
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D. Identify the methods and analysis used in the development of the limitation(s); and

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Not Applicable.  Emergency M/S services are not subject to prior authorization or Concurrent Review.	Not Applicable.  Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Not Applicable.  Cigna's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.
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**6. Pharmacy Services**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
<b>Prior Authorization Requirements</b>	<b>Prior Authorization Requirements</b>

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Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis

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<p>and the Prescription Drug Product. The authorization will at all times be subject to the plan’s terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.</p> <p>If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.</p> <p>Prescription Drug Products prescribed for the treatment of an opioid use disorder that contains methadone, buprenorphine, or naltrexone will not be subject to any prior authorization requirements.</p> <p>Cigna's formulary includes at least one Opioid Antagonist that does not require prior authorization. Opioid Antagonist means Naloxone Hydrochloride or any other similarly acting and equally safe drug approved by the FDA for the treatment of a drug overdose.</p> <p>A contraceptive drug or device that is an intrauterine device, or an implantable rod, will not be subject to prior authorization requirements, if it is approved by the U.S. Food and Drug Administration, and is obtained under a prescription written by an authorized prescriber.</p>	<p>and the Prescription Drug Product. The authorization will at all times be subject to the plan’s terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.</p> <p>If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.</p> <p>Prescription Drug Products prescribed for the treatment of an opioid use disorder that contains methadone, buprenorphine, or naltrexone will not be subject to any prior authorization requirements.</p> <p>Cigna's formulary includes at least one Opioid Antagonist that does not require prior authorization. Opioid Antagonist means Naloxone Hydrochloride or any other similarly acting and equally safe drug approved by the FDA for the treatment of a drug overdose.</p> <p>A contraceptive drug or device that is an intrauterine device, or an implantable rod, will not be subject to prior authorization requirements, if it is approved by the U.S. Food and Drug Administration, and is obtained under a prescription written by an authorized prescriber.</p>
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B. Identify the factors used in the development of the limitation(s);

<p><b>Medical/Surgical Benefits (M/S)</b></p>	<p><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is</p>	<p>Same as medical/surgical</p>

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an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.

Notably, Cigna does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. Cigna does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, Cigna applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with Cigna's application of prior authorization to controlled substances on the basis of identified safety risks, and regardless of whether the controlled substance is used to treat an M/S condition, such as pain management, or an MH/SUD condition such as ADHD or bipolar disorder. Cigna applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug's status as a controlled substance. Cigna also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand

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alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.	
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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>Notably, Cigna does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. Cigna does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, Cigna applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with Cigna's application of prior authorization to controlled substances on</p>	<p>Same as medical/surgical</p>

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<p>the basis of identified safety risks, and regardless of whether the controlled substance is used to treat an M/S condition, such as pain management, or an MH/SUD condition such as ADHD or bipolar disorder. Cigna applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug’s status as a controlled substance. Cigna also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.</p>	
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p><b>Medical/Surgical Benefits (M/S)</b></p>	<p><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Cigna requires prior authorization, step therapy, or quantity limits for certain prescription drugs to ensure the prescribed drugs are medically necessary to treat the enrollee’s condition. Cigna uses the same medical necessity standard when reviewing coverage for both M/S and MH/SUD drugs.</p> <p>Cigna's prior authorization, step therapy, or quantity limit requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.</p>	<p>Same as medical/surgical</p>

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

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Cigna has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Its written policies governing formulary placement and application of utilization management do not distinguish between the processes, factors or standards that inform design and application of the formulary placement and utilization management NQTLs. Indeed, Cigna uses one, combined policy to govern its formulary management and utilization management requirements across M/S and MH/SUD benefits, and, while uniformity in processes is not required by the NQTL requirements (only comparability), uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written.

In terms of operational parity compliance, Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&T Committee designates must be covered are, in fact, covered on the formulary, and all drugs' coverage conform to other P&T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and drugs subject to a utilization management requirement, including prior authorization, step therapy, and/or quantity limits, conform to the aforementioned standards established for inclusion in a utilization management program. That is, Cigna does not apply a utilization management requirement to an MH/SUD drug that does not exhibit the factors/standards described in the preceding columns that, as-written, justify application of a utilization management requirement to a drug, and in terms of stringency of application of the NQTL no M/S drugs are omitted from a utilization management requirement if they exhibit the same factors/standards.

While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification of benefits.

**7. Prescription Drug Formulary Design**

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
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<p><b>Prescription Drug List</b>  A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan’s Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&amp;T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.</p>	<p><b>Prescription Drug List</b>  A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan’s Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&amp;T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.</p>
<p><b>Prescription Drug List Management</b>  The Prescription Drug List (or formulary) offered under your Employer’s plan is managed by the Cigna Business Decision Team. Your plan’s Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&amp;T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its</p>	<p><b>Prescription Drug List Management</b>  The Prescription Drug List (or formulary) offered under your Employer’s plan is managed by the Cigna Business Decision Team. Your plan’s Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&amp;T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its</p>

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book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

If you are prescribed a drug that is not on Cigna's Prescription Drug List (formulary), and in the judgment of Your prescribing Physician:

- There is no equivalent drug or device in the formulary;
- An equivalent formulary drug or device has been either ineffective in treating Your disease or condition or has been or is likely to cause an adverse reaction or other harm to You; or
- For a contraceptive prescription drug or device that is not on Cigna's Prescription Drug List, is medically necessary for You to adhere to the appropriate use of the prescription drug or device.

book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

If you are prescribed a drug that is not on Cigna's Prescription Drug List (formulary), and in the judgment of Your prescribing Physician:

- There is no equivalent drug or device in the formulary;
- An equivalent formulary drug or device has been either ineffective in treating Your disease or condition or has been or is likely to cause an adverse reaction or other harm to You; or
- For a contraceptive prescription drug or device that is not on Cigna's Prescription Drug List, is medically necessary for You to adhere to the appropriate use of the prescription drug or device.

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<p>Call member services at the telephone number on your ID card, to get information about Cigna's procedures to cover a drug or device that is not on the Prescription Drug List.</p>	<p>Call member services at the telephone number on your ID card, to get information about Cigna's procedures to cover a drug or device that is not on the Prescription Drug List.</p>
<p><b>Pharmacy &amp; Therapeutics (P&amp;T) Committee</b>          A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&amp;T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.</p>	<p><b>Pharmacy &amp; Therapeutics (P&amp;T) Committee</b>          A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&amp;T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.</p>
<p><b>Prescription Drug List</b>          A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&amp;T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.</p>	<p><b>Prescription Drug List</b>          A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&amp;T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.</p>

B. Identify the factors used in the development of the limitation(s);

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<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Factors</b>                      In its decision criteria, the CHP VAC primarily considers the following factors:</p> <ol style="list-style-type: none"> <li>1. Pharmacy and Therapeutics (“P&amp;T”) Committee clinical safety and efficacy evaluation and designation.</li> <li>2. Economic implications to enrollees and plans.</li> <li>3. Status of drug as a generic, brand, or specialty drug</li> <li>4. Competitor/market practices</li> <li>5. Legal and regulatory requirements.</li> </ol> <p>When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost.</p> <p>The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.</p>	<p>Same as Medical/Surgical</p>

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Evidentiary Standards</b></p>	<p>Same as Medical/Surgical</p>

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In its decision criteria, the CHP VAC considers the following factors as defined by the noted evidentiary standards:

- Pharmacy and Therapeutics (“P&T”) Committee clinical evaluation and designation. The clinical P&T Committee’s designations are based on reviews of a drug’s safety and efficacy and place in therapy, using available clinical evidence such as FDA label information and available clinical literature and guidelines (e.g. federal regulatory publications or professional society publications). The P&T Committee assigns one of several clinical designations to a drug based on the drug’s safety/efficacy and place in therapy: Access, Include, Optional, or Exclude. These designations dictate whether, from a clinical perspective a drug must be covered on the formulary, or, alternatively, may, but is not required to be, covered on the formulary, and whether a drug may be covered more favorably than therapeutically alternative drugs. A drug designated “Include” or “Access” must be covered to the extent medically necessary, and alternative drugs may not be preferred over it through application of tier placement or step therapy. A drug designated “Optional” may or may not be covered on the formulary, and may be subject to a step therapy protocol that requires the use of alternative drugs.

These formulary placement designations are more specifically defined as follows, and are subject to any overriding plan exclusions such as exclusions of over-the-counter drugs or prescription drugs with over-the-counter alternatives:

**Include:** A drug may be given an include designation if it meets at least one of the clinical bases enumerated below and is anticipated, or validated via claims data, to treat relatively large patient population (i.e., greater than 1 in 50,000).

The clinical bases include:

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- a. It has a unique indication for use addressing a clinically significant unmet treatment need;
- b. Its efficacy is superior to that of existing therapy alternatives;
- c. Its safety profile is superior to that of existing therapy alternatives, it has a unique place in therapy; and/or
- d. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options. Include drugs must be placed on a tier of the applicable formulary by the Value Assessment Committee but may not be disadvantaged relative to other drugs in a drug grouping, as defined by the P&T Committee, with a less favorable clinical designation. A drug grouping is a list of drugs that generally possess the same mechanism of action and a similar place in therapy.

**Access:** A drug may be given an access designation if it meets at least one of the clinical bases enumerated below AND the drug is either anticipated, or validated via claims data at the time the P&T Committee renders a designation on the drug, to treat a relatively small sub-population. The clinical bases include:

- a. It has a unique indication for use addressing a clinically significant unmet treatment need;
- b. Its efficacy is superior to that of existing therapy alternatives;
- c. Its safety profile is superior to that of existing therapy alternatives;
- d. It has a unique place in therapy; and/or
- e. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.

Access drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the applicable formulary or designate the drug as non-formulary. If the Value

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Assessment Committee does not place the drug on the formulary, the P&T Committee shall establish formulary exception clinical criteria.

**Optional:** A drug may be given an optional designation if a significant proportion of its use is similar in terms of safety and efficacy to other currently available drug alternatives. In certain instances, a drug designated as optional may have a unique use in a small subset of patients in relation to the overall use of the drug. The P&T Committee shall establish formulary exceptions to account for cases where the optional drug may have a unique use in a relatively small subset of patients. Optional drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the formulary or designate the drug as non-formulary. If the drug is not placed on the formulary, the P&T Committee shall establish formulary exception clinical criteria.

**Exclude:** Drugs may be given an exclude designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Drugs recalled from the market for safety reasons are automatically designated as “Exclude” drugs, pending further P&T Committee review.

- Economic implications to enrollees and Cigna. When assessing potential formulary placement decisions, the CHP VAC reviews based on projected drug expenditure information derived from available manufacturer revenue and claims costs whether a drug is a lower net cost option relative to any therapeutic alternatives.
- Status of drug as a generic, brand, or specialty drug. A drug is identified as generic or brand based on an algorithm that considers drug indicators made available by an external vendor called First DataBank. A drug is identified as a specialty drug

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based on the presence of one more of the following characteristics: the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; the need for intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive specialty pharmacy distribution (if a drug is only available through limited specialty pharmacy distribution it is considered specialty, even if it doesn't have other specialty drug characteristics); or specialized product handling and/or administration requirements.

- Competitor/market practices. This factor refers to an assessment of how competitors are covering drugs on their formularies based on publicly available information, which, while never determinative, may be considered when making certain formulary decisions.
- Legal and regulatory requirements. This factor refers to any legal or regulatory requirements that mandate certain drug coverage, such as tier placement requirements.

Cigna offers several formularies for its large group insured business. For most formularies, some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from

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<p>claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>For large group insured plans, Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank’s drug indicator file, and not by reference to the drug’s status as an M/S or MH/SUD benefit. Once brand drug status is determined by application of the algorithm, a covered brand drug is typically placed on Tier 2 for one of several reasons, including, for example, if the drug lacks available generic alternatives or if Cigna maintains a rebate arrangement for the brand drug, even if the brand drug has generic alternatives. Conversely, a covered brand drug is typically placed on Tier 3 if it either has available generic alternatives or Cigna lacks a rebate arrangement for the brand drug. Tier 4, if elected by the client plan sponsor, includes specialty drugs identified based on application of the above-stated definition.</p>	
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Cigna offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.</p> <p>Cigna offers a variety of prescription drug formularies comprised of generic, preferred and non-preferred brand name drugs, and specialty drugs. The coverage of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, determined by two</p>	<p>Same as Medical/Surgical</p>

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internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Cigna Value Assessment Committee (a/k/a Business Decision Team).

The coverage of drugs covered on Cigna's formularies are, subject to a client policyholder's election, as applicable, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Cigna Health Plan Value Assessment Committee ("CHP VAC").

The P&T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. In rendering clinical findings on drugs, the P&T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines.

The CHP VAC is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from our sales and economics areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&T Committee - which drugs will be covered on the formularies offered by Cigna. If the P&T Committee finds that a drug must be covered on the formulary as a clinical matter, then the Value Assessment Committee must place the drug on the formulary. If the P&T Committee determines that a drug may or may not be covered on the formulary as a clinical matter, then the CHP VAC may consider other factors, including economic factors, when deciding whether to place the drug on the formulary.

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- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Cigna does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies. Formulary tiers are designed based on reasonable factors, consistent with the requirements of 45 CFR §146.136.

Cigna has confirmed that its formulary management and utilization management processes are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Specifically, all drugs, whether MH/SUD or M/S drugs, that the P&T Committee designates must be covered are, in fact, covered on the formulary, and all drugs conform to other P&T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes.

Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and

Cigna's review evidences that the processes and standards used to determine whether to subject a drug to utilization review is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&T and CHP VAC committee structure reviews M/S and MH/SUD drugs for formulary placement and whether to subject a drug to a prior authorization requirement, and pursuant to common policies and procedures. The process for reviewing drugs for coverage does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.

In terms of operational parity compliance, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a comparable, and in some cases lower, percentage of MH/SUD drugs are subject to prior authorization or step therapy requirements as compared to M/S drugs; and a comparable, and, in fact, lower, percentage of MH/SUD drugs are covered on the non-preferred brand tier (Tier 3) of the formularies offered by Cigna as compared to the MH/SUD drugs covered on Tiers 1 and 2. Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&T Committee designates must be covered are, in fact, covered on the formulary, and all drugs' coverage conform to other P&T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, for its large group formularies Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status.

Cigna has also assessed as follows across its group formularies. First, a comparable percentage of MH/SUD drug NDCs are covered on v. off-formulary as compared to M/S drug NDCs under such formularies (about 4% of MH/SUD and M/S drug NDCs each are covered off-formulary, with small variations to the tenths of a percent across the noted formularies). Second, a comparable, and, in fact, lower, percentage of MH/SUD

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drug NDCs are covered on the higher cost, non-preferred brand tier (Tier 3) of the group formularies offered by Cigna as compared to the MH/SUD drug NDCs covered on Tiers 1 and 2.

While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Cigna employs measures to ensure comparability in both design and application of the multi-tiered formulary NQTL to MH/SUD and M/S prescription drug benefits. The written policies governing how MH/SUD or M/S drugs are placed on the formulary and tiered are uniform (i.e., on/off-formulary and tiering factors/standards) to ensure that the in-writing process and factors/standards relied on are comparable irrespective of the underlying use of the drug. Moreover, Cigna assesses outcomes data, including incidence rates for the application of utilization management NQTLs (i.e., the proportion of MH/SUD and M/S drugs that are subject to utilization management), to ensure that there are no significant discrepancies in the outcomes of the NQTLs' application across MH/SUD and M/S benefits that warrant further scrutiny of the formulary decision-making process. Finally, the P&T Committee annually reviews the formularies to ensure that the CHP VAC adheres to its clinical designations, irrespective of whether they are MH/SUD or M/S drugs, when making formulary placement/tiering decisions for Cigna's formularies.

Moreover, as further evidence of comparability and equivalent stringency in-operation, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a lower absolute number of MH/SUD drugs are covered off-formulary as compared to M/S drugs; a comparable, and indeed a lower, percentage of MH/SUD brand drugs are covered on the non-preferred brand tier (Tier 3) relative to the total number of MH/SUD drugs covered on Tiers 1 and 2 of the formulary, as compared to the proportion of M/S drugs covered on Tier 3 relative to the total M/S drugs covered on Tiers 1 and 2 of the formulary. As all generic drugs covered on the formulary are placed on Tier 1 and no brand drugs are placed on Tier 1, whether MH/SUD or M/S benefits, the placement of drugs on Tier 1 of the formulary is deemed to meet the NQTL stringency and comparability requirements for formulary placement. Put differently, there are no differences in placement of covered generic drugs for MH/SUD or M/S drugs, as the evidentiary standard – which was consistently applied to the placement of MH/SUD and M/S drugs on the formulary – for Tier 1 placement is the generic status of a drug.

Additionally, by including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process.

While physicians, regardless of specialty, are qualified under their scope of licensure to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&T Committee. In the context of NQTL

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compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits.

Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions. Moreover, Cigna does not distinguish, in writing, between M/S and MH/SUD benefits in its prescription drug formulary design for its large group plan formularies, and it takes steps to monitor the consistency of decision-making across MH/SUD and M/S drugs by performing policy reviews and assessing operational outcomes periodically. As described in detail under the narrative response to Steps 2 and 3, Cigna considers the same factors and accompanying evidentiary standards for MH/SUD and M/S drugs when designing its large group formularies pursuant to a uniform formulary decision-making process. The written process for reviewing drugs for coverage does not differ by whether the drug is used to treat an M/S condition or a MH/SUD condition, and in terms of the timing of decisions, the P&T Committee and Value Assessment Committee typically review all new-to-market drugs, whether MH/SUD or M/S drugs, within six months of market availability, and typically reviews potential opportunities to make formulary changes of any kind outside the context of new-to-market drug entries up to twice per year.

In summary, the comparative analyses documented here, which construe the application of the multi-tiered formulary design NQTL designed based on the factors articulated above, demonstrate the compliance in-writing and in-operation of the NQTL. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. In this case, there were comparable, and in some cases more advantageous, outcomes for the placement and tiering of MH/SUD drugs as compared to M/S drugs based on the absolute number of, and incidence of, non-formulary v. formulary and, for on-formulary drugs, Tier 2 v. Tier 3 drugs under large group formularies. These comparable outcomes, along with the confirmation that the evidentiary standards and factors were actually applied consistently to MH/SUD drugs as compared to M/S drugs in terms of the adherence to P&T Committee clinical designations, evidence in-operation compliance in terms of comparability and equivalent stringency. Consequently, Cigna concludes that the NQTL of formulary management is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

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**8. Case Management**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Case Management</b>                      Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.</p> <p>Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.</p>	<p><b>Case Management</b>                      Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.</p> <p>Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.</p>

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- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.
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While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.
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While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p>For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive health care needs through communication and sharing available resources to promote optimal patient care.</p> <p>Health plan enrollees are not required to participate in case management services.</p> <p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.</p>	<p>Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria including self-referral which remains complimentary and voluntary.</p> <p>Health plan enrollees are not required to participate in case management services.</p> <p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.</p>

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p>For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive health care needs through communication and sharing available resources to promote optimal patient care.</p> <p>Health plan enrollees are not required to participate in case management services.</p>	<p>Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria including self-referral which remains complimentary and voluntary.</p> <p>Health plan enrollees are not required to participate in case management services.</p>

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<p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.</p>	<p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.</p>
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive health care needs through communication and sharing available resources to promote optimal patient care.</p> <p>Health plan enrollees are not required to participate in case management services.</p> <p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.</p>	<p>Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria including self-referral which remains complimentary and voluntary.</p> <p>Health plan enrollees are not required to participate in case management services.</p> <p>Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.</p>

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

<p>Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement. Notwithstanding the inapplicability of the NQTL requirement to Cigna's voluntary case management program, Cigna offers case management services to enrollees with either complex MH/SUD or M/S conditions.</p>
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**9. Process for Assessment of New Technologies**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<i>No plan language</i>	<i>No plan language</i>

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Factors</b> Cigna considers the following factors in determining whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"> <li>• inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li> <li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li> <li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li> </ul>	<p><b>Factors</b> Cigna considers the following factors in determining whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"> <li>• inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li> <li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li> <li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li> </ul>

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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"> <li>• clinical literature</li> <li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li> <li>• FDA approval or clearance</li> <li>• English language peer reviewed publications including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</li> </ul> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	<p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"> <li>• clinical literature</li> <li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li> <li>• FDA approval or clearance</li> <li>• English language peer reviewed publications including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</li> </ul> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>

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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b></p> <p>The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all M/S services, regardless of benefit classification.</p> <p>EIU services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"> <li>• not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>• not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li> <li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.</li> </ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC</p>	<p><b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b></p> <p>The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all MH/SUD services, regardless of benefit classification.</p> <p>EIU services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"> <li>• not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li> <li>• not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li> <li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.</li> </ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p>

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<p>committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p>	<p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p>
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E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The definition of experimental/investigational /unproven services is the same for MS and MH/SUD. A single review committee, Cigna’s MTAC evaluates all new technologies for M/S and MH/SUD benefits. Cigna’s methodology and processes for determining whether M/S interventions and MH/SUD interventions within a classification of benefits are experimental, investigational and/or unproven are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/s services within the same classification of benefits as written and in operation.

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Cigna collects, tracks and trends relevant metrics on a semi-annual basis for services within each classification of M/S and MH/SUD benefits. Metrics may include initial EIU coverage denials, coverage denials upheld and overturned upon internal appeal and coverage denials upheld and overturned upon external appeal/review.

An “in operation” review of claims data from a sampling of Cigna-administered plans revealed no excessive denial rates for MH/SUD claims denied as experimental, investigational and unproven as compared to M/S claims denied as experimental, investigational and unproven. An “in operation” review of Cigna’s application of the Experimental, Investigational, and Unproven NQTL, specifically approvals and denial information, in the “All Other Outpatient Services” classification revealed no statistically significant discrepancies in EIU denial rates as-between MH/SUD and M/S benefits.

While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

The use of MTAC for development of evidence based Coverage Policies for M/S and MH/SUD demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services.

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**10. Standards for Provider Credentialing and Contracting**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<i>No plan language</i>	<i>No plan language</i>

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>

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Network Admissions standards are designed and maintained by the Quality Programs & Accreditation (“QP&A”) team, which serves as an Accreditation Center of Excellence working with independent agents, such as the National Committee for Quality Assurance (“NCQA”), Utilization Review Accreditation Commission (“URAC”), the Centers for Medicare and Medicaid Services (“CMS”) and the National Alliance of HealthCare Purchaser Coalitions (“NAHPC”). Accreditation, certification and recognition by these organizations provides us with the external validation needed to show that we maintain high quality and meet nationally recognized industry standards. Cigna’s mission is to improve the health, well-being and peace of mind of those we serve through an integrated approach to healthcare quality and affordability.

Credentialing criteria for M/S Network Providers includes the following standard requirements:

1. signed agreement to participate;
2. signed application and provider attestation;
3. verification of unrestricted state medical license with appropriate licensing agency;
4. verification of valid, unrestricted DEA certificate (if applicable);
5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;
6. verification Board certification, (if applicable);
7. verification of highest level of education and training, if not board certified;
8. review and verification of malpractice claims history;
9. review of work history;
10. verification of adequate malpractice insurance; and
11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.

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Credentialing criteria for M/S Network Providers includes the following standard requirements:

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4. verification of valid, unrestricted DEA certificate (if applicable);
5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;
6. verification Board certification, (if applicable);
7. verification of highest level of education and training, if not board certified;
8. review and verification of malpractice claims history;
9. review of work history;
10. verification of adequate malpractice insurance; and
11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.

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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.</p> <p>Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.</p>	<p>Evernorth follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.</p> <p>Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.</p>

D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p>Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.</p> <p>CHLIC maintains NCQA and URAC accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members’ Rights &amp; Responsibilities (approximately 250 documents). This evidence spans a period of 2 years and the majority of the evidence has to be reviewed and approved by our Medical</p>	<p>Evernorth follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.</p> <p>Evernorth maintains NCQA Managed Behavioral Healthcare Organization (“MBHO”) and URAC accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction.</p>

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<p>Management Quality Committee (“MMQC”), Integrated Health Management Quality Committee (“IHMQC”), and Clinical Advisory Committee (“CAC”). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).</p>	<p>Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).</p>
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E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

<p>Cigna's methodology for credentialing for M/S providers and MH/SUD physician providers are the same.</p> <p>Cigna maintains one credentialing committee for the review of providers entering the network. Cigna does not routinely track credentialing exceptions for either M/S or MH/SUD Network Providers. Network Providers are re-credentialed on a three-year cycle as required by NCQA.</p> <p>NCQA Accreditation standards require that the organization maintain sufficient numbers and types of behavioral health, primary care and specialty care practitioners in its network. NCQA does not specifically dictate what the appropriate number/type should be. As a result, Cigna conducts review of its Network Adequacy standards at least annually to ensure requirements are sufficient for customer needs. Such analysis reviews external benchmarks (e.g., state laws or CMS requirements) as well as internal review of supply/demand and network adequacy enrollee complaints.</p> <p>Cigna's methodology for credentialing for M/S and MH/SUD physician providers are the same. Cigna credentialing standards for licensed physicians follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. Cigna does not maintain separate standards for MH/SUD providers. Moreover, the standard credentialing process is used for both licensed physician providers and licensed non-physician providers, whether they are M/S or MH/SUD providers. Re-credentialing is required every three years for all providers, and except for work history and education and training verification, requires providers to meet the same criteria as the initial credentialing process, unless a new specialty is being requested.</p> <p>The credentialing application process is consistent between physicians and facilities providing M/S and MH/SUD services and the required licensing, experience, CAQH application and verifications are indistinguishable. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD physician providers, and, as relevant for certain MH/SUD services or specialties, Cigna does not require that MH/SUD practitioners or facilities be licensed or accredited if such a license or accreditation would not be required by state law. Consistency in credentialing standards and process evidences compliance with the NQTL in-writing requirement.</p>
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An “in operation” review of Cigna’s credentialing applications, approvals and denials of providers revealed no disparate outcomes in credentialing approvals or denials as between M/S and MH/SUD physician providers. The average time it took Cigna to review and approve a credentialing application for both M/S and MH/SUD providers was 15.5 days, an 18 day approval average for M/S providers and a shorter 13 day approval average for MH/SUD providers. The average time it took Cigna to review and deny a credentialing application for both M/S and MH/SUD providers was 100 days; 99 day approval average for M/S providers and 101 day approval average for MH/SUD providers. These credentialing process metrics indicate a comparable process in-operation based on the time to review, a significantly lower amount of denials of MH/SUD provider credentialing applications, and comparable incidences of denials of MH/SUD and M/S provider credentialing denial overturns on appeal. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, Cigna’s network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.

Cigna’s credentialing standards for licensed non-physician providers follows NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD providers. Consistency in standards and process evidences compliance with the NQTL requirement.

Cigna does not distinguish between M/S and MH/SUD for purposes of credentialing unlicensed professionals and paraprofessionals. For M/S and MH/SUD, unlicensed providers may not be directly contracted or credentialed but may render services under a fully contracted and credentialed individual (supervising provider) or entity (clinic or facility)

Cigna’s credentialing standards for unlicensed professionals and paraprofessionals follows applicable NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD providers.

Consistency in standards and process evidences compliance with the NQTL requirement.

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**11. Exclusions for Failure to Complete a Course of Treatment**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.	Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.	Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.	Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.

D. Identify the methods and analysis used in the development of the limitation(s); and

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.	Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.

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E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Not Applicable – The plan does not exclude coverage for failure to complete a course a treatment.

**12. Restrictions that Limit Duration or Scope of Benefits for Services**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<i>No plan language</i>	<i>No plan language</i>

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

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D. Identify the methods and analysis used in the development of the limitation(s); and

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Cigna's geographic limitations on coverage for services apply uniformly across MH/SUD and M/S benefits.

Cigna standardly covers medically necessary services rendered by licensed and/or certified healthcare providers for the treatment of M/S conditions and MH/SUD conditions. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan.

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**13. Restrictions for Provider Specialty**

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Not Applicable – The plan does not include restrictions for provider specialties.	Not Applicable – The plan does not include restrictions for provider specialties.

B. Identify the factors used in the development of the limitation(s);

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.

D. Identify the methods and analysis used in the development of the limitation(s); and

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.

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- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Cigna requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. Cigna does not, in writing or in operation, further restrict provision of MH/SUD benefits to certain types of specialties so long as the rendering provider is acting within the scope of the provider’s license, and, in terms of stringency, Cigna confirms that it does not waive for any M/S providers the requirement that the M/S provider act within the scope of the provider’s license in order for services to be covered.

**14. Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)**

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>
<p><b>Maximum Reimbursable Charge</b> In no event will Cigna's allowed amount paid to a non-Participating Provider for a covered health care service be less than the allowed amount paid to a similarly licensed provider who is a Participating Provider, for the same service in the same geographical region.</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</p> <p>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum</p>	<p><b>Maximum Reimbursable Charge</b> In no event will Cigna's allowed amount paid to a non-Participating Provider for a covered health care service be less than the allowed amount paid to a similarly licensed provider who is a Participating Provider, for the same service in the same geographical region.</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</p> <p>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum</p>

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<p>Reimbursable Charge, then data in the database for similar services may be used.</p> <p><b>Note:</b> The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</p>	<p>Reimbursable Charge, then data in the database for similar services may be used.</p> <p><b>Note:</b> The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</p>
<p><b>Maximum Reimbursable Charge – Medical</b> The Maximum Reimbursable Charge for covered services is determined based on the lesser of:</p> <ul style="list-style-type: none"> <li>• the provider’s normal charge for a similar service or supply; or</li> <li>• a policyholder-selected 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 state, regional or national charge data may be used. If sufficient charge data is unavailable in the database, then data in the database for similar services may be used.</li> </ul> <p>The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.</p> <p>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.</p> <p><b>General Reimbursement Information</b> In no event will Cigna's allowed amount paid to a non-Participating Provider (Out-of-Network Provider) for a covered health care service be less than the allowed amount paid to a similarly licensed provider</p>	<p><b>Maximum Reimbursable Charge – Medical</b> The Maximum Reimbursable Charge for covered services is determined based on the lesser of:</p> <ul style="list-style-type: none"> <li>• the provider’s normal charge for a similar service or supply; or</li> <li>• a policyholder-selected 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 state, regional or national charge data may be used. If sufficient charge data is unavailable in the database, then data in the database for similar services may be used.</li> </ul> <p>The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.</p> <p>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.</p> <p><b>General Reimbursement Information</b> In no event will Cigna's allowed amount paid to a non-Participating Provider (Out-of-Network Provider) for a covered health care service be less than the allowed amount paid to a similarly licensed provider</p>

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who is a Participating Provider, for the same service in the same geographical region.

The following applies to on-call Physicians and Hospital-based Physicians who are licensed in Maryland:

With respect to on-call Physicians and Hospital-based Physicians who:

- are non-Participating Providers or Out-of-Network Providers; and
- obtain an assignment of benefits from the insured person; and
- notify Cigna, in the manner specified by the Commissioner of Insurance, that the on-call Physician or Hospital-based Physician has obtained and accepted the assignment of benefits from the insured person.

Cigna agrees as follows:

- Cigna will pay the on-call Physician or Hospital-based Physician, within 30 days after receipt of the claim; and
- On-call and Hospital-based Physicians who are licensed in Maryland may not attempt to collect from the insured person any amount in excess of the allowable amount; and
- The allowable amount used to determine the plan's benefit payment for a claim submitted by an on-call Physician, for a covered service rendered to an insured in a Hospital, no less than the greater of:
  - 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with Cigna; or
  - the average rate Cigna paid for the 12-month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service to a

who is a Participating Provider, for the same service in the same geographical region.

The following applies to on-call Physicians and Hospital-based Physicians who are licensed in Maryland:

With respect to on-call Physicians and Hospital-based Physicians who:

- are non-Participating Providers or Out-of-Network Providers; and
- obtain an assignment of benefits from the insured person; and
- notify Cigna, in the manner specified by the Commissioner of Insurance, that the on-call Physician or Hospital-based Physician has obtained and accepted the assignment of benefits from the insured person.

Cigna agrees as follows:

- Cigna will pay the on-call Physician or Hospital-based Physician, within 30 days after receipt of the claim; and
- On-call and Hospital-based Physicians who are licensed in Maryland may not attempt to collect from the insured person any amount in excess of the allowable amount; and
- The allowable amount used to determine the plan's benefit payment for a claim submitted by an on-call Physician, for a covered service rendered to an insured in a Hospital, no less than the greater of:
  - 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with Cigna; or
  - the average rate Cigna paid for the 12-month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service to a

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<p>similarly licensed provider not under written contract with Cigna, inflated by the change in the Medicare Economic Index from 2010 to the current year.</p> <ul style="list-style-type: none"> <li>• The allowable amount used to determine the plan’s benefit payment for a claim submitted by a Hospital-based Physician, for a covered service rendered to an insured, no less than the greater of:             <ul style="list-style-type: none"> <li>○ 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers who are Hospital-based Physicians under written contract with Cigna; or</li> <li>○ the final allowed amount of Cigna for the same covered service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-based Physician billing under the same federal tax identification number the Hospital-based Physician used in calendar year 2009.</li> </ul> </li> </ul>	<p>similarly licensed provider not under written contract with Cigna, inflated by the change in the Medicare Economic Index from 2010 to the current year.</p> <ul style="list-style-type: none"> <li>• The allowable amount used to determine the plan’s benefit payment for a claim submitted by a Hospital-based Physician, for a covered service rendered to an insured, no less than the greater of:             <ul style="list-style-type: none"> <li>○ 140% of the average rate Cigna paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers who are Hospital-based Physicians under written contract with Cigna; or</li> <li>○ the final allowed amount of Cigna for the same covered service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-based Physician billing under the same federal tax identification number the Hospital-based Physician used in calendar year 2009.</li> </ul> </li> </ul>
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B. Identify the factors used in the development of the limitation(s);

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>In-Network Provider Reimbursement</b> Factors for reimbursement negotiation include:</p> <ol style="list-style-type: none"> <li>1. Geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index (“GPCI”) Geographical Practice Cost Index (GPCI) reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then</li> </ol>	<p><b>In-Network Provider Reimbursement</b> Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p>

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<p>accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs). Geographic Practice Cost Index is not weighted for purposes of per diem reimbursement;</p> <ol style="list-style-type: none"><li>2. Type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g. physician practitioner v. non-physician practitioner);</li><li>3. Supply of provider type and/or specialty. Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Supply of provider type and/or specialty are not weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</li><li>4. Network need and/or demand for provider type and/or specialty. Network need and/or demand for provider type or specialty is defined by state adequacy requirements. Cigna contracts with practitioners and providers across all networks and for all product lines to meet the availability and cultural needs and preferences of customers, establishes availability standards and assesses its networks against those standards articulated in Cigna's <i>Measuring Availability of Practitioners and Providers Policy</i>. Need and/or demand for provider type and/or specialty are not weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</li><li>5. Training, experience and licensure of providers billing for</li></ol>	<p><b>Out-of-Network Provider Reimbursement (Usual, Customary &amp; Reasonable Charges)</b></p> <p>Cigna's standard out-of-network reimbursement methodology 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. These objectives are achieved through a combination of techniques described more fully below.</p>
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<p>professional services under the facility agreement. Training, experience and licensure of providers billing for professional services under the facility agreement are not specifically weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>6. Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit (“RVU”). RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. RVUs are not weighted for per diem reimbursement.</p> <p><b>Out-of-Network Provider Reimbursement (Usual, Customary &amp; Reasonable Charges)</b></p> <p>Cigna's standard out-of-network reimbursement methodology 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. These objectives are achieved through a combination of techniques described more fully below.</p>	
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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
<p><b>In-Network Provider Reimbursement Medicare Baseline.</b></p> <p>Cigna utilizes the Medicare Pricing Tool to determine if the provider’s (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard</p>	<p><b>In-Network Provider Reimbursement</b></p> <p>Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and</p>

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Medicare 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. Cigna’s RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually:

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

RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. Three components are used to make up a total RVU (1) Physician’s work – This component accounts for the providers time, technical skill, mental effort, and physiological stress; (2) Practice expense – This component includes office rent, wages, supplies, equipment; (3) Malpractice Expense - This component includes professional liability insurance cost. To fill gaps for codes not covered by RBRVS methodology Cigna uses relative values assigned by Optum (Ingenix) for M/S services. Optum (Ingenix), is a third party health data company, that uses the same methodology originally used to develop the values for Medicare covered services. For those services that cannot be valued using a resource- based methodology, values have been developed using alternative methodologies proprietary to Optum (Ingenix). In an RBRVS calculation, each component of an RVU is multiplied by its GPCI then totaled and multiplied by the conversion factor to determine the fee or payment. Cigna uses the same GPCIs as Medicare. There are approximately 89 GPCIs. Cigna uses Optum (Ingenix) values to fill gaps for codes not covered by RBRVS methodology

Facility rate categories are industry standard with the market and economy dictating rates for both M/S and MH/SUD facilities. Cigna

practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.

**Out-of-Network Provider Reimbursement (Usual, Customary & Reasonable Charges)**

The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:

- MRC1
  - Based on a percentile of charges (U&C) as compiled in a national charges database.
  - Clients select an MRC1 percentile: 50th, 60th, 70th, 80th, etc. Standard offerings are 70th percentile for HMO and POS product claims and 80th percentile for PPO and EPO products claims.
  - Emergency services provided by health care professional will be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.
  - Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.
- MRC2
  - Based on methodologies and rates used by CMS to pay Medicare claims.
  - Clients can select the percentage of MRC2 paid to non-contracted health care professionals and facilities for non-emergency services. Standard percentages are 110 percent, 150 percent, 200 percent, and 300 percent.
  - Emergency services provided by health care professional will be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.
  - Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.

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utilizes Medicare’s resource-based relative value scale (RBRVS) calculation (OP- BH & Med). This calculation is premised on the principle that payments for services should vary with the resource cost for providing the services. In each instance, the fee schedule is separately reviewed and negotiated.

DRG reimbursement is based upon Medicare DRG calculations, which assign payment levels to each DRG based on the average cost of treatment. Case rates, also referred to as *flat rates*, describe a reimbursement structure in which providers receive a flat reimbursement rate for every patient visit, regardless of the service (most often utilized in urgent care). Cigna does not determine or mandate the reimbursement type; selection of reimbursement type is determined by the facility. Generally, M/S facility providers request DRG reimbursement, while MH/SUD facility providers request per diem reimbursement. More than 90% of MH/SUD Provider Network contracts reflect per diem reimbursement. The evidentiary factors taken into consideration in the negotiation of the per-diem rate are not weighted or prioritized one more than the other; however, additional consideration may be given to meet network adequacy standards.

For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation, but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors such as patient age and diagnosis. When behavioral contracts at a per diem rate, the population and type of care are distinguished in the contract and rates are negotiated separately. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and “groups it” into the correct DRG. Then that DRG information is used to calculate the reimbursement, based on the factor in the contract; by way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement.

**Out-of-Network Provider Reimbursement (Usual, Customary & Reasonable Charges)**

- In the absence of a Medicare Fee Schedule rate, Cigna may develop a reimbursement rate using methodologies similar to the ones used by Medicare.

For out-of-network services:

- Emergency services provided by health care professional will be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.
- Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.

Cigna's out-of-network reimbursement methodology 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. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program.

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The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:

- MRC1

- Based on a percentile of charges (U&C) as compiled in a national charges database.
- Clients select an MRC1 percentile: 50th, 60th, 70th, 80th, etc. Standard offerings are 70th percentile for HMO and POS product claims and 80th percentile for PPO and EPO products claims.
- Emergency services provided by health care professional will be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.
- Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.

- MRC2

- Based on methodologies and rates used by CMS to pay Medicare claims.
- Clients can select the percentage of MRC2 paid to non-contracted health care professionals and facilities for non-emergency services. Standard percentages are 110 percent, 150 percent, 200 percent, and 300 percent.
- Emergency services provided by health care professional will be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.
- Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.
- In the absence of a Medicare Fee Schedule rate, Cigna may develop a reimbursement rate using methodologies similar to the ones used by Medicare.

For out-of-network services:

- Emergency services provided by health care professional will

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<p>be reimbursed using the MRC1 80<sup>th</sup> percentile allowable amount.</p> <ul style="list-style-type: none"> <li>• Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.</li> </ul> <p>Cigna's out-of-network reimbursement methodology 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. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program.</p>	
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D. Identify the methods and analysis used in the development of the limitation(s); and

<p align="center"><b>Medical/Surgical Benefits (M/S)</b></p>	<p align="center"><b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b></p>
<p><b>In-Network Provider Reimbursement</b> Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p>	<p><b>In-Network Provider Reimbursement</b> Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p>

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<p><b>Out-of-Network Provider Reimbursement (Usual, Customary &amp; Reasonable Charges)</b></p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p> <p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, 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 MRC for the service 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, etc.</p> <p>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 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 are run through a validation process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> 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</p>	<p><b>Out-of-Network Provider Reimbursement (Usual, Customary &amp; Reasonable Charges)</b></p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p> <p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, 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 MRC for the service 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, etc.</p> <p>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 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 are run through a validation process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> 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</p>
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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.

### **Actual Charge Data:**

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 Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> 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 70<sup>th</sup> percentile)  
 $200 \times .90 = 180$  (The charge on line 180 is the 90<sup>th</sup> percentile)

If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid.

### **Actual Charge Data (National/USA values):**

Charges collected for a given period of time are 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.

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### **Actual Charge Data:**

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 Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> 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 70<sup>th</sup> percentile)  
 $200 \times .90 = 180$  (The charge on line 180 is the 90<sup>th</sup> percentile)

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<p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for detailed description of FAIR Health’s derived charge methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> 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.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative</p>	<p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for detailed description of FAIR Health’s derived charge methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> 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.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable</p>
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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.

**Note:** 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.

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.

**Note:** 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

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<p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services such as Skilled Nursing Facility or Residential Treatment Center services, are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds the facility’s billed charges, the facility’s billed charges. If any</p>	<p>unlisted CPT codes and unlisted HCPCS codes.</p> <p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services such as Skilled Nursing Facility or Residential Treatment Center services, are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds</p>
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indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider's billed charges.

### Maximum Reimbursable Charge 2 (MRC2)

Under MRC2, the plan applies to a covered inpatient or outpatient 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.

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, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and outpatient professional services from the CMS Physician Fee Schedule. And for

the facility's billed charges, the facility's billed charges. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider's billed charges.

### Maximum Reimbursable Charge 2 (MRC2)

Under MRC2, the plan applies to a covered inpatient or outpatient 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.

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, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and outpatient

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<p>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.</p>	<p>professional services from the CMS Physician Fee Schedule. And 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.</p>
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- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

### **In-Network Provider Reimbursement**

All staff participating in a contract negotiation for M/S and MH/SUD Network Providers and facilities are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider specific reimbursement requests and escalate for justification and approval of any deviations.

#### **As Written.**

Whether for initial negotiation or renegotiation, Cigna's Network Provider reimbursement methodology for MH/SUD and M/S Network Providers are based upon the same array of factors. Re-negotiations of reimbursement rates are conducted according to the terms of the contract, or if not specified in the contract, they are conducted at the request of either party. The number of Network Providers (Individual, Group or Facility) joining or already part of the network does not factor into initial rate offerings. M/S and MH/SUD facilities may be reimbursed per diem, Diagnosis Related Group or case rate. Per diem reimbursement involves a flat dollar amount for each day as reimbursement for the service.

Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.

## MHPAEA Summary Form

### **In Operation**

Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region.

Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Cigna's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested.

#### *Provider Reimbursement – Outpatient*

In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.

#### *Facility Reimbursement – Inpatient*

In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary

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depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc.

Cigna's methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, Cigna's Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.

An 'in operation' review of Cigna's M/S and MH/SUD reimbursement rates from a sampling of Cigna-administered plans revealed that M/S providers are reimbursed on average at a higher percentage of Medicare than MH/SUD providers. While there is a disparate outcome in the in-operational review of Cigna's M/S and MH/SUD reimbursement rates that results from differences in local market dynamics, such outcome does not mean the in-practice NQTL standards are non-comparable or being applied more stringently to MH/SUD benefits. Because in-network provider reimbursement is a factor relevant to NQTL compliance insofar as it impacts accessibility to in-network providers and Cigna's network admissions criteria, itself the relevant NQTL, Cigna emphasizes that the comparable out-of-network utilization over the recent measurement period across MH/SUD and M/S benefits and the achievement of applicable network adequacy requirements for MH/SUD and M/S providers, respectively, evidences that any discrepancies in rates offered to MH/SUD providers is not affecting Cigna's ability to admit a sufficient number of providers.

### **Out-of-Network Provider Reimbursement (Usual, Customary & Reasonable Charges)**

Cigna has assessed across Cigna-administered plans the NQTL compliance of its standard out-of-network reimbursement methodology and has confirmed that its standard out-of-network reimbursement methodology, both in-writing and in-operation, applies comparably to MH/SUD benefits and no more stringently than M/S benefits received out-of-network.

More specifically, Cigna ensures consistency with the NQTL requirement in, subject to client election, its design of its out-of-network reimbursement methodology with respect to any indirect discount arrangements with out-of-network providers for reimbursement of MH/SUD or M/S services in several ways. For one, for both MH/SUD and M/S benefits Cigna retains third party vendors with which it contracts for indirect discount arrangements, whether maintained pursuant to a standing agreement between the third party vendor and provider or negotiated on a case-by-case basis with the provider, to make available, as applicable, rates that are within Cigna's established target pricing for a service. The MRC and the established MRC target pricing within which an indirect discount arrangement may be used to calculate reimbursement rates for covered services are derived identically for an MH/SUD or M/S benefit. Specifically, under the MRC1 methodology the MRC is derived from the same process, factors and evidentiary standards across MH/SUD and M/S benefits, and the target pricing for a service is equivalent to the MRC, which means that if any indirect discount arrangement that the third party vendors achieve with a provider is lower than the MRC for

## MHPAEA Summary Form

the service then the amount resulting from the indirect discount arrangement is the amount that Cigna calculates as reimbursement to the provider. Conversely, if the indirect discount arrangement equals an amount exceeding the MRC for the service, then the reimbursement amount due to the provider equals the MRC. That is, the reimbursement amount never exceeds, but may be lesser than, the client-elected percentile of the applicable MRC for any MH/SUD or M/S service under the MRC1 methodology, and the MRC itself is derived from the same process, factors, and standards across MH/SUD and M/S benefits.

Likewise, under the MRC2 methodology – which is based on a Medicare pricing methodology across MH/SUD and M/S services – any negotiations resulting in indirect discount arrangements maintained by a third party vendor and a provider, whether rendering MH/SUD or M/S services, the same MRC2 target price for MH/SUD or M/S services is utilized. Similarly 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 – 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.

In terms of the stringency of the application of the NQTL, when calculating out-of-network reimbursement for either MH/SUD or M/S benefits Cigna does not accommodate exceptions to the MRCs derived from the aforementioned sources/evidentiary standards (e.g., declining to use for a particular MH/SUD or M/S benefit claim the MRC derived from the database broadly used to derive an MRC) or the target price (e.g., agreeing through an indirect discount arrangement to pay a provider in excess of the target price for the service, which, for MRC1, would be the MRC) for M/S services or comparable MH/SUD services. That is, Cigna neither applies more stringently to MH/SUD services the limitation on the target price within which the third party vendor may negotiate with the provider for a discounted rate off of billed charges in return for an agreement not to balance-bill the patient for any difference between the billed charges and discounted rate, nor does Cigna use the methodology, including the process, factors, and evidentiary standards, for calculating reimbursement rates for covered MH/SUD benefits in a manner that disadvantages MH/SUD benefits relative to M/S benefits.

To further support its conclusion of comparability/stringency, Cigna as also assessed operational outcomes to validate that there are no potential disparities warranting closer scrutiny. Specifically, Cigna validated that across its commercial book-of-business it covers the full billed charges submitted by the MH/SUD providers at a comparable and, generally, higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. Moreover, in the aggregate Cigna generally pays to MH/SUD providers a more favorable reimbursement amount than M/S providers as measured as a discount off the providers' billed charges. Finally, for comparable services like office visits for E&M the average reimbursement for MH/SUD services across Cigna's commercial book-of-business is comparable to the average reimbursement for M/S services.

The foregoing analysis evidences comparability and no less than equivalent stringency in the application of the out-of-network reimbursement process, factors, and standards across MH/SUD and M/S benefits, in-writing and in-operation, which established compliance with the NQTL requirement.

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MHPAEA Data Report for Calendar Year Ending December 31, 2022 (§15-144(f))

Health Plan **PPO-HSAF Health Savings Acct Family**

Benefit	Classification	# of Authorization Requests Received	# of Authorization Requests Approved	# of Authorization Requests Denied	% Approved	% Denied
Mental Health Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	10	5	5	50%	50%
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
Substance Use Disorder Benefits	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	1	1	0	100%	0%
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
Medical /Surgical Benefits	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	19	10	9	53%	47%
	INN-Outpatient-Office	165	128	37	78%	22%
	OON-Outpatient-Office	2	1	1	50%	50%
	INN-Outpatient-AllOther				50%	50%
	OON-Outpatient-AllOther	2130	1068	1062		
	98	39	59	40%	60%	

MHPAEA Data Report for Calendar Year Ending December 31, 2022 (§15-144(f))

Health Plan **PPO-HSAF Health Savings Acct Family**

Benefit	Classification	# of Claims Submitted	# of Claims Approved	# of Claims Denied	% Approved	% Denied	Reasons for Denial of Claims
Mental Health Benefits	INN-Inpatient	101	97	4	96%	4%	MM 1025
	OON-Inpatient	51	49	2	96%	4%	45 587
	Emergency Services	68	64	4	94%	6%	2206 1025
	RX				82%	18%	04 77 70 7V 81 22 75 76 88 71 ET 85 7X 65 83 7M 79
	INN-Outpatient-Office	8204	6695	1509	98%	2%	392 023 407 1649 1274 781 154 788 AS 1230 1244 1680 358 369 DENY*190 2204 2067 1005
	OON-Outpatient-Office	7330	7156	174	78%	22%	1487 154 2067 1005 1171 XUC 1659 23 177 536 41 35 23 587 445 392 1650 781 789 1934
		980	768	212			

MHPAEA Data Report for Calendar Year Ending December 31, 2022 (§15-144(f))

Health Plan **PPO-HSAF Health Savings Acct Family**

Substance Use Disorder Benefits	INN-Outpatient-AllOther				96%	4%	348 1680 258 1091 C4 XQS 407 1966 154 1976
		770	743	27			
	OON-Outpatient-AllOther				45%	55%	154 587 45 1730 1124 VRS 2067 445 1514
		185	84	101			
	INN-Inpatient				#DIV/0!	#DIV/0!	0
		0	22	0			
	OON-Inpatient				#DIV/0!	#DIV/0!	0
		0	68	0			
	Emergency Services RX				#DIV/0!	#DIV/0!	0
		103	77	26			
Medical /Surgical Benefits	INN-Outpatient-Office				75%	25%	79
					94%	6%	1514 1680 407 41
	OON-Outpatient-Office				74%	26%	781 41
		149	140	9			
	INN-Outpatient-AllOther				86%	14%	AO 2195
		259	224	35			
	OON-Outpatient-AllOther				98%	2%	XW7 322 177 41 781 45
		403	393	10			
	INN-Inpatient				93%	7%	29 1649 407 298 1675 1513 XBB 1253 1487 1500 MR1 XCR 30 1778 1244 466 3 154 45 ZA3 GLC g38 1000
		1977	1841	136			
OON-Inpatient				96%	4%	45 154 1698 2010 407	
	230	220	10				
Emergency Services				#DIV/0!	#DIV/0!	0	
	0	4525	0				

MHPAEA Data Report for Calendar Year Ending December 31, 2022 (§15-144(f))

Health Plan

PPO-HSAF Health Savings Acct Family

RX				75%	25%	04 34 77 60 7Z 41 22 71 70 88 75 81 8E 78 7M 76 6Z 7V 606 MR 56 85 65 9G E3 ET 7X na
INN-Outpatient-Office	36446	27500	8946	90%	10%	298 1005 761 1285 238 27 307 301 587 84 1500 1954 311 760 154 403 K. 1649 407 1626 358 570 PXN 407 1669 1650 VL4 AA
	44421	39853	4568			

MHPAEA Data Report for Calendar Year Ending December 31, 2022 (§15-144(f))

Health Plan

PPO-HSAF Health Savings Acct Family

OON-Outpatient-Office				85%	15%	2098
						32
						346
						1650
						2011
						30
						154
						2094
						17
						45
						41
						902
						29
						369
						578
						e06
						AS
						XW7
						41
						317
						301
						1648
						1603
						587
						5
						1659
						84
1254	1062	192				1647
				96%	4%	1605
						1487
						45
						1778
						41
						1340
						154
						2207
						1054
						1485
						3
						2204
						84
						SR
						B8
						719
						2206
						f21
						XU4
						M7
						JP
						1114
						1875
						1231
						17
						f16
18029	17257	772				111

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Health Plan

PPO-HSAF Health Savings Acct Family

OON-Outpatient- AllOther				85%	15%	301
						2067
						587
						1659
						407
						84
						1672
						421
						TO
						2098
						322
						788
						719
						EP
						92
						737
						154
						1514
						445
						1778
						795
						2204
						1501
						392
						369
	2759	2343	416			

Denial Code	Denial Meaning
04	M/I PROCESSOR CONTROL NUMBER
09	M/I DATE OF BIRTH
11	M/I PATIENT RELATIONSHIP CODE
13	M/I OTHER COVERAGE CODE
21	SERVICE INCLUDED IN PRICER
22	M/I DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE
23	M/I INGREDIENT COST SUBMITTED
27	OUR RECORDS INDICATED THAT THIS DEPENDENT IS NOT COVERED BY YOUR PLAN.
28	M/I DATE PRESCRIPTION WRITTEN
34	AGE INVALID FOR DIAGNOSIS
34	M/I SUBMISSION CLARIFICATION CODE
41	SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER
45	YOUR PLAN BOOKLET LISTS THE SERVICES AND PROCEDURES COVERED BY YOUR PLAN. THE PLAN WILL ONLY PAY FOR SERVICES LISTED IN THE BOOKLET.
45	YOUR PLAN BOOKLET LISTS THE SERVICES AND PROCEDURES COVERED BY YOUR PLAN. THE PLAN WILL ONLY PAY FOR SERVICES LISTED IN THE BOOKLET.
54	NON-MATCHED PRODUCT/SERVICE ID NUMBER
56	NON-MATCHED PRESCRIBER ID
60	PRODUCT/SERVICE NOT COVERED FOR PATIENT AGE
65	PATIENT IS NOT COVERED
66	NOT COVERED UNDER MEDICAL PLAN--TO BE PAID AS 'HRA ONLY' SERVICE
70	PRODUCT/SERVICE NOT COVERED - PLAN/BENEFIT EXCLUSION
71	PRESCRIBER ID IS NOT COVERED
73	ADDITIONAL FILLS ARE NOT COVERED
75	PRIOR AUTHORIZATION REQUIRED
76	PLAN LIMITATIONS EXCEEDED
77	DISCONTINUED PRODUCT/SERVICE ID NUMBER
78	COST EXCEEDS MAXIMUM
79	FILL TOO SOON
81	CLAIM TOO OLD
81	CLAIM TOO OLD
83	DUPLICATE PAID/CAPTURED CLAIM
85	CLAIM NOT PROCESSED
88	DUR REJECT ERROR
212	HEALTH CARE PROFESSIONAL: YOU SUBMITTED THIS CLAIM TO THE INCORRECT ADDRESS. WE HAVE FORWARDED IT TO AMERICAN SPECIALTY HEALTH FOR PROCESSING.
320	CHARGES FOR TREATMENT OF INTENTIONALLY SELF-INFLICTED INJURY OR TREATMENT OF CONDITIONS RESULTING FROM OR IN ANY WAY RELATED TO THAT INJURY ARE NOT COVERED UNDER YOUR PLAN.
348	THIS AMOUNT WAS PREVIOUSLY PAID UNDER A DIFFERENT CLAIM NUMBER.
606	BRAND DRUG/SPECIFIC LABELER CODE REQUIRED
816	PHARMACY BENEFIT EXCLUSION, MAY BE COVERED UNDER PATIENT'S MEDICAL BENEFIT
895	ALLOWED NUMBER OF OVERRIDES EXHAUSTED
1000	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE PRE- ADMISSION REVIEW PROCEDURES OUTLINED IN THE PLAN WERE NOT FOLLOWED. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRE-CERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE PROVIDER IS PROHIBITED FROM BILLING THE PATIENT FOR THIS AMOUNT. IF YOU HAVE ALREADY PAID THIS AMOUNT, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.
1005	PROVIDER: THESE BENEFITS WERE REDUCED DUE TO FAILURE TO OBTAIN PRE-CERTIFICATION APPROVAL AS OUTLINED IN THE PLAN. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRE-CERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE PROVIDER IS PROHIBITED FROM BILLING THE PATIENT FOR THIS AMOUNT. CUSTOMER: IF YOU HAVE ALREADY PAID THIS AMOUNT, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.
1046	THIS CHARGE IS DENIED AS THE MODIFIER SUBMITTED WITH THE PROCEDURE CODE IS INAPPROPRIATE ACCORDING TO CPT GUIDELINES. A CORRECTED CLAIM MAY BE SUBMITTED ALONG WITH A COPY OF THIS EOP TO THE ABOVE ADDRESS. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1049	THIS CHARGE IS DENIED AS THERE IS A CONFLICT WITH EITHER THE PROCEDURE CODE AND PLACE OF SERVICE, THE DIAGNOSIS AND PROCEDURE CODE, OR PROCEDURE IS INAPPROPRIATE FOR AN OUTPATIENT SETTING. PLEASE VERIFY THE PROCEDURE AND/OR PLACE OF SERVICE AND FORWARD A CORRECTED CLAIM WITH THIS EOP TO THE ABOVE ADDRESS. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS
1053	THIS CHARGE IS DENIED. THE PLAN HAS ALREADY PROCESSED A FACILITY CHARGE FOR THIS SERVICE. IT NEEDS TO BE SUBMITTED GLOBALLY ON A HCFA 1500. SEND A CORRECTED STATEMENT WITH A COPY OF THIS EOP TO THE ADDRESS ABOVE. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1091	ZERO DOLLARS BILLED; NO PAYMENT DUE.
1221	MISSING SEMI-PRIVATE ROOM RATE - WE HAVE RECEIVED YOUR CLAIM FOR SERVICES WITH A MISSING SEMI-PRIVATE ROOM RATE. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE SEMI-PRIVATE ROOM RATE AND SEND IT WITH A COPY OF THIS EOP TO THE ABOVE ADDRESS. AFTER THIS INFORMATION IS RECEIVED, THE CLAIM WILL BE PROCESSED IN ACCORDANCE WITH THE PLAN'S BENEFIT PROVISIONS. IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.

1223	SERVICES ARE REDUCED OR DENIED FOR NO BEHAVIORAL HEALTH AUTHORIZATION ON FILE. QUESTIONS SHOULD BE DIRECTED TO CIGNA HEALTHCARE MEMBER SERVICES DEPARTMENT INDICATED ON THE BACK OF THE MEMBER S ID CARD. SUBMIT APPEAL INFORMATION TO EVERNORTH BEHAVIORAL HEALTH, APPEALS, P. O. BOX 188064, CHATTANOOGA, TN 37422.
1224	THIS CHARGE IS DENIED. THE PROCEDURE CODE SUBMITTED DOES NOT DESCRIBE THE PROCEDURE NOTED IN THE OPERATIVE REPORT OR OFFICE NOTES. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1244	CODE FOR DOCUMENTATION PURPOSES ONLY. NO SEPARATE REIMBURSEMENT WARRANTED. NOT PAID. DO NOT BILL MEMBER.
1274	OUR RECORDS DO NOT REFLECT AN AUTHORIZATION ON FILE AND ADDITIONAL INFORMATION FROM THE HEALTH CAREPROVIDER IS NEEDED TO REVIEW THE CLAIM FOR MEDICAL NECESSITY. PLEASE SUBMIT FACILITY RECORDS, OFFICE NOTES, AND HISTORY, PHYSICAL & DIAGNOSTIC REPORTS TO: CIGNA HEALTHSOLUTIONS, PO BOX 188064, CHATTANOOGA, TN 37422. IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.
1285	THIS CHARGE IS DENIED BECAUSE THE IMMUNIZATION WAS SUPPLIED BY YOUR STATE. PLEASE CONTACT YOUR STATE FOR INFORMATION. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1317	MUTUALLY EXCLUSIVE - ONE OF THE BILLED PROCEDURES HAS BEEN DENIED BECAUSE IT IS NOT TYPICALLY PERFORMED ON THE SAME DATE OF SERVICE AS THE OTHER BILLED PROCEDURES THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1329	THIS CHARGE IS DENIED BECAUSE OF EITHER A MISSING NPI, ATTENDING/RENDERING PHYSICIAN NAME, OR CREDENTIALS. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THIS INFORMATION AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1330	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID CPT/HCPCS CODE(S). PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE CPT/HCPCS CODE(S) AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT
1331	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID DAYS OR UNITS. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THIS INFORMATION AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1335	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID DATE(S) OF SERVICE. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE DATE(S) OF SERVICE AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1336	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID ICD DIAGNOSIS CODE(S). PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE ICD DIAGNOSIS CODE(S) AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1337	THIS CHARGE IS DENIED BECAUSE OF AN INVALID DIAGNOSIS OR PROCEDURE CODE WITH PATIENT'S AGE AND/OR GENDER PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE DIAGNOSIS OR PROCEDURE CODE FOR THIS PATIENT'S AGE AND/OR GENDER AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS
1339	THIS CHARGE IS DENIED BECAUSE OF AN INCOMPLETE BILLING. PLEASE RE-SUBMIT A CORRECTED CLAIM IDENTIFYING ALL PAGES OF THE BILL AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS
1340	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID MODIFIER. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE CORRECT MODIFIER AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1342	THIS CHARGE IS DENIED BECAUSE AN OUTPATIENT INTERIM BILL HAS BEEN RECEIVED. PLEASE RE-SUBMIT A COMPLETE UB92 FOR THIS SAME DATE OF SERVICE AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1343	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID PATIENT STATUS CODE. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE PATIENT STATUS CODE AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1344	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID PLACE OF SERVICE CODE. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE PLACE OF SERVICE CODE AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1346	THIS CHARGE IS DENIED BECAUSE OF A MISSING OR INVALID TYPE OF BILL. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE APPROPRIATE TYPE OF BILL CODE AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1363	THIS CHARGE IS DENIED BECAUSE OF A MISSING INVOICE COST. PLEASE RE-SUBMIT A CORRECTED CLAIM THAT INCLUDES THE INVOICE COST AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS
1365	THIS CHARGE IS DENIED BECAUSE THE PROVIDER MUST SUBMIT THE LAB SERVICE DIRECTLY TO JOINT VENTURE HOSPITAL (JVHL). THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1366	THIS CHARGE IS DENIED BECAUSE OF THE PROVIDER'S INCORRECT NAME, TAX IDENTIFICATION NUMBER/HPFIN COMBINATION. PLEASE RE-SUBMIT A CORRECTED CLAIM WITH THE CORRECT PROVIDER'S NAME/TIN/HPFIN COMBINATION AND SEND IT TO THE CLAIM ADDRESS INDICATED ON THE BACK OF THE MEMBER'S ID CARD. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1373	AFTER REVIEW OF THE MEDICAL RECORDS SUBMITTED, THESE CHARGES ARE NOT BEING CONSIDERED BECAUSE THEY WERE NOT DOCUMENTED IN THE PROVIDER'S RECORDS. THE PATIENT IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1487	MEDICAL DIRECTOR DECISION TO DENY OR PARTIALLY DENY COVERAGE AS NOT MEDICALLY NECESSARY. AN EXPLANATION WAS SENT IN A SEPARATE LETTER. THE PATIENT IS NOT RESPONSIBLE FOR DENIED CHARGES.
1494	THIS SERVICE IS NOT COVERED BECAUSE IT IS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN FOR ALL INDICATIONS.
1501	ON THE CLAIM SUBMITTED, THE SERVICES AND/OR UNITS BILLED DO NOT MATCH THOSE THAT CIGNA APPROVED. THE CUSTOMER IS RESPONSIBLE TO PAY THIS AMOUNT.

1513	HEALTH CARE PROFESSIONAL: WE CANNOT PAY THIS CLAIM BECAUSE THE MEDICAL DIRECTOR HAS DETERMIED THAT THE SERVICE IS NOT MEDICALLY NECESSARY. A DETAILED EXPLNATION WILL BE SENT SEPARATELY. DO NOT BILL THE PATIENT. SEND APPEAL REQUESTS TO MEDSOLUTIONS, INC AT 730 COOL SPRINGS BOULEVANRD, SUTIE 800, FRANKLIN, TENNESSEE 37067
1514	YOU DID NOT REQUEST APPROVAL FOR THESE SERVICES PRIOR TO THE SERVICES BEING PERFORMED. HOWEVER, WE REVIEWED THE RELATED DOCUMENTATION AND FOUND NO REASON TO MAKE A PAYMENT EXCEPTION IN THIS CASE. YOU CAN T BILL THE PATIENT. PLEASE SEND APPEAL REQUESTS TO MEDSOLUTIONS AT 730 COOL SPRINGS BOULEVARD, SUITE 800, FRANKLIN, TENNESSEE 37067.
1532	THIS CHARGE IS DENIED. THE PROVIDER'S SPECIALTY DOES NOT ALLOW BILLING FOR THIS PROCEDURE. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1543	PAYMENT FOR THIS SERVICE IS DENIED. THE FREQUENCY LIMITATION SET BY THE PLAN'S PAYMENT POLICY FOR THIS CODE HAS BEEN EXCEEDED. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1544	THIS CHARGE IS DENIED AS THE UNITS SUBMITTED HAVE EXCEEDED THE LIMIT SET BY THE PLAN'S PAYMENT POLICY. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1545	THIS EVALUATION & MANAGEMENT PROCEDURE IS DENIED. ANOTHER E&M PROCEDURE HAS ALREADY BEEN SUBMITTED FOR THIS MEMBER FOR THIS DATE OF SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1550	THIS CHARGE HAS BEEN DENIED AS THE MODIFIER SUBMITTED IS INAPPROPRIATE FOR THE PROCEDURE CODE BILLED. A CORRECTED CLAIM MAY BE SUBMITTED.
1552	THIS CHARGE IS DENIED. THE ADD-ON PROCEDURE CODE WAS DENIED BECAUSE THE CORRESPONDING PRIMARY PROCEDURE CODE WAS NOT PAID OR WAS NOT IDENTIFIED ON THE CLAIM. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1554	PAYMENT FOR THIS SERVICE IS DENIED. THIS PROCEDURE IS MUTUALLY EXCLUSIVE OF ANOTHER PROCEDURE BILLED FOR THE SAME DATE OF SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1555	THIS CHARGE IS DENIED. THE PROCEDURE DOES NOT REQUIRE THE SERVICES OF AN ASSISTANT SURGEON. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1556	THIS CHARGE IS DENIED. PAYMENT FOR THIS SERVICE IS INCLUDED IN THE PRIMARY PROCEDURE. THIS PROCEDURE IS CONSIDERED AN "INCIDENT TO SERVICE". THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1563	THIS CHARGE IS DENIED. THE PRIMARY PROCEDURE, REQUIRED FOR THIS CODE, WAS NOT SUBMITTED OR HAS BEEN DENIED. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1568	THIS CHARGE IS DENIED. THE PROCEDURE CODE SUBMITTED WAS INAPPROPRIATELY CODED BASED ON THE INFORMATION INDICATED ON THE CLAIM AND THE PLAN'S PAYMENT POLICY. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1573	THIS CHARGE IS DENIED. THE PROCEDURE, AS DEFINED BY CPT-4, IS BILATERAL IN NATURE. MODIFIER 50 IS NOT APPROPRIATE TO BE BILLED WITH THIS PROCEDURE. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1574	THIS CHARGE HAS BEEN DENIED. THE PLACE OF SERVICE INDICATED IS NOT APPROPRIATE FOR THIS PROCEDURE. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1576	THIS CHARGE IS DENIED. THE PROCEDURE HAS BEEN SUBMITTED AS A TECHNICAL COMPONENT AND IS THEREFORE NOT PAYABLE FOR THE PLACE OF SERVICE INDICATED ON THE CLAIM. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1578	THIS CLAIM IS DENIED. THE DIAGNOSIS IS INAPPROPRIATELY CODED PER ICD CODING GUIDELINES. SUBMIT A CORRECTED CLAIM. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.
1599	BASED ON THE INFORMATION WE HAVE AVAILABLE, THE SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
1600	BASED ON THE INFORMATION WE HAVE AVAILABLE, THE SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
1603	HEALTH CARE PROFESSIONAL: WE DENIED THIS CHARGE BECAUSE THE ICD DIAGNOSIS/PROCEDURE CODE USED IS NOT CURRENTLY VALID. PLEASE UPDATE THE CLAIM WITH THE APPROPRIATE CODE AND SEND IT TO THE ADDRESS ON THE BACK OF THE PATIENT S ID CARD.
1604	HEALTH CARE PROFESSIONAL: YOU DID NOT OBTAIN THE PRECERTIFICATION FOR THIS PROCEDURE CODE THAT IS REQUIRED BY THE CIGNA RADIATION THERAPY PROGRAM. IF YOU HAVE QUESTIONS PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1605	HEALTH CARE PROFESSIONAL: THE APPROVED QUANTITIES FOR THIS PROCEDURE HAVE ALREADY BEEN PROCESSED FOR THIS PATIENT. PER THE CIGNA RADIATION THERAPY PROGRAM TREATMENT PLAN, THERE ARE NO QUANTITIES REMAINING FOR THIS PROCEDURE. IF YOU HAVE QUESTIONS, PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1606	HEALTH CARE PROFESSIONAL: CIGNA'S RADIATION THERAPY PROGRAM ALLOWS THIS PROCEDURE CODE TO BE BILLED ONLY ONCE PER TREATMENT DAY. IF YOU HAVE QUESTIONS, PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1609	HEALTH CARE PROFESSIONAL: CIGNA'S RADIATION THERAPY PROGRAM DOES NOT ALLOW THIS PROCEDURE TO BE BILLED WITH OTHER PROCEDURES FOR THE SAME DATE OF SERVICE. IF YOU HAVE QUESTIONS, PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1611	HEALTH CARE PROFESSIONAL: CIGNA'S RADIATION THERAPY PROGRAM ALLOWS THIS PROCEDURE ONLY ONCE PER TREATMENT COURSE. IF YOU HAVE QUESTIONS, PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1614	HEALTH CARE PROFESSIONAL: THE DATE OF SERVICE IS NOT WITHIN THE APPROVED CIGNA RADIATION THERAPY PROGRAM TREATMENT PLAN DATES. IF YOU HAVE QUESTIONS, PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY 12449.
1637	PROVIDER: WE ARE UNABLE TO DETERMINE IF THE SERVICES PERFORMED ARE PART OF A PROGRAM OR IF THEY ARE INDIVIDUAL SERVICES. PLEASE PROVIDE THE CORRECT REVENUE/PROCEDURE CODE(S) AND A BRIEF DESCRIPTION OF THE SERVICES BEING PERFORMED. PLEASE SUBMIT TO: CIGNA HEALTHSOLUTIONS, PO BOX 188064 CHATTANOOGA, TN 37422. IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.

1647	HEALTH CARE PROFESSIONAL: YOUR CLAIM WAS RECEIVED WITH A MISSING OR INVALID SERVICE CODE BASED ON OUR REIMBURSEMENT POLICY. PLEASE CORRECT THE INFORMATION AND RE-SUBMIT THE CLAIM, ALONG WITH A COPY OF THIS EOP, TO THE CLAIM ADDRESS ON THE BACK OF THE PATIENT'S ID CARD. IF WE DON T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
1648	HEALTH CARE PROFESSIONAL: YOUR CLAIM WAS RECEIVED WITH A MISSING OR INVALID SERVICE CODE BASED ON OUR REIMBURSEMENT POLICY. PLEASE CORRECT THE INFORMATION AND RE-SUBMIT THE CLAIM, ALONG WITH A COPY OF THIS EOP, TO THE CLAIM ADDRESS ON THE BACK OF THE PATIENT'S ID CARD. IF WE DON T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
1649	HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
1650	HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
1676	THIS PROCEDURE REQUIRES EITHER AN INVOICE FOR IMMUNOLOGY, OR A DESCRIPTION OF THE SERVICES PROVIDED IF ANOTHER PROCEDURE CODE(S) IS NOT APPLICABLE. TO RECEIVE PAYMENT, PLEASE RESUBMIT THE CLAIM WITH THIS INFORMATION THROUGH THE PROVIDER PAYMENT DISPUTE PROCESS. PATIENT NOT RESPONSIBLE FOR PAYMENT.
1770	THIS SERVICE OR AMOUNT IS NOT COVERED BY MEDICARE. YOUR CIGNA PLAN DOESN T PAY FOR EXPENSES NOT APPROVED BY MEDICARE.
1778	THIS SERVICE HAS BEEN DENIED. PAYMENT FOR THIS CHARGE IS INCLUDED IN THE FACILITY PAYMENT.
1778	HIS SERVICE HAS BEEN DENIED. PAYMENT FOR THIS CHARGE IS INCLUDED IN THE FACILITY PAYMENT.
1785	HEALTH CARE PROFESSIONAL: THE PROCEDURE CODE SUBMITTED IS NOT CONSIDERED MEDICALLY NECESSARY ACCORDING TO THE APPROVED PERCERTIFICATION ON FILE. IF YOU HAVE QUESTIONS PLEASE CALL 866.668.9250. PLEASE SEND APPEAL REQUESTS TO CIGNA RADIATION THERAPY PROGRAM AT P.O. BOX 698, LAKE KATRINE, NY, 12449.
1802	THE SERVICES BILLED WERE NOT THE SERVICES AUTHORIZED AND THE PATIENT CAN'T BE BILLED FOR THIS AMOUNT. CALL THE NUMBER ON THE CUSTOMER'S CIGNA ID CARD IF YOU HAVE QUESTIONS. YOU MAY SUBMIT APPEAL INFORMATION TO EVERNORTH BEHAVIORAL HEALTH, APPEALS, P. O. BOX 188064, CHATTANOOGA, TN 37422.
1808	THE SERVICES BILLED WERE NOT THE SERVICES AUTHORIZED. CALL THE NUMBER ON THE CUSTOMER'S CIGNA ID CARD IF YOU HAVE QUESTIONS. YOU MAY SUBMIT APPEAL INFORMATION TO EVERNORTH BEHAVIORAL HEALTH, APPEALS, P. O. BOX 188064, CHATTANOOGA,
1839	HEALTH CARE FACILITY: OCE62: THE CODE NOT APPROPRIATE FOR APC BILLING. AN ALTERNATE CODE MAY BE AVAILABLE.
1879	HEALTH CARE FACILITY: PSI B: THE CODE IS NOT APPROPRIATE FOR APC BILLING. AN ALTERNATE CODE MAY BE AVAILABLE.
1880	HEALTH CARE FACILITY: PSI C: THIS SERVICE DEEMED INPATIENT ONLY UNDER APC.
1895	EXPENSES FOR SHORT TERM REHABILITATIVE SERVICES ARE NOT COVERED FOR THIS CONDITION. PLEASE REFER TO THE SHORT TERM REHABILITATIVE SERVICES SECTION OF YOUR PLAN BOOKLET.
1898	HEALTH CARE FACILITY: YY: THIS SERVICE IS NOT REIMBURSABLE PER YOUR CONTRACT.
1899	EXPENSES FOR MENTAL HEALTH SERVICES ARE NOT COVERED UNDER YOUR PLAN. PLEASE REFER TO YOUR PLAN BOOKLET.
1908	BENEFITS WERE REDUCED DUE TO FAILURE TO COMPLY WITH PRE-CERTIFICATION RECOMMENDATIONS. SEND APPEALS TO EVICORE, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067.
1928	HEALTH CARE PROFESSIONAL: YOUR CLAIM WAS RECEIVED WITH A MISSING CPT/HCPCS CODE FOR THE REVENUE CODE SUBMITTED BASED ON OUR REIMBURSEMENT POLICY. PLEASE CORRECT THE INFORMATION AND RE-SUBMIT THE CLAIM, ALONG WITH A COPY OF THIS EOP, TO THE CLAIM ADDRESS ON THE BACK OF THE PATIENT'S ID CARD. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
1934	CHARGES FOR MISSED AND/OR CANCELLED APPOINTMENTS ARE NOT COVERED BY YOUR PLAN.
1943	EXCESS UNITS ARE DENIED. PLEASE SUBMIT A CORRECTED CLAIM WITH THE JW MODIFIER IF DENIED UNITS ARE DUE TO WASTE. CUSTOMER IS NOT LIABLE.
1954	THIS CODE IS ASSOCIATED WITH A PRIMARY SERVICE THAT WAS PREVIOUSLY DENIED. VISIT CIGNAFORHCP.COM FOR A COPY OF OUR REIMBURSEMENT POLICIES.
1954	THIS CODE IS ASSOCIATED WITH A PRIMARY SERVICE THAT WAS PREVIOUSLY DENIED. VISIT CIGNAFORHCP.COM FOR A COPY OF OUR REIMBURSEMENT POLICIES.
1957	THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO AN INJURY OR ILLNESS THAT HAPPENED AT YOUR WORKPLACE.
1957	THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO AN INJURY OR ILLNESS THAT HAPPENED AT YOUR WORKPLACE.
1958	THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO A SERVICE THAT YOUR PLAN DOESN'T COVER. PLEASE REFER TO YOUR PLAN
1966	THE REIMBURSEMENT TO THE PROVIDER FOR EVALUATION & MANAGEMENT (E&M) SERVICES IS INCLUDED IN THE REIMBURSEMENT TO THE HEATHL CARE PROFESSIONAL AND IS NOT SEPARATELY REIMBURSED.
1966	THE REIMBURSEMENT TO THE PROVIDER FOR EVALUATION & MANAGEMENT (E&M) SERVICES IS INCLUDED IN THE REIMBURSEMENT TO THE HEATHL CARE PROFESSIONAL AND IS NOT SEPARATELY REIMBURSED.
1976	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE SERVICES RENDERED EXCEEDED THE AUTHORIZATION. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRECERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE CUSTOMER IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1976	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE SERVICES RENDERED EXCEEDED THE AUTHORIZATION. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRECERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE CUSTOMER IS NOT RESPONSIBLE TO PAY THIS AMOUNT.
1977	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE SERVICES RENDERED EXCEEDED THE AUTHORIZATION. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRECERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE CUSTOMER IS RESPONSIBLE TO PAY THIS AMOUNT.
1977	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE SERVICES RENDERED EXCEEDED THE AUTHORIZATION. THIS AMOUNT REPRESENTS DOLLARS ASSOCIATED WITH THE PRECERTIFICATION NOT OBTAINED FOR THE SERVICES RENDERED. THE CUSTOMER IS RESPONSIBLE TO PAY THIS AMOUNT.

1983	PLEASE SUBMIT A CORRECTED CLAIM BECAUSE THE REVENUE CODE(S) BILLED DOES NOT CORRESPOND WITH THE NARRATIVE OR DOCUMENTATION DESCRIPTION RECEIVED FOR THE SERVICES PERFORMED. PLEASE SUBMIT TO: EVERNORTH BEHAVIORAL HEALTH, P.O. BOX 188064, CHATTANOOGA, TN 37422. IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.
1985	THE CLAIM HAS A GENDER/PROCEDURE CODE MISMATCH. IF THE GENDER AND PROCEDURE CODE ARE CORRECT, LET US KNOW AND WE LL REPROCESS THE CLAIM.
!'	HEALTH CARE FACILITY: EDIT 015: THE ALLOWED UNITS REPRESENT THE MEDICALLY UNLIKELY EDIT LIMIT.
!	HEALTH CARE FACILITY: NCCI 111: THESE SERVICES ARE NOT TYPICALLY PERFORMED TOGETHER.
@A	HEALTH CARE FACILITY: PSI N: PACKAGED/INCIDENTAL SERVICES ARE NOT SEPARATELY PAYABLE.
@T	HEALTH CARE FACILITY: N1: PACKAGED/ INCIDENTAL SERVICES ARE NOT SEPARATELY PAYABLE.
@X	HEALTH CARE FACILITY: YY: THIS SERVICE IS NOT REIMBURSABLE PER YOUR CONTRACT.
`E	UNITS FOR THIS AND PREVIOUSLY SUBMITTED CLAIM(S) EXCEED THE MAXIMUM UNITS ALLOWED PER DATE OF SERVICE. THE SUBMITTED UNITS ARE DISALLOWED.
`J	THE SUPPLY IS NOT SEPARATELY REIMBURSED IN ADDITION TO THE SURGICAL SERVICE THAT WAS SUBMITTED ON THE SAME DATE OF
`O	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS A COMPONENT OF ANOTHER PROCEDURE OR SERVICE THAT WAS BILLED ON THE SAME DATE OF SERVICE.
`P	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS A COMPONENT OF ANOTHER PROCEDURE OR SERVICE THAT WAS SUBMITTED ON A PREVIOUS CLAIM.
`Q	THE UNLISTED CODE IS DISALLOWED BECAUSE A DESCRIPTION OF THE SERVICE IS REQUIRED BUT WAS NOT RECEIVED.
`V	MODIFIER 25 SHOULD BE ADDED TO THE PROBLEM-BASED VISIT AS PER OUR REIMBURSEMENT POLICY.
`Z	HEALTH CARE PROFESSIONAL: THE SUBMITTED PROCEDURE CODE IS DISALLOWED BECAUSE REIMBURSEMENT IS INCLUDED IN THE PRIMARY SERVICE.
~~	THIS SERVICE IS DENIED. WE RECEIVED YOUR CLAIM WITH AN INAPPROPRIATE OR MISSING MODIFIER NEEDED FOR PROPER
~P	THIS CODE IS ASSOCIATED WITH A PRIMARY SERVICE THAT WAS PREVIOUSLY DENIED. VISIT CIGNAFOR HCP.COM FOR A COPY OF OUR REIMBURSEMENT POLICIES.
~Z	THE REIMBURSEMENT TO THE PROVIDER FOR EVALUATION & MANAGEMENT (E&M) SERVICES IS INCLUDED IN THE REIMBURSEMENT TO THE HEALTH CARE PROFESSIONAL AND IS NOT SEPARATELY REIMBURSED.
2C	THE ICD DX/PX CODE USED IS EXPIRED OR NOT EFFECTIVE FOR THE DATE OF SERVICE. PLEASE SUBMIT A NEW CLAIM TO THE ADDRESS ON THE PATIENT'S ID CARD.
4A	DOCTOR: YOU DID NOT OBTAIN PRECERTIFICATION FOR THIS PROCEDURE THROUGH THE CIGNA RADIATION THERAPY PROGRAM. PLEASE CALL 866.668.9250 WITH QUESTIONS.
4B	DOCTOR: NO MORE QUANTITIES ARE AVAILABLE FOR THIS PROCEDURE CODE THROUGH CIGNA'S RADIATION THERAPY PROGRAM. PLEASE CALL 866.668.9250 WITH QUESTIONS.
4C	DOCTOR: CIGNA'S RADIATION THERAPY PROGRAM ALLOWS THIS PROCEDURE CODE TO BE BILLED ONCE PER TREATMENT DAY. PLEASE CALL 866.668.9250 WITH QUESTIONS.
4O	DOCTOR: THE PROC. CODE IS NOT MEDICALLY NECESSARY PER THE PRECERT ON FILE WITH CIGNA RADIATION THERAPY PRGRM. PLEASE CALL 866.668.9250 WITH QUESTIONS.
6Z	PROVIDER NOT ELIGIBLE TO PERFORM SERVICE/DISPENSE PRODUCT
7A	PROVIDER DOES NOT MATCH AUTHORIZATION ON FILE
7M	DISCREPANCY BETWEEN OTHER COVERAGE CODE AND OTHER COVERAGE INFORMATION ON FILE
7V	DUPLICATE FILL NUMBER
7W	NUMBER OF REFILLS AUTHORIZED EXCEED ALLOWABLE REFILLS
7X	DAYS SUPPLY EXCEEDS PLAN LIMITATION
7Z	COMPOUND REQUIRES TWO OR MORE INGREDIENTS
8A	COMPOUND REQUIRES AT LEAST ONE COVERED INGREDIENT
8E	M/I DUR/PPS LEVEL OF EFFORT
8F	Your compound medication contains non covered ingredient(s)
8K	DAW CODE VALUE NOT SUPPORTED
8R	SUBMISSION CLARIFICATION CODE VALUE NOT SUPPORTED
9E	QUANTITY DOES NOT MATCH DISPENSING UNIT
9G	QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED
AA	A WRITTEN EXPLANATION OF THE REASON FOR THIS DENIAL AND YOUR RIGHT TO APPEAL WAS MAILED TO YOU UNDER SEPARATE COVER.
AG	DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE
B1	WE DO NOT REIMBURSE FOR CONSUMABLE MEDICAL SERVICES PROVIDED IN THE PHYSICIAN'S OFFICE.
BB	SERVICES ARE NOT COVERED BY THE CONTRACT. PLEASE REFER TO THE PLAN DOCUMENT.
BJ	STATE-SUPPLIED IMMUNIZATION.
BN	SERVICES NOT COVERED OUT OF NETWORK OR ARE AVAILABLE IN MEMBER'S NETWORK. PLEASE CALL MEMBER SERVICES AT THE NUMBER ON YOUR ID CARD WITH QUESTIONS.
BO	DENIED COVERED UNDER GLOBAL MA
BT	SERVICES ARE NOT COVERED BY THE MEMBER'S PLAN. PLEASE REFER TO THE PLAN DOCUMENT. CALL MEMBER SERVICES AT THE NUMBER ON YOUR ID CARD WITH QUESTIONS.
CD	INAPPROPRIATE BILLING
DU	M/I GROSS AMOUNT DUE
e04	THE CODE IS DISALLOWED. IT WAS RECEIVED AFTER THE AMERICAN MEDICAL ASSOCIATION OR CENTERS FOR MEDICARE AND MEDICAID SERVICES DELETION DATE.

e06	THE SERVICE IS DISALLOWED. THE MODIFIER AND CODE COMBINATION IS INVALID. APPEALS REQUIRE THE FACILITY NAME, ADDRESS AND TIN WHERE RENDERED.
e08	THE UNLISTED CODE IS DISALLOWED BECAUSE A DESCRIPTION OF THE SERVICE IS REQUIRED BUT WAS NOT RECEIVED.
e11	ANESTHESIA SERVICES ARE NOT WARRANTED FOR THIS PROCEDURE OR SERVICE.
e12	THE SUBMITTED PROCEDURE CODE IS DISALLOWED BECAUSE IT IS INCONSISTENT WITH THE PATIENT'S AGE.
e14	THIS PROCEDURE CODE IS DISALLOWED BECAUSE THE RELATED PRIMARY SERVICE WAS EITHER NOT BILLED OR DENIED.
e19	THE PROCEDURE CODE IS DISALLOWED BECAUSE A SURGICAL CODE WAS BILLED RATHER THAN AN ANESTHESIA CODE.
e26	ACCORDING TO CMS, THIS PROCEDURE IS ALWAYS BUNDLED WHEN BILLED WITH ANY OTHER PROCEDURE, SO THE SUBMITTED CODE IS DISALLOWED.
e27	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS INCIDENTAL TO A CODE BILLED ON THE SAME DATE OF SERVICE.
e29	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS A COMPONENT OF ANOTHER PROCEDURE OR SERVICE THAT WAS BILLED ON THE SAME DATE OF SERVICE.
E3	M/I INCENTIVE AMOUNT SUBMITTED
e31	THIS SERVICE IS NOT ALLOWED BECAUSE IT IS PART OF A CMS NCCI COLUMN 1/COLUMN 2 EDIT.
e32	THE SUPPLY IS NOT SEPARATELY REIMBURSED IN ADDITION TO THE SURGICAL SERVICE THAT WAS SUBMITTED ON THE SAME DATE OF
E5	M/I PROFESSIONAL SERVICE CODE
e73	THE QUANTITY OF UNITS BILLED EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
e81	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT SHOULD ONLY BE PERFORMED ONCE PER DATE OF SERVICE.
e82	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE THE MAXIMUM NUMBER OF UNITS THAT CAN BE PERFORMED PER DATE OF SERVICE HAS BEEN EXCEEDED.
E84	PROVIDER: INCONSISTENT WITH INDUSTRY STANDARDS, THE CPT/HCPCS CODE IS MISSING FOR THE REVENUE CODE SUBMITTED. RESUBMIT A CORRECTED CLAIM.
e96	YOUR PLAN DOES NOT PROVIDE COVERAGE FOR THESE EXPENSES.
e97	THIS CODE IS ASSOCIATED WITH A PRIMARY SERVICE THAT WAS PREVIOUSLY DENIED. VISIT CIGNAFORHCP.COM FOR A COPY OF OUR REIMBURSEMENT POLICIES.
EDL	OUR RECORDS INDICATE THIS MEMBER IS OVER THE MAXIMUM DEPENDENT AGE LIMIT.
EE	M/I COMPOUND INGREDIENT DRUG COST
ET	M/I QUANTITY PRESCRIBED
EZ	M/I PRESCRIBER ID QUALIFIER
f02	BASED ON THE INFORMATION WE HAVE AVAILABLE, SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
f16	HEALTH CARE PROFESSIONAL: THIS SERVICE CODE IS INVALID. REFER TO OUR REIMBURSEMENT POLICY ON CIGNAFORHCP.COM, AND SUBMIT A CORRECTED CLAIM.
f18	HEALTH CARE PROFESSIONAL: THE SUBMITTED PROCEDURE CODE IS DISALLOWED BECAUSE REIMBURSEMENT IS INCLUDED IN THE PRIMARY SERVICE.
f19	HEALTH CARE PROFESSIONAL: THIS SERVICE HAS BEEN DENIED. PAYMENT FOR THIS CHARGE IS INCLUDED IN THE FACILITY PAYMENT.
f21	HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
f26	HEALTH CARE PROFESSIONAL: THE SUBMITTED CODE IS DISALLOWED BECAUSE REIMBURSEMENT IS INCLUDED IN THE PRIMARY SERVICE PREVIOUSLY CONSIDERED.
f53	THE SUBMITTED CODE IS DISALLOWED AS IT IS ASSOCIATED WITH AN INJURY OR ILLNESS THAT OCCURRED IN THE WORKPLACE.
f54	FACILITY FEES FOR EVALUATION & MANAGEMENT (E & M) CARE ARE NOT SEPARATELY PAID.
g28	THE SUBMITTED CODE IS DISALLOWED DUE TO A PRIOR CLAIM. PER CMS, THE SUBMITTED CODE IS ALWAYS BUNDLED WHEN BILLED WITH ANY OTHER PROCEDURE.
g30	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS INCIDENTAL TO A CODE BILLED ON THE SAME DATE OF SERVICE FOR A PRIOR
g32	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS MUTUALLY EXCLUSIVE TO A CODE BILLED ON THE SAME DATE OF SERVICE FOR A PRIOR CLAIM.
g33	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS MUTUALLY EXCLUSIVE TO A CODE BILLED ON THE SAME DATE OF SERVICE.
g34	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS A COMPONENT OF ANOTHER PROCEDURE OR SERVICE THAT WAS SUBMITTED ON A PREVIOUS CLAIM.
g38	THIS SERVICE IS NOT ALLOWED BECAUSE IT IS PART OF A CMS NCCI COLUMN 1/COLUMN 2 EDIT THAT INCLUDES A PROCEDURE OR SERVICE ON A PRIOR CLAIM
g40	THE SUPPLY IS NOT SEPARATELY REIMBURSED IN ADDITION TO THE SURGICAL SERVICE THAT WAS PREVIOUSLY SUBMITTED.
g44	THIS PRE-OPERATIVE SRVC/MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART AN ASSOCIATED SURGICAL PROCEDURE SUBMITTED ON A SEPARATE CLAIM.
g46	THIS POST-OPERATIVE SRVC/MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF AN ASSOCIATED SURGICAL PROCEDURE SUBMITTED ON A SEPARATE CLAIM.
g75	THE QUANTITY OF UNITS ON THE CLAIM, IN ADDITION TO BILLED UNITS ON A PREVIOUSLY SUBMITTED CLAIM, EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
g80	THE COMBINED UNITS FOR THIS CLAIM AND A PREVIOUSLY SUBMITTED CLAIM EXCEED THE MAXIMUM NUMBER OF UNITS PER DATE OF
g81	THE PROCEDURE IS DISALLOWED BECAUSE THIS SERVICE OR A COMPONENT OF THIS SERVICE WAS PREVIOUSLY BILLED BY ANOTHER HEALTH CARE PROFESSIONAL.
GL	PAYMENT EXCEPTION WILL NOT BE MADE. YOU CAN'T BILL PATIENT. PLEASE SEND APPEALS TO MEDSOLUTIONS, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067.
h28	THE QUANTITY OF UNITS BILLED EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.

HD	BASED UPON THE INFORMATION REPORTED OR CONTAINED IN THE FILE, SERVICES WERE NOT RENDERED AS BILLED. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.
I-	THE CODE IS DISALLOWED DUE TO A PREVIOUSLY RECEIVED CLAIM WITH A PRIMARY SERVICE BILLED WITH A QUANTITY GREATER THAN ONE.
I;	THE SUBMITTED CONSULTATION CODE IS DISALLOWED BECAUSE A CONSULTATION CODE FOR AN OUTPATIENT STAY WAS PREVIOUSLY SUBMITTED.
I[	THE SUBMITTED CODE IS DISALLOWED DUE TO A PRIOR CLAIM. PER CMS, THE SUBMITTED CODE IS ALWAYS BUNDLED WHEN BILLED WITH ANY OTHER PROCEDURE.
I^	ANESTHESIA SERVICES ARE NOT WARRANTED FOR THIS PROCEDURE OR SERVICE.
I'	THIS PROCEDURE CODE IS DISALLOWED BECAUSE THE RELATED PRIMARY SERVICE WAS EITHER NOT BILLED OR DENIED.
I+	ACCORDING TO CMS, THIS PROCEDURE IS ALWAYS BUNDLED WHEN BILLED WITH ANY OTHER PROCEDURE, SO THE SUBMITTED CODE IS DISALLOWED.
I3	THIS POST-OPERATIVE SERVICE/MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE ASSOCIATED SURGICAL PROCEDURE SUBMITTED ON THIS CLAIM.
I5	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS INCIDENTAL TO A CODE BILLED ON THE SAME DATE OF SERVICE FOR A PRIOR
I6	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS MUTUALLY EXCLUSIVE TO A CODE BILLED ON THE SAME DATE OF SERVICE FOR A PRIOR CLAIM.
I7	CCI-THIS PROCEDURE CODE REPRESENTS SERVICES INTEGRAL TO THE MORE COMPLEX PRIMARY PROCEDURE SUBMITTED ON THIS CLAIM.
i92	THE MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE SURGICAL PROCEDURE PERFORMED ON THE SAME DATE OF SERVICE SUBMITTED ON THIS CLAIM
IC	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS INCIDENTAL TO A CODE BILLED ON THE SAME DATE OF SERVICE.
IG	THIS SERVICE IS NOT COVERED BECAUSE IT IS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN FOR ALL INDICATIONS.
IH	THIS MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE ASSOCIATED SURGICAL PROCEDURE ON THE SAME DATE OF SERVICE AND SUBMITTED ON THIS CLAIM.
II	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT IS MUTUALLY EXCLUSIVE TO A CODE BILLED ON THE SAME DATE OF SERVICE.
IM	THE SUBMITTED PROCEDURE IS DISALLOWED BECAUSE IT DOES NOT TYPICALLY REQUIRE AN ASSISTANT SURGEON.
IX	THE BILLED PROCEDURE CODE WAS DISALLOWED. A SIMILAR AND/OR MORE ACCURATE PROCEDURE CODE WAS APPLIED TO THE CLAIM FOR REIMBURSEMENT.
j16	SERVICES BILLED WITH MODIFIER TC ON A PROFESSIONAL CLAIM IN A FACILITY PLACE OF SERVICE ARE INCLUDED IN THE FACILITY REIMBURSEMENT.
J4	CODE FOR DOCUMENTATION PURPOSES ONLY. NO SEPARATE REIMBURSEMENT WARRANTED. NOT PAID. DO NOT BILL MEMBER.
j59	UNITS FOR THIS AND PREVIOUSLY SUBMITTED CLAIM(S) EXCEED THE MAXIMUM UNITS ALLOWED PER DATE OF SERVICE. THE SUBMITTED UNITS ARE DISALLOWED.
JP	SVC DENIED-NO PCP SELECTED
K-	THE SERVICE IS DISALLOWED. THE MODIFIER AND CODE COMBINATION IS INVALID. APPEALS REQUIRE THE FACILITY NAME, ADDRESS AND TIN WHERE RENDERED.
K"	THE NEW PATIENT PROCEDURE CODE SUBMITTED IS DISALLOWED. IT IS REPLACED BY AN ESTABLISHED PATIENT PROCEDURE CODE.
K#	THE PROCEDURE IS DISALLOWED BECAUSE THIS SERVICE OR A COMPONENT OF THIS SERVICE WAS PREVIOUSLY BILLED BY ANOTHER HEALTH CARE PROFESSIONAL.
K{	MODIFIER 26 IS ADDED TO THE SUBMITTED CODE DENOTING THE PROFESSIONAL COMPONENT WAS PERFORMED IN A FACILITY SETTING.
K.	HEALTH CARE PROFESSIONAL ONLY: SERVICE IS DENIED. IT S PART OF A CMS NCCI COLUMN1/COLUMN 2 EDIT THAT INCLUDES A SERVICE ON A PRIOR CLAIM.
K]	THE QUANTITY OF UNITS ON THE CLAIM, IN ADDITION TO BILLED UNITS ON A PREVIOUSLY SUBMITTED CLAIM, EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
K^	THE PROCEDURE IS DISALLOWED BECAUSE THIS SERVICE OR A COMPONENT OF THIS SERVICE WAS PREVIOUSLY BILLED BY ANOTHER HEALTH CARE PROFESSIONAL.
K_	THE QUANTITY OF UNITS BILLED EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
K{	THE QUANTITY OF UNITS BILLED EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
K	THE QUANTITY OF UNITS BILLED EXCEEDS THE MEDICALLY UNLIKELY EDIT LIMIT.
K<	HEALTH CARE PROFESSIONAL ONLY: CIGNA DOESN T ALLOW THIS SERVICE. IT S PART OF A CMS NCCI COLUMN1/COLUMN 2 EDIT.
K=	THE QUANTITY OF UNITS FOR THIS SERVICE, IN ADDITION TO BILLED UNITS ON A PRIOR CLAIM, EXCEEDS THE MEDICALLY UNLIKELY EDIT
K1	BASED ON THE INFORMATION WE HAVE AVAILABLE, THE SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
K3	HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
K4	HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.
K5	WE HAVE RECEIVED YOUR CLAIM FOR AN INVALID SERVICE CODE BASED ON OUR REIMBURSEMENT POLICY. PLEASE CORRECT THE INFORMATION AND RE-SUBMIT.
K6	WE HAVE RECEIVED YOUR CLAIM FOR AN INVALID SERVICE CODE BASED ON OUR REIMBURSEMENT POLICY. PLEASE CORRECT THE INFORMATION AND RE-SUBMIT.
KH	THIS PRE-OPERATIVE SERVICE/MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE ASSOCIATED SURGICAL PROCEDURE SUBMITTED ON THIS CLAIM.
KJ	THIS POST-OPERATIVE SERVICE/MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE ASSOCIATED SURGICAL PROCEDURE SUBMITTED ON A SEPARATE CLAIM.
KK	THE MEDICAL VISIT IS INCLUDED IN AND CONSIDERED PART OF THE SURGICAL PROCEDURE PERFORMED ON THE SAME DATE OF SERVICE SUBMITTED PREVIOUSLY.

KM	THIS PROCEDURE CODE SUBMISSION REPRESENTS MULTIPLE UNITS. REFER TO LINES BELOW FOR INDIVIDUAL UNIT DISPOSITION.
KN	THIS PROCEDURE AND ONE SUBMITTED SEPARATELY ARE CONSIDERED PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY AND SUBMITTED ON THIS CLAIM.
MO	CLAIM REVIEWED AND DENIED FOR FAILURE TO OBTAIN PRIOR AUTHORIZATION. DO NOT BILL MEMBER.
MR	PRODUCT NOT ON FORMULARY
MR2	MEMBER'S BENEFIT PLAN LIMITS PAYMENT TO MAXIMUM REIMBURSABLE CHARGE. THE PROVIDER MAY BILL THE MEMBER FOR THE
MS	HEALTH CARE PROFESSIONAL: YOU SUBMITTED THIS CLAIM TO THE INCORRECT ADDRESS. WE HAVE FORWARDED IT TO EVICORE FOR
MU	SERVICES PROVIDED BY NON-PARTICIPATING PROVIDER ARE NOT COVERED SINCE THE MEMBER'S PLAN HAS NO OUT OF NETWORK BENEFITS. MEMBER RESPONSIBLE
N17	THIS SERVICE IS NOT COVERED WHEN PERFORMED IN THIS SETTING.
N29	CLINICAL DAILY MAXIMUM EXCEEDED
OAS	THIS SERVICE IS NOT NORMALLY COVERED FOR MEMBERS IN THIS AGE RANGE
P[	HEALTH CARE PROFESSIONAL: YOU SUBMITTED THIS CLAIM TO THE INCORRECT ADDRESS. WE HAVE FORWARDED IT TO AMERICAN SPECIALTY HEALTH FOR PROCESSING.
PE	M/I REQUEST COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT
PL	HEALTH CARE PROFESSIONAL: THIS IS A NON-PAYABLE; NON-PERMITTED SERVICE PER YOUR CONTRACTUAL AGREEMENT. DO NOT BILL THE PATIENT.
PN	SERVICE NOT PAYABLE PER PROVIDER CONTRACT. DO NOT BILL MEMBER.
QS	Drug Coverage limitations
R9	VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULAE
RX	No Refills or limited refills authorized
S20	EXPENSES INCURRED PRIOR TO THE EFFECTIVE DATE OF COVERAGE ARE INELIGIBLE.
SC	THE PATIENT IS NOT A COVERED MEMBER UNDER THE PLAN
SM	WE REQUESTED INFORMATION WITH NO RESPONSE. WE MUST CLOSE OUR FILE. IF INFORMATION IS SUBMITTED, WE WILL RECONSIDER THE INITIAL CLAIM REVIEW.
SN	WE REQUESTED INFORMATION WITH NO RESPONSE. WE MUST CLOSE OUR FILE. IF INFORMATION IS SUBMITTED, WE WILL RECONSIDER THE INITIAL CLAIM REVIEW.
SS	EXPENSES INCURRED AFTER THE DATE COVERAGE TERMINATES ARE INELIGIBLE.
ST	EXPENSES INCURRED AFTER THE DATE COVERAGE TERMINATES ARE INELIGIBLE.
ST	COVERED UNDER GLOBAL FEE
SW	CLAIM NOT SUBMITTED ON TIME. YOUR CONTRACT PROHIBITS BILLING THE PATIENT. SEND PROOF OF TIMELY FILING TO ADDRESS ON ID
TF0	CLAIM NOT SUBMITTED ON TIME. IN-NETWORK HEALTH CARE PROFESSIONALS CAN'T BILL THE PATIENT. SEND PROOF OF TIMELY FILING TO ADDRESS ON ID CARD.
TF1	CLAIM NOT SUBMITTED ON TIME. IN-NETWORK HEALTH CARE PROFESSIONALS CAN'T BILL THE PATIENT. SEND PROOF OF TIMELY FILING TO ADDRESS ON ID CARD.
UM0	SERVICES WERE DISALLOWED BY UTILIZATION MANAGEMENT
UM1	UNITS EXCEED A UTILIZATION MANAGEMENT AUTHORIZATION
V01	DOCTOR: YOU DID NOT OBTAIN PRECERTIFICATION FOR THIS PROCEDURE THROUGH THE CIGNA RADIATION THERAPY PROGRAM. CALL 866.668.9250 WITH QUESTIONS
V02	DOCTOR: NO MORE QUANTITIES ARE AVAILABLE FOR THIS PROCEDURE CODE THROUGH CIGNA'S RADIATION THERAPY PRGM. CALL 866.668.9250 WITH QUESTIONS.
V06	DOCTOR THE CIGNA RADIATION THERAPY PROCEDURE CAN'T BE BILLED ON THE SAME DATE OF SERVICE AS OTHER SERVICES. CALL 866.668.9250 WITH QUESTIONS
V08	DOCTOR: CIGNA'S RADIATION THERAPY PROGRAM ALLOWS THIS PROCEDURE ONLY ONCE PER TREATMENT COURSE. CALL 866.668.9250 WITH QUESTIONS.
V11	DOCTOR: THE DATE OF SERVICE IS NOT WITHIN THE APPROVED CIGNA RADIATION THERAPY PRGM TREATMENT PLAN DATE. CALL 866.668.9252 WITH QUESTIONS.
V13	THE PROC. CODE IS NOT MEDICALLY NECESSARY PER THE PRECERT ON FILE WITH CIGNA RADIATION THERAPY PRGRM. CALL 866.668.9250 WITH QUESTIONS.
VBM	THE HEALTHCARE PROFESSIONAL PROVIDED INSUFFICIENT INFORMATION TO CONSIDER THESE CHARGES.
VBX	THE PROCEDURE IS DISALLOWED EITHER BECAUSE IT IS A COMPONENT OR DUPLICATE OF THE GLOBAL OBSTETRICAL PACKAGE CODE PREVIOUSLY SUBMITTED.
VCI	DRUG KITS WITH BOTH DRUGS AND SUPPLIES ARE NOT COVERED. THE DRUG(S) SHOULD BE BILLED SEPARATELY WITH THE CODING FOR THE DRUG(S) ALONE.
VFB	THE SUBMITTED PROCEDURE CODE IS DISALLOWED BECAUSE IT EXCEEDS THE RECOMMENDED LIMIT AS OUTLINED IN OUR COVERAGE OR REIMBURSEMENT POLICY.
VGD	NO SEPARATE REIMBURSEMENT WARRANTED. NOT PAID. DO NOT BILL MEMBER.
VGE	THE CLAIM HAS A GENDER/PROCEDURE CODE MISMATCH. IF THE GENDER AND PROCEDURE CODE ARE CORRECT, LET US KNOW AND WE LL REPROCESS THE CLAIM.
VL4	SERVICE NOT COVERED DOES NOT MEET YOUR PLAN'S DEFINITION FOR MEDICALLY NECESSARY CARE OR TREATMENT.
VNB	OUR RECORDS DO NOT INDICATE YOUR NEWBORN CHILD IS ENROLLED FOR COVERAGE. PLEASE CONTACT YOUR EMPLOYER IF THIS INFORMATION IS INCORRECT.
VNJ	HEALTH CARE PROFESSIONAL: THIS SERVICE IS MUTUALLY EXCLUSIVE TO ANOTHER CODE BILLED ON A SEPARATE CLAIM FOR THE SAME DATE OF SERVICE.

VNK	HEALTH CARE PROFESSIONAL: THE SERVICE THIS PROCEDURE CODE REPRESENTS IS MUTUALLY EXCLUSIVE TO ANOTHER PROCEDURE CODE ON THIS CLAIM.
VQD	SUBMITTED PROCEDURE IS DISALLOWED, INCIDENTAL TO OTHER PROCEDURES.
VQS	THIS SERVICE IS NOT ALLOWED, BECAUSE IT HAS BEEN UNBUNDLED FROM AN ALL-INCLUSIVE SERVICE. THE PATIENT ISN T RESPONSIBLE FOR THIS AMOUNT.
VQT	THIS SERVICE IS NOT ALLOWED, BECAUSE IT HAS BEEN UNBUNDLED FROM AN ALL-INCLUSIVE SERVICE. THE PATIENT ISN T RESPONSIBLE FOR THIS AMOUNT.
VTF	CLAIM NOT SUBMITTED ON TIME. IN-NETWORK HEALTH CARE PROFESSIONALS CAN'T BILL THE PATIENT. SEND PROOF OF TIMELY FILING TO ADDRESS ON ID CARD.
VTP	THE CODE IS DISALLOWED. IT WAS RECEIVED AFTER THE AMERICAN MEDICAL ASSOCIATION OR CENTERS FOR MEDICARE AND MEDICAID SERVICES DELETION DATE.
VUX	THIS SERVICE IS DENIED. WE RECEIVED YOUR CLAIM WITH AN INAPPROPRIATE OR MISSING MODIFIER NEEDED FOR PROPER
VVB	THIS ISN'T A COVERED EXPENSE, BASED ON THE INFORMATION WE RECEIVED RELATED TO THIS CLAIM.
VWC	NO BENEFIT IS PAYABLE FOR AN ILLNESS OR INJURY FOR WHICH A MEMBER CAN RECEIVE BENEFITS UNDER WORKERS' COMPENSATION OR SIMILAR LAWS.
X04	MEMBER NOT ELIGIBLE FOR COVERAGE.
XAB	RECORDS SHOW THE PATIENT ASSISTANCE PROGRAM PROVIDED THIS DRUG. PLEASE PROVIDE AN INVOICE FROM THE MANUFACTURER THAT SHOWS YOU WERE BILLED.
XAM	MAXIMUM BENEFITS FOR DURABLE MEDICAL EQUIPMENT HAVE NOW BEEN ISSUED FOR THIS EQUIPMENT/SUPPLY.
XB2	SERVICES RENDERED BY UNLICENSED PROVIDERS OR ENTITIES ARE NOT COVERED UNDER BENEFIT PLANS ADMINISTERED OR UNDERWRITTEN BY CIGNA.
XB7	SERVICES RENDERED BY UNLICENSED PROVIDERS OR ENTITIES ARE NOT COVERED UNDER BENEFIT PLANS ADMINISTERED OR UNDERWRITTEN BY CIGNA.
XBD	INCOMPLETE CLAIM - INVALID DIAGNOSIS CODE. PLEASE CORRECT AND RESUBMIT WITH THIS CLAIM.
XC1	BASED ON THE INFORMATION WE HAVE AVAILABLE, SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
XCW	PRECERTIFICATION IS NOT FOUND. SUPPORTING DOCUMENTATION NEEDED FROM THE SURGEON FOR CONSIDERATION BASED ON THE PLAN S BENEFIT PROVISIONS.
XDD	THESE ARE DUPLICATE CHARGES. PREVIOUS CHARGES APPLIED TO THE DEDUCTIBLE OR CO-PAY.
XE1	BASED ON THE INFORMATION WE HAVE AVAILABLE, SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.
XEP	EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES ARE NOT COVERED AS DEFINED BY YOUR PLAN.
XFF	WHEN CIGNA ADMINISTERS OR UNDERWRITES A PLAN, WE DON'T COVER CHARGES NOT BILLED TO YOU OR THAT YOU AREN'T REQUIRED TO
XFG	WHEN CIGNA ADMINISTERS OR UNDERWRITES A PLAN, WE DON'T COVER CHARGES NOT BILLED TO YOU OR THAT YOU AREN'T REQUIRED TO
XJA	EQUIPMENT/SUPPLIES DO NOT APPEAR MEDICALLY NECESSARY FOR THE DIAGNOSIS
XJH	THIS PROCEDURE IS CONSIDERED INCIDENTAL TO OR A PART OF THE PRIMARY PROCEDURE.
XJK	DUPLICATE PROCEDURES DENIAL. PROVIDER, PLEASE SUBMIT OFFICE NOTES IF SEPARATE VISITS OCCURRED IN THE SAME DAY.
XJM	SERVICE EXCEEDS AUTHORIZED LIMITS OR WAS NOT AUTHORIZED.
XMG	HEALTH CARE PROFESSIONAL:BASED ON INFORMATION IN OUR FILE FOR THIS CLAIM, THE SERVICES YOU PROVIDED DON'T MATCH THE SERVICES YOU BILLED
XMH	HEALTH CARE PROFESSIONAL: BASED ON INFORMATION IN OUR FILE FOR THIS CLAIM, THE SERVICES YOU PROVIDED DON'T MATCH THE SERVICES YOU BILLED.
XMR	YOUR PLAN LIMITS EXPENSES FOR ROOM AND BOARD. PLEASE SEE YOUR PLAN DOCUMENTS FOR MORE DETAILS.
XQW	INAPPROPRIATE BILLING - PLEASE BILL PER THE LIFESOURCE CONTRACT AGREEMENT.
XS1	THIS SERVICE IS NOT A COVERED EXPENSE AS DEFINED BY YOUR PLAN.
XS2	SERVICE NOT COVERED DOES NOT MEET YOUR PLAN'S DEFINITION FOR MEDICALLY NECESSARY CARE OR TREATMENT.
XS5	THIS SERVICE IS NOT COVERED WHEN RENDERED BY A NON-NETWORK PROVIDER AS SHOWN IN YOUR PLAN'S BENEFITS SCHEDULE
XS9	THIS SERVICE IS NOT COVERED WHEN RENDERED BY A NON-NETWORK PROVIDER AS SHOWN IN YOUR PLAN'S BENEFITS SCHEDULE.
XSJ	THERE IS INSUFFICIENT INFORMATION TO CONSIDER THESE CHARGES. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.
XSW	THIS SERVICE IS NOT A COVERED EXPENSE AS DEFINED BY YOUR PLAN.
XT1	THIS SERVICE IS NOT A COVERED EXPENSE AS DEFINED BY YOUR PLAN.
XT2	THIS SERVICE IS NOT COVERED AS BILLED. PLEASE RESUBMIT WITH A VALID CPT4 CODE.
XU0	PRE-TREATMENT AUTHORIZATION REQUIRED BY THE PLAN WAS OBTAINED BUT NOT FOLLOWED. MEMBER NOT LIABLE FOR NOT COVERED AMOUNT.
XU1	SERVICE NOT COVERED WAS NOT PRE-AUTHORIZED AS REQUIRED BY THE PLAN OR AUTHORIZATION WAS DENIED. MEMBER NOT LIABLE IF CONTRACTED PROVIDER.
XU4	NON-COVERED SERVICE WAS NOT PRE-AUTHORIZED AS REQUIRED BY THE PLAN. MEMBER NOT LIABLE FOR NOT COVERED AMOUNT.
XU8	PRE-TREATMENT AUTHORIZATION REQUIRED, BUT NOT OBTAINED. PLEASE SUBMIT MEDICAL NECESSITY.
XU9	PRE-TREATMENT AUTHORIZATION REQUIRED BY THE PLAN WAS OBTAINED BUT NOT FOLLOWED. MEMBER NOT LIABLE FOR NOT COVERED AMOUNT.
XUC	DENIED AS NOT MEDICALLY NECESSARY. PATIENT NOT LIABLE. SEND APPEALS TO MEDSOLUTIONS, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067.
XUD	PAYMENT EXCEPTION WILL NOT BE MADE. PATIENT NOT LIABLE. SEND APPEALS TO MEDSOLUTIONS, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067.
XUE	THE SERVICE NOT COVERED DOES NOT MEET YOUR PLAN'S DEFINITION FOR MEDICALLY NECESSARY CARE OR TREATMENT.
XUF	SERVICE NOT COVERED WAS NOT PRE-AUTHORIZED AS REQUIRED BY THE PLAN OR AUTHORIZATION WAS DENIED. MEMBER NOT LIABLE IF CONTRACTED PROVIDER.

XUG	PAYMENT EXCEPTION WILL NOT BE MADE. PATIENT NOT LIABLE. SEND APPEALS TO EVICORE, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067.
XUH	AUTHORIZATION WAS OBTAINED BUT NOT FOLLOWED. MEMBER NOT LIABLE. SEND APPEALS TO EVICORE, 730 COOL SPRINGS BLVD., STE 800, FRANKLIN, TN 37067
XV1	THIS SERVICE IS NOT A COVERED EXPENSE AS DEFINED BY YOUR PLAN.
XV8	PRE-TREATMENT AUTHORIZATION REQUIRED, BUT NOT OBTAINED. PLEASE SUBMIT MEDICAL NECESSITY.
ZA9	ADDITIONAL INFORMATION REQUIRED: HEALTH CARE PROFESSIONAL, PLEASE SUBMIT COPY OF PATIENT'S MEDICAL RECORDS WITH A COPY OF THIS REQUEST.
ZAG	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT NAME, ADDRESS, AND TELEPHONE NUMBER WITH A COPY OF THIS
ZAO	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT ITEMIZED HOSPITAL BILL WITH A COPY OF THIS REQUEST.
ZAX	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT THE NDC NUMBER AND DRUG NAME FOR THIS SERVICE WITH A COPY OF THIS REQUEST.
ZB3	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT A BREAKDOWN BY SERVICE FOR THIS CHARGE WITH A COPY OF THIS
ZB9	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE RESUBMIT THE CLAIM WITH THE RELATED CPT4/HCPCS/REV CODES FOR ALL FEES.
ZBC	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE RESUBMIT WITH CONTRACTED PRICING FOR THESE SERVICES.
ZBO	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE HAVE THE REFERRING PHYSICIAN SUBMIT DIAGNOSIS/ICD 10 CODE AND RELATED CPT4/HCPCS CODES WITH A COPY OF THIS REQUEST.
ZBP	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT ITEMIZED BILL INCLUDING REVENUE CODES FOR EACH CHARGE WITH A COPY OF THIS REQUEST.
ZC6	ADDITIONAL INFORMATION REQUIRED. PROVIDER, PLEASE SUBMIT DENTAL X-RAYS AND A PERIODONTAL CHART WITH A COPY OF THIS
ZD2	ADDITIONAL INFORMATION REQUIRED. PROVIDER, PLEASE SUBMIT A DESCRIPTION OF SERVICE OR SUPPLIES FURNISHED.
ZDA	ADDITIONAL INFORMATION REQUIRED. PROVIDER, PLEASE SUBMIT THE PURCHASE PRICE OF THIS ITEM WITH A COPY OF THIS REQUEST.
ZDC	ADDITIONAL INFORMATION REQUIRED. PROVIDER, PLEASE SUBMIT A COPY OF YOUR W-9 WITH THIS REQUEST.
ZDQ	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT MEDICAL RECORDS AND AN ITEMIZED HOSPITAL BILL WITH A COPY OF THIS REQUEST.
ZDR	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT A COPY OF THE PATIENT'S MEDICAL RECORDS WITH A COPY OF THIS
ZDY	ADDITIONAL INFORMATION REQUIRED: PROVIDER, PLEASE SUBMIT DIAGNOSIS/ICD10 CODE AND RELATED CPT4/HCPCS CODES WITH A COPY OF THIS REQUEST.
ZEF	INCOMPLETE CLAIM - INVALID DIAGNOSIS CODE. PLEASE CORRECT AND RESUBMIT WITH THIS CLAIM.
ZEK	INCOMPLETE CLAIM - INVALID TYPE OF BILL. PROVIDER, PLEASE CORRECT AND RESUBMIT WITH THIS CLAIM.