Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Cigna Health and Life Insurance Company (CHLIC)	Last Revised: October 23, 2025
Health Plan Products: Open Access Plus; Preferred Provider Organization; Network Point of Service; Network Point of Service Open Access; Point of Service	
Utilization Management (UM) Model: Inpatient & Outpatient	**Funding Types:** Insured and Self-Funded

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Medical Necessity	Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health”) an affiliate of CHLIC, performs utilization management (UM) for MH/SUD benefits. All entities collectively referred to as “Cigna” and references to “Cigna” contained herein include Evernorth Behavioral Health. Peer Reviewers apply the definition of “medical necessity” set forth in the governing plan document or the definition required by state law. Notwithstanding the above, Cigna 's standard definition of “medical necessity” is as follows: **Medically Necessary/Medical Necessity** Typically, Cigna considers medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, or devices to be medically necessary of the following criteria are met: • 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 professional. • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent	Cigna Health Management, Inc., an affiliate of CHLIC, performs utilization management (UM) for most medical/surgical (M/S) benefits. Cigna delegates UM to EviCore for the medical necessity review of M/S services including high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, spinal procedures, vascular intervention, sleep, molecular labs and gastrointestinal endoscopic procedures. EviCore utilizes co-branded clinical coverage policies (which Cigna reviews and approves) when performing utilization management. A separate unrelated entity, American Specialty Health (“ASH”), reviews physical therapy, occupational therapy, massage therapy, acupuncture and chiropractic services on behalf of Cigna Health and Life Insurance Company. Similarly, ASH utilizes their own clinical coverage policies (which Cigna reviews, approves and co-brands) when performing utilization reviews. Peer Reviewers apply the definition of “medical necessity” set forth in the governing plan document or the definition required by state law. Notwithstanding the above, Cigna’s standard definition of “medical necessity” is as follows: **Medically Necessary/Medical Necessity** Typically, Cigna considers medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, or devices to be medically necessary of the following criteria are met:

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	therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of the member's 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 Peer Reviewer or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications, or settings when determining least intensive setting. As outlined in Cigna's definition of medical necessity, the factors below determine when to apply the Medical Necessity NQTL. All factors are based on generally accepted standards of medical practice. These standards include: • Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community • Physician and health care provider specialty society recommendations • The views of physicians and health care providers practicing in relevant clinical areas and • Any other relevant factor as determined by statute(s) and/or regulation(s). **Factors:** When establishing or selecting clinical criteria Cigna utilizes the following factors: 1. FDA Approval/Clearance 2. Peer Reviewed Evidence/Publication 3. Clinical Trials and Studies **Sources for Factors:**	• 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 professional. • 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 the member's 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 Peer Reviewer or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications, or settings when determining least intensive setting. As outlined in Cigna's definition of medical necessity, the factors below determine when to apply the Medical Necessity NQTL. All factors are based on generally accepted standards of medical practice. These standards include: • Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community • Physician and health care provider specialty society recommendations • The views of physicians and health care providers practicing in relevant clinical areas and

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	1. FDA approval or clearance, as appropriate, is necessary, but not sufficient for Cigna to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, Cigna reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for Healthcare Research and Quality (AHRQ). 2. Demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the Federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services. 3. Clinical Trials and Studies a. A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. b. Healthcare Therapeutic Assessment Committee (HTAC) reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National Pharmacy and Therapeutics (P&T) Committee process.	• Any other relevant factor as determined by statute(s) and/or regulation(s). **Factors:** When establishing or selecting clinical criteria Cigna utilizes the following factors: 1. FDA Approval/Clearance 2. Peer Reviewed Evidence/Publication 3. Clinical Trials and Studies **Sources for Factors:** 1. FDA approval or clearance, as appropriate, is necessary, but not sufficient for Cigna to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, Cigna reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for Healthcare Research and Quality (AHRQ). 2. Demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the Federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Evidentiary Standards and Applicable Thresholds: The following evidentiary standards are used to evaluate the clinical appropriateness, effectiveness and safety of MH/SUD treatments and services. 1. FDA Safety Protocols and regulatory guidance 2. Use of hierarchy of Levels of Scientific Evidence: **Level 1:** Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. **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. **Level 3:** Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. **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. **Level 5:** Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. 3. Safety Protocols Compliance Guidelines Enforcement Activity Clinical Trial phases: • Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted. • Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may	medical value of health services. 3. Clinical Trials and Studies a. A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. b. Healthcare Therapeutic Assessment Committee (HTAC) reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National Pharmacy and Therapeutics (P&T) Committee process. **Evidentiary Standards and Applicable Thresholds:** The following evidentiary standards are used to evaluate the clinical appropriateness, effectiveness and safety of M/S treatments and services. 1. FDA Safety Protocols and regulatory guidance 2. Use of hierarchy of Levels of Scientific Evidence: **Level 1:** Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. **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 **Level 3:** Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. **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. **Level 5:** Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.

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	be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied. • Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs. • Phase IV: Studies occurring after FDA has approved a drug for marketing. These include post market requirement and commitment studies that are required of or agreed to by the sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021). **Sources for Evidentiary Standards:** 1. FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents 2. The Levels of Evidence Table was adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009. Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo • Web of Science • Academic Search Complete (EBSCOHost) • The Council of Autism Service Providers (CASP)	3. Safety Protocols Compliance Guidelines Enforcement Activity Clinical Trial phases: • Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted. • Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied. • Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs. • Phase IV: Studies occurring after FDA has approved a drug for marketing. These include post market requirement and commitment studies that are required of or agreed to by the sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021). **Sources for Evidentiary Standards:** 1. FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents 2. The Levels of Evidence Table was adapted from the Centre

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	• World Professional Association for Transgender Health (WPATH) 3. Clinicaltrials.gov FDA's Role: ClinicalTrials.gov Information | FDA Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: • National Institutes of Health (NIH) • Centers for Disease Control and Prevention (CDC) • Agency for Health Care Research and Quality (AHRQ) • Centers for Medicare and Medicaid Services (CMS) • A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA) A qualified non-governmental research entity identified in NIH guidelines for center support grants ANY of the following: • Department of Defense • Department of Veterans Affairs • Department of Energy if of the following conditions are met: ○ study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health ○ assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. ○ The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration. ○ The study or investigation is a drug trial that is exempt from having such an investigational new drug application. **Design Factors:**	for Evidence Based Medicine, University of Oxford, March 2009. Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo • Web of Science • Academic Search Complete (EBSCOHost) • The Council of Autism Service Providers (CASP) • World Professional Association for Transgender Health (WPATH) 3. Clinicaltrials.gov FDA's Role: ClinicalTrials.gov Information | FDA Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: • National Institutes of Health (NIH) • Centers for Disease Control and Prevention (CDC) • Agency for Health Care Research and Quality (AHRQ) • Centers for Medicare and Medicaid Services (CMS) • A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA) A qualified non-governmental research entity identified in NIH guidelines for center support grants ANY of the following: • Department of Defense • Department of Veterans Affairs

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	Adoption of Clinical Criteria The clinical criteria are rules or standards on which a medical necessity decision or judgment is based. Cigna utilizes MCG™ clinical criteria when conducting Medical Necessity reviews of MH services and technologies; The ASAM Criteria® when conducting Medical Necessity reviews of SUD services and technologies, and an internally developed Coverage Policy for Transcranial Magnetic Stimulation (TMS) and Applied Behavior Analysis (ABA) (medical necessity decisions). The use of the various clinical criteria to determine medical necessity (both external and internal) does not overlap 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 Coverage Policy or Clinical Criteria applies, that Coverage Policy or Clinical Criteria applies in whole without regard to other more general guidelines. To develop Clinical Criteria, Cigna's Payment Policy and Coding (PP&C), in partnership with Cigna's Healthcare Medical Assessment Committee ("HMAC"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The Healthcare Medical Assessment Committee (HMAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to behavioral health services,	• Department of Energy if of the following conditions are met: ○ study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health ○ assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. ○ The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration. ○ The study or investigation is a drug trial that is exempt from having such an investigational new drug application. **Design Factors:** **Adoption of Clinical Criteria** The clinical criteria are rules or standards on which a Medical Necessity decision or judgment is based. Cigna utilizes MCG™ clinical criteria and its internally developed coverage policies to evaluate Medical Necessity of medical services and technologies. The use of the various clinical criteria to determine medical necessity (both external and internal) does not overlap 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 Coverage Policy or Clinical Criteria applies, that Coverage Policy or Clinical Criteria applies in whole without regard to other more general guidelines. To develop Clinical Criteria, Cigna's Payment Policy and Coding (PP&C), in partnership with Cigna's Healthcare Medical Assessment Committee ("HMAC"),

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	therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address MH/SUD services determined to be experimental and investigational. While Coverage Policies are reviewed at least once annually, re-review and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, Payment Policy and Coding (PP&C) and the impetus of new, emerging and evolving technologies. **Application Factors:** When applying MH/SUD Medical Necessity, Cigna follows a hierarchy of clinical review. 1. Federal Coverage Mandate (if applicable) 2. State Coverage Mandate (if applicable) 3. Group's Benefit Plan Document (e.g. Group Service Agreement Evidence of Coverage, Certificate of Coverage, Summary Plan Description or similar document) 4. Clinical Coverage Policies (CPs) • In determining whether health care services, supplies, or medications are Medically Necessary, the 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. 5. The ASAM Criteria® 6. MCG™ 7. Utilization Management Policies and Procedures (such as	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. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The Healthcare Medical Assessment Committee (HMAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to medical services, therapies, procedures, devices, and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address M/S services determined to be experimental and investigational. While Coverage Policies are reviewed at least once annually, re-review and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, PP&C and the impetus of new, emerging and evolving technologies. **Application Factors:** When applying M/S Medical Necessity, Cigna follows a hierarchy of clinical review: 1. Federal Coverage Mandate (if applicable)

<table>
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<tr>
<td></td>
<td>
Network Adequacy, Lack of Information, Continuity of Care and Transition of Care)
8. Administrative Policies
• Administrative Policies are intended to provide further information about the administration of standard Cigna benefit plans. In the event of a conflict, a customer's benefit plan document always supersedes the information in an Administrative Policy.
9. Reimbursement and Modifier Policies
• Reimbursement policies are intended to supplement certain standard benefit plans. Please note the terms of an individual's particular benefit plan document
10. Medical Inquiry Database
• A database housing a history of the evidence-based clinical reviews conducted to make recommendations about coverage.

Clinical Coverage Policies, MCG behavioral guidelines, and The ASAM Criteria®, are separate, distinct and <u>do not overlap</u>.

Cigna utilizes the following resources in its medical necessity determinations:
<table>
<tr><th>Benefit Classification</th><th>MH</th><th>SUD</th></tr>
<tr><td>Inpatient In-Network</td><td>MCG™</td><td>The ASAM Criteria®</td></tr>
<tr><td>Inpatient Out-of-Network</td><td>MCG™</td><td>The ASAM Criteria®</td></tr>
<tr><td>Outpatient In-Network All Other</td><td>Cigna-Developed (TMS, ABA)</td><td>Not applicable – No SUD services require authorization in the category.</td></tr>
<tr><td>Outpatient Out-of-Network All Other</td><td>Cigna-Developed (TMS, ABA)</td><td>Not applicable – No SUD services require</td></tr>
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<td>
2. State Coverage Mandate (if applicable)
3. Group's Benefit Plan Document (e.g. Group Service Agreement Evidence of Coverage, Certificate of Coverage, Summary Plan Description or similar document)
4. Coverage Policies (CPs) including Medical Coverage CPs and Drug CPs
• In determining whether health care services, supplies, or medications are Medically Necessary, the 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.
5. Vendor Partner Co-Branded Guidelines (e.g. EviCore, American Specialty Health)
6. Cigna Coverage Review Department Criteria Manual
7. MCG™
8. Utilization Management Policies and Procedures (such as Network Adequacy, Lack of Information, Continuity of Care and Transition of Care)
9. Administrative Policies
• Administrative Policies are intended to provide further information about the administration of standard Cigna benefit plans. In the event of a conflict, a customer's benefit plan document always supersedes the information in an Administrative Policy.
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<tr><td></td><td></td><td>authorization in the category.</td></tr>
<tr><td>Outpatient In-Network Office Visit</td><td>Not applicable – no authorization is required for routine in-network outpatient services</td><td>Not applicable – no authorization is required for routine in-network outpatient services</td></tr>
<tr><td>Outpatient Out-of-Network Office Visit</td><td>Not applicable – no authorization is required for routine out-of-network outpatient services</td><td>Not applicable – no authorization is required for routine out-of-network outpatient services</td></tr>
<tr><td>Emergency In-Network</td><td>Not applicable</td><td>Not applicable</td></tr>
<tr><td>Emergency Out-of-Network</td><td>Not applicable</td><td>Not applicable</td></tr>
</table></td><td>
11. Medical Inquiry Database
A database housing a history of the evidence-based clinical reviews conducted to make recommendations about coverage.
Clinical Coverage Policies and MCG™ are separate, distinct and <u>do not overlap</u>.
Cigna utilizes the following resources in its medical necessity determinations:
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<tr><th>Benefit Classification</th><th>M/S</th></tr>
<tr><td>Inpatient In-Network</td><td>Cigna-Developed supplemented with MCG™</td></tr>
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<tr><td>Outpatient In-Network All Other</td><td>Cigna-Developed supplemented with MCG™.
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</table>
Cigna Healthcare will only supplement Clinical Coverage Policies (CPs) with MCG™ if there is not an established Clinical CP.
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<tr><td colspan="5">Medical Necessity As Written, In Operation, Conclusion:</td></tr>
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Cigna has completed its comparative analysis for the Medical Necessity NQTL and identified that the medical necessity definition is consistent for both M/S and MH/SUD. Cigna's Payment Policy and Coding (PP&C), in partnership with Cigna's Healthcare Medical Assessment Committee (HMAC), oversee both MH/SUD and M/S processes. They are responsible for conducting evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical/behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. Cigna maintains one policy applicable to M/S and MH/SUD that outlines the requirements for a consistent process in the development of evidence-based coverage policies for a wide variety of medical technologies.

As Written:
M/S and MH/SUD consider the same factors, sources, and evidentiary standards in determining services to which medical necessity will apply.
Cigna's analysis confirmed the consistent sources for the development and adoption of its medical necessity criteria/guidelines; FDA Approval/Clearance, Peer Reviewed Evidence/Publication, and Clinical Trials and Studies. This is reflected in Cigna's documented policies and procedures.

Cigna has utilized MCG™ Clinical Criteria in M/S decisions for over 20 years. In November 2020 Cigna chose to also use MCG™ for MH Clinical Criteria, specifically to ensure that the process for development and updates of Clinical Criteria would align. Additionally, MCG™'s development of MH Clinical Criteria extensively references literature from the following non-profit organizations and publications:

- American Society of Addiction Medicine (The ASAM Criteria®)
- Early Childhood Service Intensity Instrument (ECSII)
- American Psychiatric Association
- American Academy of Child and Adolescent Psychiatry
- American Association of Community Psychiatrists
- Association for Ambulatory Behavioral Healthcare

Cigna decided to pursue the implementation of the ASAM Criteria® for SUD medical necessity decisions. With multiple states requiring the use of the ASAM Criteria®, it has become the national standard for SUD decisions. Their process for development is aligned with MCG™, meeting regulatory requirements.

In Operation:
The medical necessity definition is applied across all benefit classifications for M/S and MH/SUD. That said, MH/SUD does not apply medical necessity to routine office visits. Comparatively, M/S does not apply medical necessity for routine office visits, but some services performed in an office setting may require authorization (e.g. high-tech imaging, outpatient surgery).

The metrics used to monitor performance are consistent between MH/SUD and M/S:
- Approval/Denial rates
- Appeal volumes and determinations

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<tr><td colspan="3">• Claim determinations

MH/SUD and M/S both conduct Inter-Rater Reliability (IRR) exercises to evaluate the consistency of clinical decision-making across reviewers and to identify the need for any potential revisions to coverage policies; IRR exercise results show consistency when applying medical necessity.

Conclusion:
Based upon its analysis, Cigna has concluded that the processes, strategies, evidentiary standards, and other factors used to determine MH/SUD services subject to Medical Necessity requirements are comparable to, and no more stringent than those used for the M/S services in all benefit classifications.</td></tr>
<tr><td colspan="3">Prior Authorization/Pre-Certification Review</td></tr>
<tr><td>Definition: Any request for service that occurs before treatment has started or an enrollee has been admitted.

Inpatient, In-Network
Inpatient, Out-of-Network

No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.</td><td>Prior Authorization is applied to all non-emergent inpatient benefits, including residential services. The MH/SUD services assigned to the inpatient classification include services rendered by a hospital or other facility to plan enrollees who are confined overnight to a MH/SUD hospital or other facility.

Inpatient, In-Network and Out-of-Network Services requiring Prior Authorization include:

• Non-Emergent Inpatient (Mental Health and Substance Use)
• Residential Treatment (Mental Health and Substance Use)
• Non-Emergent Inpatient Detoxification

Cigna utilizes the factors outlined below to determine services that are subject to prior authorization. These factors are not weighted.

Factors:
1. Experimental/Investigational/Unproven service
2. Potential benefit exclusion
3. Serious safety risk
4. Significant variation in Evidence-based practice
5. Potential for Fraud, Waste or Abuse</td><td>Prior Authorization is applied to all non-emergent inpatient benefits, including sub-acute services. The M/S services assigned to the inpatient classification include services rendered by a hospital or other facility to plan enrollees who are confined overnight to a M/S hospital or other facility.

Inpatient, In-Network and Out-of-Network Services requiring Prior Authorization include:

• Non-Emergent Inpatient Services,
• Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.

Cigna utilizes the factors outlined below to determine services that are subject to prior authorization. These factors are not weighted.

Factors:
1. Experimental/Investigational/Unproven service
2. Potential benefit exclusion
3. Serious safety risk
4. Significant variation in Evidence-based practice
5. Potential for Fraud, Waste or Abuse
6. Estimated average cost</td></tr>
</table>

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	6. Estimated average cost **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna 's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"*	**Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"*

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna historical paid claims, exceeds $500. Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a	3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna historical paid claims, exceeds $500. Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to

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	deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna 's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data	Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna’s book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Design and Application: Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies 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. 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 such services considered for application of prior authorization. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Prior Authorization NQTL is applied to MH/SUD benefits no more stringently. Moreover, the	**Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. Cigna applies distinct and aligned processes in the application of the Prior Authorization NQTL. Services, procedures, drugs, devices, durable medical equipment, and certain therapies (collectively referred to as "services") that may be subject to Prior Authorization and/or are represented by industry accepted procedure codes developed by external sources. All M/S non-emergency (i.e. pre-scheduled) services in the Inpatient benefit classifications are subject to Prior Authorization.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	frequency of review of the services subject to prior authorization and their continued appropriateness is comparable Cigna applies distinct and aligned processes in the application of the Prior Authorization NQTL. Services, procedures, drugs, and certain therapies (collectively referred to as "services") that may be subject to Prior Authorization and/or are represented by industry accepted procedure codes developed by external sources. All MH/SUD non-emergency services in the Inpatient benefit classifications are subject to Prior Authorization. For a standard clinical review, for MH/SUD, a provider may submit a request for an initial approval by submitting it via fax, email, or phone. The case is referred to a care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the care manager determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the care manager determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she will either schedule a live conversation with the requesting physician and a Cigna peer reviewer or share the medical records with the Cigna peer reviewer. The Cigna peer reviewer will make a decision after review of records or conversation with requesting physician.	For a standard clinical review, for M/S, a provider may submit a request for an initial approval by submitting it via fax, email, or phone. The case is referred to a nurse reviewer (M/S) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the nurse reviewer determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she refers the case to a Cigna peer reviewer who will review available clinical and make a decision. Cigna delegates the application of Prior Authorization to EviCore for the medical necessity review of M/S services for high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, and gastrointestinal endoscopic procedures.
Inpatient Prior Authorization: As Written, In Operation, Conclusion: **As Written:** For both M/S and MH/SUD benefits, a provider may submit a request for an initial approval via fax, email, or phone. The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer to complete the peer-to-peer review. A peer-to-peer review is a clinical discussion within the initial utilization review process between a clinician making a request for authorization, and a same/similar licensed clinician who is responsible for the determination of whether the		

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

requested service is medically necessary. A peer review may involve the discussion of the type of services, treatments, or procedures being requested based on established medical/behavioral criteria and standards. The roles and responsibilities of individuals involved in the prior authorization process are outlined in more detail below.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies.

In Operation:

In operation, M/S and MH/SUD approval process have been compared and determined comparable because:

- Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to Prior Authorization as written 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 selection and application of the medical necessity criteria is similar as both M/S and MH/SUD follow the same process for completing a peer-to-peer review and provide a peer physician with licensure and board certification.
- The roles and responsibilities for the clinical and non-clinical staff are comparable.
  - Clinical:
    - Required to be independently licensed
    - Have similar years of experience
    - Only a physician or peer reviewer can issue a denial
  - Non-clinical
    - Only permitted administrative functions under the supervision of clinical staff
- The metrics used to monitor performance are consistent
  - Approval/denial rates
  - Decision timeliness
  - Appeal volumes and determinations
  - Claim determinations

Cigna reviewed and determined the evidentiary standards for the factors used in the application of Prior Authorization are identical as written and applied no more stringently to MH/SUD services than to M/S services. Cigna maintains an integrated approach to policy development and maintenance and identified opportunities for adjustments to ensure that standards are consistently applied.

Conclusion:

The comparative analysis performed for application of the Prior Authorization NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation. On review of the Cigna book of business data, the number of Prior Authorization decisions holistically reflects lower MH/SUD average denial rates. Cigna's analysis of the benefit plan

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
language and process and policies governing the application of Prior Authorization across M/S and MH/SUD benefits and the process by which M/S and MH/SUD services are selected for application of Prior Authorization demonstrates comparability and equivalent stringency in-writing and in-operation.		
Outpatient Office Visits, In-Network; **Outpatient Office Visits, Out-of-Network**	Prior Authorization is not required for routine outpatient/office visits for MH/SUD benefits	While routine office visits themselves do not require authorization for M/S, some services performed in an office setting may require authorization (e.g. high-tech imaging, outpatient surgery).
All Other Outpatient Services, In-Network; **All Other Outpatient Services, Out-of-Network**	**All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization include:** • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization (prior authorization removed as of 1/1/2025) Cigna utilizes the factors outlined below to determine services that are subject to Prior Authorization review. These factors are not weighted. **Factors** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse (including drivers of high-cost growth) 6. Estimated average cost 7. Return on Investment (ROI) **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents	**All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization include:** • Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) • Certain outpatient surgical procedures Certain cardiology procedures • Clinical trials • Procedures that may be considered cosmetic in nature • Durable Medical Equipment (DME) • Experimental / Investigational / Unproven (EIU) Procedures • Genetic testing • Home Health Care (HHC) / home infusion therapy • Hormone Implant • Hyperbaric Oxygen Therapy • Infertility services • Infused / injectable medications • Medical oncology • Musculoskeletal services (major joint surgery and pain management services) • Negative Pressure Wound Therapy • Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive Rehabilitation, Hearing Therapy, • Outpatient radiation therapy services

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
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	7. Services with a projected ROI ratio of 7.5 or greater **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies 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. 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 such services considered for application of prior authorization. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Prior Authorization	care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Services with a projected ROI ratio of 7.5 or greater

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	NQTL is applied to MH/SUD benefits no more stringently. Moreover, the frequency of review of the services subject to prior authorization and their continued appropriateness is comparable. Cigna applies distinct and aligned processes in the application of the Prior Authorization NQTL. Services, procedures, drugs, devices, and certain therapies (collectively referred to as “services”) may be subject to Prior Authorization and are represented by industry accepted procedure codes developed by external sources. For a standard clinical review, a provider may submit a request for initial approval via fax, email, or phone. The case is referred to a care manager who collects and reviews the supporting clinical information for medical necessity. If the care manager (MH/SUD) determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the care manager determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she will either schedule a live conversation with the requesting physician and a Cigna clinical peer reviewer or share the medical records with the Cigna clinical peer reviewer. The Cigna clinical peer reviewer will make a decision after review of records or conversation with requesting physician.	**Design and Application:** Cigna’s Healthcare Medical Assessment Committee (“HMAC”) is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. Cigna applies distinct and aligned processes in the application of the Prior Authorization NQTL. Services, procedures, drugs, devices, durable medical equipment, and certain therapies (collectively referred to as “services”) may be subject to Prior Authorization and are represented by industry accepted procedure codes developed by external sources. For a standard clinical review, a provider may submit a request for initial approval via fax, email, or phone. The case is referred to a

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
		nurse reviewer (M/S) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer who will review available clinical and make a decision. Cigna delegates the application of Prior Authorization to EviCore for the medical necessity review of M/S services for high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, and gastrointestinal endoscopic procedures.

Outpatient Prior Authorization: As Written, In Operation, Conclusion: 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.

As Written:
For both M/S and MH/SUD benefits, a provider may submit a request for an initial approval via fax, email, or phone. The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer. The roles and responsibilities of individuals involved in the prior authorization process are outlined in more detail below.

Cigna does not require prior authorization for MH/SUD or M/S office visits, nor for preventive services.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies.

In Operation:
In operation, M/S and MH/SUD approval process have been compared and determined comparable because:

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

- Cigna's methodology for determining which M/S and MH/SUD services within a classification of benefits are subject to Prior Authorization as written 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 selection and application of the medical necessity criteria is similar as both M/S and MH/SUD follow the same process for completing a peer-to-peer and provide a peer physician with licensure and board certification.
- The roles and responsibilities for the clinical and non-clinical staff are comparable.
  - Clinical:
    - Required to be independently licensed
    - Have similar years of experience
    - Only a physician or peer reviewer can issue a denial
  - Non-clinical
    - Only permitted administrative functions under the supervision of clinical staff
- The metrics used to monitor performance are consistent
  - Approval/denial rates
  - Decision timeliness
  - Appeal volumes and determinations
  - Claim determinations

Cigna reviewed and determined the evidentiary standards for the factors used in the application of Prior Authorization are identical as written and applied no more stringently to MH/SUD services than to M/S services. Cigna maintains an integrated approach to policy development and maintenance and identified opportunities for adjustments to ensure that standards are consistently applied.

Conclusion:
The comparative analysis performed for application of the Prior Authorization NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation. Holistically, the number of Prior Authorization decisions across the Cigna book of business data, reflects lower MH/SUD average denial rates. Cigna's analysis of the benefit plan language and process and policies governing the application of Prior Authorization across M/S and MH/SUD benefits and the process by by which M/S and MH/SUD services are selected for application of Prior Authorization demonstrates comparability and equivalent stringency in-writing and in-operation.

Concurrent Care Review

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Definition: A request for service that occurs after an admission or treatment has begun, even if it is the initial request. **Inpatient, In-Network** **Inpatient, Out-of-Network**	Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity including non-emergent MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and certain outpatient benefits, without service/procedure level distinctions for the inpatient benefit classification. **Inpatient, In-Network and Out-of-Network Services requiring Concurrent Review include:** • Non-Emergent Inpatient (Mental Health and Substance Use) • Residential Treatment (Mental Health and Substance Use) • Non-Emergent Inpatient Detoxification Cigna utilizes the factors outlined below to determine services that are subject to Concurrent Care review. These factors are not weighted. **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies	Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity including non-emergent M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and certain outpatient benefits, without service/procedure level distinctions for the inpatient benefit classification. **Inpatient, In-Network and Out-of-Network Services requiring Concurrent Review include:** • Acute Inpatient Services, • Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc. Cigna utilizes the factors outlined below to determine services that are subject to Concurrent Care review. These factors are not weighted. **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost **Sources for Factors**: 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"* 3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s).	4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" 3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna's historical paid claims, exceeds $500 Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization Examples of safety	the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna's historical paid claims, exceeds $500 Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s).

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical	• Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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,

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies 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. 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 such services considered for application of concurrent review. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Concurrent Review NQTL is applied to MH/SUD benefits no more stringently. Moreover, the frequency of review of the services subject to concurrent review and their continued appropriateness is comparable. Cigna applies distinct and aligned processes in the application of the Concurrent Review NQTL. Services, procedures, drugs, and certain therapies (collectively referred to as “services”) that may be subject to Concurrent Review and or are represented by industry accepted procedure codes developed external sources. All MH/SUD non-emergency services in the Inpatient benefit classifications are subject to Concurrent Review.	neurosurgeons, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. Cigna applies distinct and aligned processes in the application of the Concurrent Review NQTL. Services, procedures, drugs, devices, durable medical equipment, and certain therapies (collectively referred to as “services”) that may be subject to Concurrent Review and/or are represented by industry accepted procedure codes developed by external sources. All M/S non-emergency (i.e. pre-scheduled) services in the Inpatient benefit classifications are subject to Concurrent Review. For a standard clinical review, for M/S, a provider may submit a request for approval by submitting it via fax, email, or phone. The case is referred to a nurse reviewer (M/S) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the nurse reviewer determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she refers the case

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	For a standard clinical review, for MH/SUD, a provider may submit a request for approval by submitting it via fax, email, or phone. The case is referred to a care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the care manager determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the care manager determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she will either schedule a live conversation with the requesting physician and a Cigna peer reviewer or share the medical records with the Cigna peer reviewer. The Cigna peer reviewer will make a decision after review of records or conversation with requesting physician.	to a Cigna peer reviewer who will review available clinical and make a decision.

Inpatient Concurrent Review: As Written, In Operation, Conclusion:

As Written:
For both M/S and MH/SUD benefits, a provider may submit a request via fax, email, or phone. The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer. The roles and responsibilities of individuals involved in the concurrent review process are outlined in more detail below.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies.

In Operation:
In operation, M/S and MH/SUD approval process have been compared and determined comparable because:

- Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to Concurrent Review as written 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 selection and application of the medical necessity criteria is similar as both M/S and MH/SUD follow the same process for completing a peer-to-peer and provide a peer physician with licensure and board certification.
- The roles and responsibilities for the non-clinical and clinical staff are Comparable.
  - Clinical:

<table>
<tr><th>Non-Quantitative Treatment Limitation (NQTL)</th><th>Mental Health/Substance Use Disorder Benefits (MH/SUD)</th><th>Medical/Surgical (M/S)</th></tr>
<tr><td colspan="3">

Required to be independently licensed
Have similar years of experience
Only a physician or peer reviewer can issue a denial

Non-clinical

Only permitted administrative functions under the supervision of clinical staff

The metrics used to monitor performance are consistent

Approval/denial rates
Decision timeliness
Appeal volumes and determinations
Claim determinations

Cigna reviewed and determined the evidentiary standards for the factors used in the application of Concurrent Review are identical as written and applied no more stringently to MH/SUD services than to M/S services. Cigna maintains an integrated approach to policy development and maintenance and identifies opportunities for adjustments to ensure that standards are consistently applied.

Conclusion:
The comparative analysis performed for application of the Concurrent NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation. Holistically, the number of Concurrent Review decisions across the Cigna book of business data reflects lower MH/SUD average denial rates. Cigna's analysis of the benefit plan language and process and policies governing the application of Concurrent Review across M/S and MH/SUD benefits and the process by which M/S and MH/SUD services are selected for application of Concurrent Review demonstrates comparability and equivalent stringency in-writing and in-operation.
</td></tr>
<tr><td>Concurrent Review

Outpatient Office Visits, In-Network
Outpatient Office Visits, Out-of-Network</td><td>Concurrent Review is not applicable to MH/SUD benefits in this classification</td><td>Concurrent Review is not applicable to M/S benefits in this classification</td></tr>
<tr><td>Concurrent Review

All Other Outpatient Services, In-Network</td><td>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review include:

• Applied Behavior Analysis (ABA)
• Transcranial Magnetic Stimulation (TMS)</td><td>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review include:

• Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology)</td></tr>
</table>

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
All Other Outpatient Services, Out-of-Network	• Partial Hospitalization (Concurrent review removed as of 1/1/2025) Cigna utilizes the factors outlined below to determine services that are subject to Concurrent review. These factors are not weighted. **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost 7. Return on Investment (ROI) **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna 's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Cigna claims data, denial rates, and average estimated cost of review	• Certain outpatient surgical procedures Certain cardiology procedures • Clinical trials • Procedures that may be considered cosmetic in nature • Durable Medical Equipment (DME) • Experimental / Investigational / Unproven (EIU) Procedures • Genetic testing • Home Health Care (HHC) / home infusion therapy • Hormone Implant • Hyperbaric Oxygen Therapy • Infertility services • Infused / injectable medications • Medical oncology • Musculoskeletal services (major joint surgery and pain management services) • Negative Pressure Wound Therapy • Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive Rehabilitation, Hearing Therapy, Occupational Therapy, Physical Therapy, Chiropractic, Acupuncture) • Outpatient radiation therapy services • Sleep testing • Therapeutic apheresis (aka Extracorporeal photopheresis (ECP) External Counterpulsation • Unlisted procedures or services (note: the phrase “unlisted procedure or service” refers to an instance where a procedure or service is billed as “unlisted,” meaning that no existing CPT code exists for the procedure or service) **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Evidentiary Standards and Applicable Thresholds: 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"* 3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behaviour to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna 's historical paid claims, exceeds $500. 7. Cigna claims data, denial rates, and average estimated cost of review	3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost 7. Return on Investment (ROI) **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Cigna claims data, denial rates, and average estimated cost of review **Evidentiary Standards and Applicable Thresholds:** 1. 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; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:**	marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: “CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage” 3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider’s billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna’s historical paid claims, exceeds $500 7. Cigna claims data, denial rates, and average estimated cost of review Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Services with a projected ROI ratio of 7.5 or greater **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the	scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. • Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies 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. 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 such services considered for application of concurrent review. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Concurrent Review NQTL is applied to MH/SUD benefits no more stringently. Moreover, the frequency of review of the services subject to concurrent review and their continued appropriateness is comparable. Cigna applies distinct and aligned processes in the application of the Concurrent Review NQTL. Services, procedures, drugs, and certain therapies (collectively referred to as “services”) that may be subject to Concurrent Review and or are represented by industry accepted procedure codes developed external sources. All MH/SUD services in the Outpatient benefit classifications are subject to Concurrent Review For a standard clinical review, for MH/SUD, a provider may submit a request for an initial approval by submitting it via fax, email, or phone. The case is referred to a care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the care manager determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the care manager determines that the enrollee does not appear to meet medical necessity	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna’s book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Services with a projected ROI ratio of 7.5 or greater **Design and Application:** Cigna’s Healthcare Medical Assessment Committee (“HMAC”) is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	criteria for the service requested, he/she will either schedule a live conversation with the requesting physician and a Cigna peer reviewer or share the medical records with the Cigna peer reviewer. The Cigna peer reviewer will make a decision after review of records or conversation with requesting physician.	issues related to conflicts and potential bias of the study authors and institutional associations. Cigna applies distinct and aligned processes in the application of the Concurrent Review NQTL. Services, procedures, drugs, devices, durable medical equipment, and certain therapies (collectively referred to as “services”) that may be subject to Concurrent Review and or are represented by industry accepted procedure codes developed external sources. All M/S services in the Outpatient benefit classifications listed in the Master Precertification List are subject to Concurrent Review. For a standard clinical review, for M/S, a provider may submit a request for approval by submitting it via fax, email, or phone. The case is referred to a nurse reviewer (M/S) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the nurse reviewer determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she refers the case to a Cigna peer reviewer who will review available clinical and make a decision.
Outpatient Concurrent: As Written, In Operation, Conclusion: Cigna applies the Concurrent Review NQTL consistently to M/S benefits and MH/SUD benefits. **As Written:** For both M/S and MH/SUD benefits, a provider may submit a request via fax, email, or phone. The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer. The roles and responsibilities of individuals involved in the concurrent review process are outlined in more detail below.		

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

Cigna does not require concurrent review for routine MH/SUD or M/S office visits, nor for preventive services. While routine office visits themselves do not require authorization for M/S, some services performed in an office setting may require authorization (e.g. high-tech imaging, outpatient surgery).

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies.

In Operation:
Cigna has compared M/S and MH/SUD in operation:

- Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to Concurrent Review as written 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 selection and application of the medical necessity criteria is similar as both M/S and MH/SUD follow the same process for completing a peer-to-peer and provide a peer physician with licensure and board certification.
- The roles and responsibilities for the non-clinical and clinical staff are comparable.
  - Clinical:
    - Required to be independently licensed
    - Have similar years of experience
    - Only a physician or peer reviewer can issue a denial
    - Non-clinical
      - Only permitted administrative functions under the supervision of clinical staff
- The metrics used to monitor performance are consistent
  - Approval/denial rates
  - Decision timeliness
  - Appeal volumes and determinations
  - Claim determinations

Conclusion:
Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to Concurrent Review 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.

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Retrospective Review		
Definition: Any request for care or services that have already been received (e.g., post-service). **Inpatient, In-Network** **Outpatient, In-Network (including applicable sub-classifications)** **Inpatient, Out-of-Network** **Outpatient, Out-of-Network (including applicable sub-classifications).** Cigna does not incorporate language related to Retrospective Review in its certificate or benefits booklet.	**Inpatient, In-Network and Out-of-Network Services Subject to Retrospective include:** **Inpatient (MH/SUD):** • Non-Emergent Inpatient (Mental Health and Substance Use) • Residential Treatment (Mental Health and Substance Use) • Non-Emergent Inpatient Detoxification **All Other Outpatient, In-Network and Out-of-Network Services Subject to Retrospective Review include (MH/SUD):** • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization (Review requirement removed effective 01/01/2025) Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may be subject to retrospective review if a prior authorization or concurrent review request was required but not obtained. Cigna utilizes the factors outlined below to determine services that are subject to Retrospective review. These factors are not weighted. **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost 7. Return on Investment (ROI) – Outpatient services only	**Inpatient, In-Network and Out-of-Network Services Subject to Retrospective include:** **Inpatient (M/S):** • Acute Inpatient Services, • Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc. **All Other Outpatient, In-Network and Out-of-Network Services Subject to Retrospective Review include (M/S):** • Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) • Certain outpatient surgical procedures • Certain cardiology procedures • Clinical trials • Procedures that may be considered cosmetic in nature • Durable Medical Equipment (DME) • Experimental / Investigational / Unproven (EIU) Procedures • Genetic testing • Home Health Care (HHC) / home infusion therapy • Hormone Implant • Hyperbaric Oxygen Therapy • Infertility services • Infused / injectable medications • Medical oncology • Musculoskeletal services (major joint surgery and pain management services) • Negative Pressure Wound Therapy • Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Sources for Factors: 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Cigna claims data, denial rates, and average estimated cost of review – Outpatient services only **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"*	Rehabilitation, Hearing Therapy, Occupational Therapy, Physical Therapy, Chiropractic, Acupuncture) • Outpatient radiation therapy services • Sleep testing • Therapeutic apheresis (aka Extracorporeal photopheresis (ECP) External Counterpulsation • Unlisted procedures or services (note: the phrase "unlisted procedure or service" refers to an instance where a procedure or service is billed as "unlisted," meaning that no existing CPT code exists for the procedure or service) Services covered under a Cigna-administered benefit plan, including M/S benefits, may be subject to retrospective review if a prior authorization or concurrent review request was required but not obtained. Cigna utilizes the factors outlined below to determine services that are subject to Retrospective review. These factors are not weighted. **Factors:** 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost 7. Return on Investment (ROI) – Outpatient services only **Sources for Factors:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	3. 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. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted as evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna's historical paid claims, exceeds $500 7. Cigna claims data, denial rates, and average estimated cost of review – Outpatient services only Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.	2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Cigna claims data, denial rates, and average estimated cost of review – Outpatient services only **Evidentiary Standards and Applicable Thresholds:** 1. 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; 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; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2. CMS.gov: "*CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"* 3. Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and Prescriber Analytics; Cigna	technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted as evidenced by increased volume. 6. Any service where the average service cost, based on an assessment of Cigna 's historical paid claims, exceeds $500 7. Cigna claims data, denial rates, and average estimated cost of review – Outpatient services only Cigna is providing the following definitions as they relate to the above evidentiary standards: • Inadequate volume of existing peer-reviewed refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	claims data 6. Cigna claims data 7. Services with a projected ROI ratio of 7.5 or greater – Outpatient services only **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies 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. 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	• Significant variation is defined as greater frequency of deviation from evidence-based practice compared to Cigna's book of business. A variation in evidence-based care must reflect a deviation from the expected treatment use, frequency, or duration. ○ Such variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). • Serious Safety Risk is any service that is potentially life-threatening according to available Clinical Evidence shall be placed on identified for Prior Authorization. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product). **Sources for Evidentiary Standards:** 1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Customer, Pharmacy and

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	appropriate evaluation of such services considered for application of retrospective review. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Retrospective Review NQTL is applied to MH/SUD benefits no more stringently. Moreover, the frequency of review of the services subject to retrospective review and their continued appropriateness is comparable. Retrospective reviews are only performed when a service requires prior authorization, and that authorization was never obtained or secured. A request for a post-service (retrospective) review may be initiated at the request of a customer, behavioral health provider, or the Cigna claims unit. MH/SUD allows providers to submit records for retrospective reviews for 365 days after the date of service. Additionally, a single level appeal may be requested at any time, from within one year from when the MH/SUD Utilization Management (UM) team issued an adverse benefit determination unless otherwise specified by the plan.	Prescriber Analytics; Cigna claims data 6. Cigna claims data 7. Services with a projected ROI ratio of 7.5 or greater – Outpatient services only **Design and Application:** Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies. Cigna's HMAC implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. Retrospective reviews are only performed when a service requires prior authorization, and that authorization was never obtained or secured. A request for a post-service (retrospective) review may be initiated

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
		at the request of a customer, medical provider, or the Cigna claims unit. M/S allows providers to submit records for retrospective reviews for 365 days after the date of service. Additionally, a single level appeal may be requested at any time, from within one year from when the M/S Utilization Management (UM) team issued an adverse benefit determination unless otherwise specified by the plan.

Retrospective: As Written, In Operation, Conclusion:
Cigna has assessed several components of its Retrospective Review 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.

As Written:
For both M/S and MH/SUD benefits, a provider may submit a retrospective request via mail, fax, or email. The request is routed to a nurse reviewer (M/S)/care manager (MH/SUD) who reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes the services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the requested service, he/she refers the case to a Cigna peer reviewer. The roles and responsibilities of individuals involved in the prior authorization process are outlined in more detail below.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies.

In Operation:
In operation, M/S and MH/SUD approval process have been compared and determined comparable because:

- Cigna's methodology for determining which M/S services and which MH/SUD services are subject to Retrospective Review as written reflects they are comparable and no more stringent for MH/SUD services.
- The selection and application of the medical necessity criteria is similar as both M/S and MH/SUD follow the same process for completing a peer-to-peer and provide a peer physician with licensure and board certification.
- The roles and responsibilities for the clinical staff are Comparable.
  - Clinical:
    - Required to be independently licensed

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

- Have similar years of experience
- Only a physician or peer reviewer can issue a denial

- The metrics used to monitor performance are consistent
  - Approval/denial rates
  - Decision timeliness
  - Appeal volumes and determinations
  - Claim determinations

Cigna reviewed and determined the evidentiary standards for the factors used in the application of Retrospective Review are identical as written and applied no more stringently to MH/SUD services than to M/S services. Cigna maintains an integrated approach to policy development and maintenance and identified opportunities for adjustments to ensure that standards are consistently applied.

Conclusion:
The comparative analysis performed for application of the Retrospective Review NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation. Holistically, the number of Retrospective Review decisions across the Cigna book of business data, reflects lower MH/SUD average denial rates. Cigna's analysis of the benefit plan language and process and policies governing the application of Retrospective Review across M/S and MH/SUD benefits and the process by which M/S and MH/SUD services are selected for application of Retrospective Review demonstrates comparability and equivalent stringency in-writing and in-operation.

Process for Appeals

Any services which resulted in a medical necessity adverse determination during the prior authorization, concurrent review or retrospective review process have available appeal options. Appeals are an intrinsic part of the UM process; therefore, the same factors, sources and evidentiary standards established for prior authorization, concurrent review and retrospective review apply.

Internal Appeals
Cigna follows a single-level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for M/S and MH/SUD. For medical necessity appeal 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 Single level pre-service medical necessity appeals are completed within 30 calendar days and
- Standard Single level post-service medical necessity appeals are completed within 60 calendar days

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Note- Cigna will follow any state requirements in regard to the appeals process. Cigna provides written notification of the decision, including the clinical rationale for the determination to the customer and the treating provider or facility. **External Appeals** Cigna informs customers of their right to request an external appeal to an Independent Review Organization (IRO), at no cost to the Customer, in the final internal appeal denial letter for M/S and MH/SUD. 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 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 binding. 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.		
Process for Emergency Services		
Process for Emergency Services	Prior Authorization, Concurrent Review and Retrospective Review are not applicable to Emergency MH/SUD benefits. Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; • Serious impairment to bodily function;	Prior Authorization, Concurrent Review and Retrospective Review are not applicable to Emergency M/S benefits. Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Serious dysfunction of any bodily organ or part; • Imminent harm to self or others	• Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; • Serious impairment to bodily function; • Serious dysfunction of any bodily organ or part; • Imminent harm to self or others
Case Management		
What case management services are available?	Case Management does not impact the scope of care, treatment or benefits delivered to MH/SUD services and does not function as an NQTL under the parity requirements. 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.	Case Management does not impact the scope of care, treatment or benefits delivered to M/S services and does not function as an NQTL under the parity requirements. For Cigna enrollees with complex medical 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 customer care.
What case management services are required?	Health plan enrollees are not required to participate in case management services.	Health plan enrollees are not required to participate in case management services.
What are the eligibility criteria for case management services?	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.
Assessment of New Technologies		

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Definition of Experimental/ Investigational/Unproven	**Services Subject to the Assessment of New Technologies - Experimental, Investigational and Unproven, (EIU)** For Cigna plans, the terms experimental, investigational and unproven are used together or interchangeably and this phrase reflects a common intent. Cigna considers medical, surgical, diagnostic, behavioral health or other health care technologies, supplies, treatments, procedures, or devices to be EIU if either of the following criteria is met: • The technology, supply, treatment, procedure, or device has not been demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or sickness, regardless of U.S. Food and Drug Administration (FDA) approval status; or • When subject to FDA or other appropriate regulatory agency review, it is not approved to be lawfully marketed for any indication. Cigna 's *CPU-05 Healthcare Medical Assessment and Coverage (HMAC) Process for Experimental Investigational and Unproven Services (EIU), Including Exceptions and Clinical Trials* demonstrates the same factors are used in determining which services are deemed EIU. Where there is no clear guideline, as referenced above, Cigna will assign an inquiry to the Medical Inquiry Unit. The team is staffed by authors who are Registered Nurses with oversight from a Senior Medical director. The authors will conduct an evidence-based review and make recommendations about coverage. The function of the inquiry is to assist the peer reviewer in considering the clinical appropriateness of the specific clinical request in question. Inquiry requests are reviewed periodically by HMAC to determine if a coverage policy should be considered for development. A summary of the evidence or lack thereof is presented to HMAC who will make a final determination.	**Services Subject to the Assessment of New Technologies - Experimental, investigational or unproven services (EIU)** For Cigna plans, the terms experimental, investigational and unproven are used together or interchangeably and this phrase reflects a common intent. Cigna considers medical, surgical, diagnostic, behavioral health or other health care technologies, supplies, treatments, procedures, or devices to be EIU if either of the following criteria is met: • The technology, supply, treatment, procedure, or device has not been demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or sickness, regardless of U.S. Food and Drug Administration (FDA) approval status; or • When subject to FDA or other appropriate regulatory agency review, it is not approved to be lawfully marketed for any indication. Cigna's *CPU-05 Healthcare Medical Assessment and Coverage (HMAC) Process for Experimental Investigational and Unproven Services (EIU), Including Exceptions and Clinical Trials* demonstrates the same factors are used in determining which services are deemed EIU. Where there is no clear guideline, as referenced above, Cigna will assign an inquiry to the coverage policy authors, who are Registered Nurses. The coverage policy authors will conduct an evidence-based review and make recommendations about coverage. The inquiry is performed by reviewing the published peer-reviewed evidence-based literature as well as specialty society guidelines. The function of the inquiry is to assist the

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	The inquiry review is based on a search of the body of knowledge available, relevant to the technology in question, and includes specific citations from appropriate sources used in research, which include the following: • peer-reviewed scientific studies published in journals that meet nationally recognized requirements for scientific manuscripts • standard medical reference compendia and authoritative medical textbooks • This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the Federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services • nationally recognized professional specialty society recommendations • FDA-approval/clearance when applicable During the review process, health disparity issues are taken into consideration and may have an impact on coverage when supported by the evidence. A health disparity is a particular type of health difference that is closely linked with social or economic disadvantages. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations.	physician reviewer in considering the clinical appropriateness of the specific clinical request in question. Inquiry requests are reviewed periodically by HMAC to determine if a coverage policy should be considered for development. A summary of the evidence or lack thereof is presented to HMAC who will make a final determination. The inquiry review is based on a search of the body of knowledge available, relevant to the technology in question, and includes specific citations from appropriate sources used in research, which include the following: • peer-reviewed scientific studies published in journals that meet nationally recognized requirements for scientific manuscripts • standard medical reference compendia and authoritative medical textbooks • This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services • nationally recognized professional specialty society recommendations • FDA-approval/clearance when applicable During the review process, health disparity issues are taken into consideration and may have an impact on coverage when supported by the evidence. A health disparity is a particular type of

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	HMAC is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberative process, and in preparing published coverage policies. **Factors:** In determining services which may be subjected to the EIU policy, Cigna considers the following factors: 1. Absence of FDA Approval/Clearance 2. Absence of Peer Reviewed Evidence/Publication 3. Absence of effective Clinical Trials and Studies There is no specific formulaic way in which Cigna measures the volume of data needed. Study detail is scrutinized using the scientific method of evidence review. **Sources for Factors:** 1. As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient for Cigna to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, Cigna reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for	health difference that is closely linked with social or economic disadvantages. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations. HMAC is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC 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, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberative process, and in preparing published coverage policies. **Factors:** In determining services which may be subjected to the EIU policy, Cigna considers the following factors: 1. Absence of FDA Approval/Clearance 2. Absence of Peer Reviewed Evidence/Publication 3. Absence of effective Clinical Trials and Studies There is no specific formulaic way in which Cigna measures the volume of data needed. Study detail is scrutinized using the scientific method of evidence review.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Healthcare Research and Quality (AHRQ). 2. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the Federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services. 3. a. A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. b. HTAC reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National P&T Committee process **Evidentiary Standards and Applicable Thresholds:** In establishing the factors used to determine what services are considered EIU, Cigna considers the following sources and evidentiary standards: 1. FDA Safety Protocols and regulatory guidance 2. Use of hierarchy of Levels of Scientific Evidence: **Level 1**: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. **Level 2:** Non-randomized controlled trials (an experimental study, but not an ideal design). Also, systematic reviews and meta-	**Sources for Factors:** 1. As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient for Cigna to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, Cigna reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for Healthcare Research and Quality (AHRQ). 2. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. This literature includes findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services. 3. a. A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. b. HTAC reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National P&T Committee process

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	analyses of non-randomized controlled trials. **Level 3**: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. **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. **Level 5**: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. 3. Safety Protocols Compliance Guidelines Enforcement Activity Clinical Trial phases: • Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted. • Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied. • Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs. • Phase IV: Studies occurring after FDA has approved a drug for marketing. These include post-market requirement and commitment studies that are required of or agreed to by the	**Evidentiary Standards and Applicable Thresholds:** In establishing the factors used to determine what services are considered EIU, Cigna considers the following sources and evidentiary standards: 1. FDA Safety Protocols and regulatory guidance 2. Use of hierarchy of Levels of Scientific Evidence: **Level 1**: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. **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. **Level 3**: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. **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. **Level 5**: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. 3. Safety Protocols Compliance Guidelines Enforcement Activity Clinical Trial phases: • Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021) **Sources for Evidentiary Standards:** 1. FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents 2. The Levels of Evidence Table was adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009. Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo • Web of Science • Academic Search Complete (EBSCOHost) 3. Clinicaltrials.gov FDA's Role: ClinicalTrials.gov Information | FDA Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: • National Institutes of Health (NIH) • Centers for Disease Control and Prevention (CDC) • Agency for Health Care Research and Quality (AHRQ) • Centers for Medicare and Medicaid Services (CMS) • A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)	• Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied. • Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs. • Phase IV: Studies occurring after FDA has approved a drug for marketing. These include post-market requirement and commitment studies that are required of or agreed to by the sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021) **Sources for Evidentiary Standards:** 1. FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents 2. The Levels of Evidence Table was adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009. Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

	A qualified non-governmental research entity identified in NIH guidelines for center support grants ANY of the following:
	
	• Department of Defense
	• Department of Veterans Affairs
	• Department of Energy if of the following conditions are met:
	  ○ study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
	  ○ The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
	  ○ The study or investigation is a drug trial that is exempt from having such an investigational new drug application
	
	Design and Application:
	Cigna's Healthcare Medical Assessment and Coverage (HMAC) committee performs an internal review of published treatment guidelines that identify covered treatments or services which lack clinical efficacy (defined by the National Institute of Health as "a positive therapeutic effect") utilizing comparable experts to make determinations for MH/SUD conditions. These experts evaluate and apply nationally recognized treatment guidelines or other criteria in a comparable manner. Using the factors, sources, and evidentiary standards documented above, the panel evaluates the service or treatment to determine its appropriateness for approval.
	
	Cigna health plans, consistent with the industry standards, do not cover services that are not medical in nature or not directly medically related. Services that are not medical in nature are not eligible for coverage under
		• Web of Science
		• Academic Search Complete (EBSCOHost)
		3. Clinicaltrials.gov
		FDA's Role: ClinicalTrials.gov Information | FDA
		Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
		• National Institutes of Health (NIH)
		• Centers for Disease Control and Prevention (CDC)
		• Agency for Health Care Research and Quality (AHRQ)
		• Centers for Medicare and Medicaid Services (CMS)
		• A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
		
		A qualified non-governmental research entity identified in NIH guidelines for center support grants ANY of the following:
		
		• Department of Defense
		• Department of Veterans Affairs
		• Department of Energy if of the following conditions are met:
		  ○ study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
		  ○ The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
		  ○ The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	a health plan and arguably may not be supported for coverage with pretax dollars. Cigna explicitly cites these services in the plan document to be helpful because customers and clients occasionally ask about whether or not they are covered. Cigna has collected this diverse list of services together in one exclusion solely based on their one common element: each is not medical or not directly medically related in nature. Cigna does not reimburse for services performed by an unlicensed/non-certified provider unless required by state law. However, the fact that a service is being provided by a licensed/certified provider does not automatically mean the service should be covered. Licensure itself is not a standalone factor used to determine if a service is appropriate. EIU services are excluded on the basis that there is not enough scientific evidence to prove their efficacy. Hence, the services would be reviewed for medical necessity regardless of who is providing the care. Customers are made aware of E/I/U services through their plan documentation provided to them at benefit enrollment. To affirm, only the EIU portion of the services would be denied, while medically necessary services could be reimbursed.	**Design and Application:** Cigna's Healthcare Medical Assessment and Coverage (HMAC) committee performs an internal review of published treatment guidelines that identify covered treatments or services which lack clinical efficacy (defined by the National Institute of Health as "a positive therapeutic effect") utilizing comparable experts to make determinations for M/S conditions. These experts evaluate and apply nationally recognized treatment guidelines or other criteria in a comparable manner. Using the factors, sources, and evidentiary standards documented above, the panel evaluates the service or treatment to determine its appropriateness for approval. Cigna health plans, consistent with the industry standards, do not cover services that are not medical in nature or not directly medically related. Services that are not medical in nature are not eligible for coverage under a health plan and arguably may not be supported for coverage with pretax dollars. Cigna explicitly cites these services in the plan document to be helpful because customers and clients occasionally ask about whether or not they are covered. Cigna has collected this diverse list of services together in one exclusion solely based on their one common element: each is not medical or not directly medically related in nature. Cigna does not reimburse for services performed by an unlicensed/non-certified provider unless required by state law. However, the fact that a service is being provided by a licensed/certified provider does not automatically mean the service should be covered. Licensure itself is not a standalone factor used to determine if a service is appropriate. EIU services are excluded on the basis that there is not enough scientific evidence to prove

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
		their efficacy. Hence, the services would be reviewed for medical necessity regardless of who is providing the care. Customers are made aware of E/I/U services through their plan documentation provided to them at benefit enrollment. To affirm, only the EIU portion of the services would be denied, while medical services could be reimbursed.

EIU: As Written, In Operation, Conclusion:

As Written:
The definition of experimental/investigational /unproven services is the same for M/S and MH/SUD.
A single review committee, Cigna's HMAC, 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.

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.

In Operation:
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 all classifications revealed no statistically significant discrepancies in EIU

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
denial rates as-between M/S and MH/SUD benefits. **Conclusion:** The comparative analysis performed for application of the EIU NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation. Holistically, the number of EIU decisions across the Cigna commercial book of business data reflects lower MH/SUD average denial rates. Cigna's analysis of the benefit plan language and process and policies governing the application of EIU across M/S and MH/SUD benefits and the process by which M/S and MH/SUD services are selected for application of EIU demonstrates comparability and equivalent stringency in-writing and in-operation. Based upon its analysis, Cigna has concluded that the processes, strategies, evidentiary standards, and other factors used to determine MH/SUD services subject to EIU requirements are comparable to, and no more stringent than those used for the M/S services in all benefit classifications.		
Standards for Provider Credentialing and Contracting		
Is the provider network open or closed?	Cigna maintains an open network for MH/SUD providers, such that new providers looking to contract with Cigna will be admitted if they agree to contract language and terms, including reimbursement rates and meet Cigna's Network Provider admission criteria (“Credentialing Criteria”).	Cigna maintains an open network for M/S providers, such that new providers looking to contract with Cigna will be admitted if they agree to contract language and terms, including reimbursement rates and meet Cigna's Network Provider admission criteria (“Credentialing Criteria”).
What are the credentialing standards?	Credentialing standards for providers and facility approval to participate in a network 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 standards for providers and facility approval to participate in a network 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.

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Credentialing criteria for MH/SUD Network Providers may vary depending on provider/facility type, but generally includes the following standard requirements: 1. Credentialing Application 2. Signed Contract/Agreement 3. License 4. DEA or CDS Certification (when applicable) 5. Hospital Affiliation 6. Education 7. Work History 8. Acceptable History of Malpractice 9. Proof of Adequacy Professional Liability Coverage 10. Medicare & Medicaid Sanction History 11. Other Sanction Information The credentialing process is activated when a provider/facility signs an agreement/contract to participate in the Cigna network, submits a complete credentialing application via Council for Affordable Quality Healthcare (CAQH) or other state/provider specifical application to the Onboarding team. The Onboarding team reviews the practitioners'/facilities' information to ensure it is complete, then forwards the information to the Credentialing team for processing and approval/denial based on established criteria. The entire application to contract effective date completion timeframe is 90 days. Cigna maintains an open network and will contract with any MH/SUD provider or facility requesting admission to the network. Cigna does not limit parties with whom it will contract and negotiate rates. Provider admissions standards for entrance to the network are activated by either a provider request or Cigna's recruitment of the provider to join the network. Cigna 's credentialing process and requirements apply to all MH/SUD practitioners and facility types, including those affiliated with clinics and hospitals, as required by NCQA, state, and federal standards	Credentialing criteria for M/S Network Providers may vary depending on provider/facility type, but generally includes the following standard requirements: 1. Credentialing Application 2. Signed Contract/Agreement 3. License 4. DEA or CDS Certification (when applicable) 5. Hospital Affiliation 6. Education 7. Work History 8. Acceptable History of Malpractice 9. Proof of Adequacy Professional Liability Coverage 10. Medicare & Medicaid Sanction History 11. Other Sanction Information The credentialing process is activated when a provider/facility signs an agreement/contract to participate in the Cigna network, submits a complete credentialing application via Council for Affordable Quality Healthcare (CAQH) or other state/provider specifical application to the Onboarding team. The Onboarding team reviews the practitioners'/facilities' information to ensure it is complete, then forwards the information to the Credentialing team for processing and approval/denial based on established criteria. The entire application to contract effective date completion timeframe is 90 days. Cigna maintains an open network and will contract with any M/S provider or facility requesting admission to the network. Cigna does not limit parties with whom it will contract and negotiate rates. Provider admissions standards for entrance to the network are activated by either a provider request or Cigna's recruitment of the provider to join the network. Cigna's credentialing process and requirements apply to all M/S practitioners and facility types,

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<tr><td></td><td>A provider applicant must meet, at a minimum, the established discipline specific Credentialing Criteria for network participation. For example, depending on licensure level: the appropriate degree, state licensure, DEA (if applicable), State Controlled Substance Registration Certificate (where applicable), professional liability insurance, and other criteria related to professional training and work history. Additionally, providers are required to enter into a contract with Cigna that includes negotiated reimbursement rates. Credentialing policies set forth the requirements and standards for providers to join the Cigna network including, licensing, hospital affiliation, education, etc. A full list of requirements and how they are applied across MH/SUD is presented below.
<table>
<tr><th>Requirement</th><th>MH/SUD Policies
Practitioner Credentialing and Re-Credentialing (HM-NET-016)
Healthcare Facilities and Programs Credentialing and Re-credentialing (HM-NET-009)</th></tr>
<tr><td>Credentialing Application</td><td>Signed application required.</td></tr>
<tr><td>Signed Contract/Agreement</td><td>Signed Agreement (provider contract) to Participate required.</td></tr>
<tr><td>License</td><td>Unrestricted State License/Certification required, with the exception of Physician Assistants and Board-Certified Associate Behavior Analysts (BCaBA), providers shall have an unrestricted state license/certification that allows them to practice independently in the state. PA-Cs must practice under the supervision of a physician. In instances where a state does not license a specific discipline, Plan may accept a national certification/registration in place of state license/certification.</td></tr>
</table></td><td>including those affiliated with clinics and hospitals, as required by NCQA, state, and federal standards A provider applicant must meet, at a minimum, the established discipline specific Credentialing Criteria for network participation. For example, depending on licensure level: the appropriate degree, state licensure, DEA (if applicable), State Controlled Substance Registration Certificate (where applicable), professional liability insurance, and other criteria related to professional training and work history. Additionally, providers are required to enter into a contract with Cigna that includes negotiated reimbursement rates. Credentialing policies set forth the requirements and standards for providers to join the Cigna network including, licensing, hospital affiliation, education, etc. A full list of requirements and how they are applied across M/S is presented below.
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Practitioner Credentialing and Recredentialing Policy (CR-01) and Facility Credentialing/Re-credentialing (CR-04)</th></tr>
<tr><td>Credentialing Application</td><td>Signed application required.</td></tr>
<tr><td>Signed Contract/Agreement</td><td>Signed Agreement (provider contract) to Participate required.</td></tr>
<tr><td>License</td><td>Providers shall have an unrestricted state license/certification that allows them to practice independently in the state, except in cases where a state requires oversight of an allied practitioner by a supervising physician; the supervising physician must have an existing contract in good standing with Cigna. For Direct Entry Midwives specific certification by the state may be accepted in lieu of licensure.</td></tr>
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Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)		Medical/Surgical (M/S)	
	DEA or CDS Certification (when applicable)	Prescribing providers shall have a valid Drug Enforcement Agency certificate (DEA) or Controlled Dangerous Substance certificate (CDS).	DEA or CDS Certification (when applicable)	Prescribing providers shall have a valid Drug Enforcement Agency certificate (DEA) or Controlled Dangerous Substance certificate (CDS).
	Hospital Affiliation	If a provider's practice requires inpatient work, the provider shall be in good standing at the hospital/institution at which they have privileges.	Hospital Affiliation	Other than valid exception situations, practitioners must have privileges in good standing for at least one Cigna participating hospital
	Education	With the exception of PAs, BCaBAs and substance use professionals, each non-physician provider will have obtained a minimum of a master's degree in mental health or substance use field. PAs shall have completed training at a program accredited by the Commission on Accreditation of Allied health Education Programs and have been certified by the National Commission of Certification of Physician Assistants. BCBAs must have a bachelor's degree and have completed rigorous training in applied behavior analysis. Substance use providers may have a variety of educational backgrounds.	Education	All providers shall have completed the required level of education as mandated by the applicable state licensing board and training for each requested specialty. This includes graduation from medical or professional school, residency (if applicable), or board certification.
	Work History	Five years of work history should be included with the application or on the curriculum vitae (CV). Any gaps in work history greater than 6 months must be explained either orally or in writing. All gaps in work history greater than one year must be clarified in writing.	Work History	Five years of work history should be included with the application or on the curriculum vitae (CV). Any gaps in work history greater than 6 months must be explained either orally or in writing. All gaps in work history greater than one year must be clarified in writing.
	Acceptable History of Malpractice	Review of applicant's history (minimum 5 years) of malpractice claims, if any,	Acceptable History of Malpractice	Review of applicant's history (minimum 5 years) of malpractice claims, if any, to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)		Medical/Surgical (M/S)	
		to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank.	Proof of Adequacy Professional Liability Coverage	Each provider must carry professional liability coverage. All practitioners: $1M/occurrence and $3M aggregate, unless a lower amount is mandated by the state where the provider provides care to customers.
	Proof of Adequacy Professional Liability Coverage	Each provider must carry professional liability coverage. Physicians and other providers with prescriptive authority must carry $1M/occurrence and $3M aggregate unless a lower amount is mandated by the state where the provider provides care to customers. All other providers $1M/occurrence and $1M aggregate (unless state law dictates otherwise).	Medicare & Medicaid Sanction History	An applicant with an active Medicare/Medicaid sanction will not be accepted for participation. Medicare/Medicaid sanction review should be no older than 180 days at the time of the credentialing decision.
	Medicare & Medicaid Sanction History	An applicant with an active Medicare/Medicaid sanction will not be accepted for participation. Medicare/Medicaid sanction review should be no older than 180 days at the time of the credentialing decision.	Other Sanction Information	Query the appropriate verifying source depending on the type of practitioner. Review of the information should cover the most recent five-year period available. The report should be no older than 180 days at the time of the credentialing decision.
	Other Sanction Information	Query the appropriate verifying source depending on the type of practitioner. Review of the information should cover the most recent five-year period available. The report should be no older than 180 days at the time of the credentialing decision.		

The credentialing processes are developed by Cigna in accordance with NCQA accreditation requirements for Health Plans and Managed Behavioral Health Organizations No other factors were considered and rejected and no factors were weighted more than another. The **factors and sources** for the application of the NQTL include:

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• Cigna Application
• Provider attestation and required documentation</td></tr>
<tr><td>Facility and Facility-Based Practitioners</td><td>• the completed credentialing application and attestation
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• state licensing board, operating/certificate of occupancy, accreditation entity.</td></tr>
<tr><td>Hospitals</td><td>• the completed credentialing application and attestation
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Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Cigna maintains NCQA Managed Behavioral Healthcare Organization ("MBHO") Accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). CHLIC also maintains NCQA accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members' Rights & Responsibilities (approximately 250 documents). This evidence spans a period of 2 years, and the majority of the evidence has to be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC"). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). Cigna maintains a credentialing committee for the review of providers entering the MH/SUD networks. Cigna does not routinely track credentialing exceptions for MH/SUD Network Providers. Network Providers are re-credentialed on a three-year cycle as required by NCQA. The Credentialing Committee is responsible for the following:	Cigna maintains an open network for M/S Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria"). 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). CHLIC also maintains NCQA accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members' Rights & Responsibilities (approximately 250 documents). This evidence spans a period of 2 years, and the majority of the evidence has to be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC"). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). Cigna maintains a credentialing committee for the review of providers entering the M/S networks. Cigna does not routinely track credentialing exceptions for M/S Network Providers. Network Providers are re-credentialed on a three-year cycle as required by NCQA. The Credentialing Committee is responsible for the following: • implementation and oversight of credentialing policy

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• implementation and oversight of credentialing policy • approval and oversight of delegated credentialing activity • approval or rejection of all practitioner participation and continued participation • contract terminations All cases that are high profile or high risk will be reviewed by the National Medical Director prior to going to the committee. The Credentialing Committee meets once a month. Committee members are required to sign a confidentiality/nondiscrimination statement annually. **Membership:** The members of the Credentialing Committee will consist of: • Chairperson(s) – must be within MH/SUD • Co-chairperson(s) – must be within MH/SUD • To the extent practical, at least five (5) licensed providers from a variety of clinical specialties. The committee members include providers with backgrounds in MH/SUD and represent a broad range of academic and clinical backgrounds. The credentialing committee partners with the Quality programs and accreditation team to understand and implement requirements set forth by the various accreditation bodies. Cigna develops participation standards and credentialing processes in accordance with NCQA accreditation requirements for Health Plans and Managed Behavioral Health Organizations. These requirements ensure efficient, accurate, and consistent credentialing, including protecting information, verifying credentials, and ongoing monitoring. Cigna's credentialing department is NCQA certified.	• approval and oversight of delegated credentialing activity • approval or rejection of all practitioner participation and continued participation • contract terminations All cases that are high profile or high risk will be reviewed by the National Medical Director prior to going to the committee. The Credentialing Committee meets once a month. Committee members are required to sign a confidentiality/nondiscrimination statement annually. **Membership:** The members of the Credentialing Committee will consist of: • Chairperson – must be within M/S • Co-chairperson – must be within M/S • To the extent practical, at least five (5) licensed providers from a variety of medical specialties. The committee members include providers with backgrounds in M/S and represent a broad range of academic and medical backgrounds. The credentialing committee partners with the Quality programs and accreditation team to understand and implement requirements set forth by the various accreditation bodies. Cigna develops participation standards and credentialing processes in accordance with NCQA accreditation requirements for Health Plans and Managed Behavioral Health Organizations. These requirements ensure efficient, accurate, and consistent credentialing, including protecting information, verifying credentials,

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• verification of valid, unrestricted DEA certificate (if applicable);
• verification of full, unrestricted admitting privileges at a Cigna participating hospital;
• verification Board certification, (if applicable);
• verification of highest level of education and training, if not board certified;
• review and verification of malpractice claims history;
• review of work history;
• verification of adequate malpractice insurance; and
verification of prior and current sanction activities</td></tr>
<tr><td>State licensing boards, OIG, CAQH, NCQA standards, State, or federal requirements</td><td>the completed credentialing application and attestation received. Cigna Provider Manual, NCQA standards, State or Federal Requirements</td></tr>
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Credentialing standards for provider admission to participate in a network 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
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Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	("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. **Plan Standards for Facilities** To help ensure EBH network providers meet quality standards for participation and to comply with accreditation requirements, hospitals and ancillary facilities are credentialed before participating in a network. Participating hospitals and ancillary facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of customer care, pursues improvement opportunities, and resolves problems. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department of Health, or Medicare certification evidence is not available, Cigna may perform a site visit and review of the hospital or ancillary facility quality improvement program. In accordance with the Cigna 's national credentialing requirements, hospitals and ancillary facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The Cigna credentialing and recredentialing policies and procedures are reviewed at least annually and revised as necessary, including revisions to reflect state and local quality assurance standards for facility types, including but not limited to, hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, residential medical/behavioral facilities, ambulatory services, inpatient, etc. The plan standards for facilities include:	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 provide 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. **Plan Standards for Facilities** To help ensure Cigna Healthcare network providers meet quality standards for participation and to comply with accreditation requirements, hospitals and ancillary facilities are credentialed before participating in a network. Participating hospitals and ancillary facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of customer care, pursues improvement opportunities, and resolves problems. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department of Health, or Medicare certification evidence is not available, Cigna Healthcare may perform a site visit and review of the hospital or ancillary facility quality improvement program. In accordance with the Cigna's national credentialing requirements, hospitals and ancillary facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The Cigna Healthcare credentialing and recredentialing policies and procedures are reviewed at least

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Copy of unrestricted state license, permit, or state operating certificate, as applicable • Copy of current accreditation letter or certificate. • Proof of current professional and general liability insurance coverage that meets Cigna minimum guidelines • National Provider Identifier • Any explanation requested on application, including a list of malpractice settlements and judgments • If not accredited, a copy of the most recent Centers for Medicare & Medicaid Services (CMS) evaluation report • Onsite assessment, if not accredited or Medicare and Medicaid certified • Copy of the quality management plan, if not accredited or Medicare and Medicaid certified • List of available services that can be rendered by facility • Absence of current sanctions from Medicaid or Medicare If an ancillary facility is not subject to state licensure requirements, the Cigna Credentialing Committee will determine if the facility meets remaining credentialing standards for participation in the Cigna network. **Plan Standards for Physicians** Physicians applying for participation in the network for MH/SUD services are required to sign an agreement for participation and complete the credentialing process prior to becoming a participating provider. The criteria for credentialing is determined by the National Committee for Quality Assurance (NCQA), state, and federal standards. The plan standards for physicians include: • A completed signed and dated application via Counsel for Affordable Quality Healthcare (CAQH) or state approved application • A completed, signed, and dated authorization and release form (if not included in the application form)	annually and revised as necessary, including revisions to reflect state and local quality assurance standards for facility types, including but not limited to, hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, residential medical/behavioral facilities, ambulatory services, inpatient, etc. The plan standards for facilities include: • Copy of unrestricted state license, permit, or state operating certificate, as applicable • Copy of current accreditation letter or certificate. • Proof of current professional and general liability insurance coverage that meets Cigna Healthcare minimum guidelines • National Provider Identifier • Any explanation requested on application, including a list of malpractice settlements and judgments • If not accredited, a copy of the most recent Centers for Medicare & Medicaid Services (CMS) evaluation report • Onsite assessment, if not accredited or Medicare and Medicaid certified • Copy of the quality management plan, if not accredited or Medicare and Medicaid certified • List of available services that can be rendered by facility • Absence of current sanctions from Medicaid or Medicare If an ancillary facility is not subject to state licensure requirements, the Cigna Credentialing Committee will determine if the facility meets remaining credentialing standards for participation in the Cigna network. **Plan Standards for Physicians** Physicians applying for participation in the Cigna network for M/S services are required to sign an agreement for participation and complete the credentialing process prior to becoming a Cigna

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Documented work history for the past 5 years (initial cred only) • Current unrestricted license to practice • Current unrestricted DEA/CDS certificate (if applicable) • Board Certification (if board certified) • Verifiable education/training (if not board certified) • Unrestricted admitting privileges to at least one Cigna participating hospital (if provider admits patients). Exceptions may be granted (i.e., an applicant's specialty does not typically require admitting privileges, satisfactory alternative mechanism has been established as determined by Cigna and industry standards) • Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits • Acceptable history of professional liability claim experience from the National Practitioner Data Bank (NPDB) • Acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization. Cigna's Credentialing Committee will evaluate exceptions to the credentialing criteria on a case-by-case basis. Exceptions include, but are not limited to, hospital privileges for providers that do not typically admit, waiving DEA for providers who do not prescribe, etc. Cigna also confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between cycles. and, if applicable, is reviewed and approved by Cigna's Credentialing Committee	participating provider. The criteria for credentialing is determined by the National Committee for Quality Assurance (NCQA), state, and federal standards. The plan standards for physicians include: • A completed signed and dated application via Counsel for Affordable Quality Healthcare (CAQH) or state approved application • A completed, signed, and dated authorization and release form (if not included in the application form) • Documented work history for the past 5 years (initial cred only) • Current unrestricted license to practice • Current unrestricted DEA/CDS certificate (if applicable) • Board Certification (if board certified) • Verifiable education/training (if not board certified) • Unrestricted admitting privileges to at least one Cigna participating hospital (if provider admits patients). Exceptions may be granted (i.e., an applicant's specialty does not typically require admitting privileges, satisfactory alternative mechanism has been established as determined by Cigna Healthcare and industry standards) • Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits • Acceptable history of professional liability claim experience from the National Practitioner Data Bank (NPDB) • Acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization. Cigna's Credentialing Committee will evaluate exceptions to the credentialing criteria on a case-by-case basis. Exceptions include, but are not limited to, hospital privileges for providers that do not typically admit, waiving DEA for providers who do not prescribe, etc.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
		Cigna also confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between cycles. and, if applicable, is reviewed and approved by Cigna's Credentialing Committee
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards (e.g., nurse practitioners, physician assistants, psychologists, clinical social workers)	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. **Plan Standards for Non-Physicians** Non-physicians applying for participation in the Cigna network for MH/SUD services follow the same standards/criteria to the physicians' standards, where applicable. Examples of non-physician practitioners include, but are not limited to, physician assistants, naturopaths, nurses, acupuncturists, and midwives (subject to state laws). The credentialing criteria for non-physicians is also determined by the National Committee for Quality Assurance (NCQA), state, and federal standards. Cigna's Credentialing Committee evaluates exceptions to the credentialing criteria on a case-by-case basis. Exceptions include, but are not limited to, hospital privileges for providers that do not typically admit, waiving DEA for providers who do not prescribe, etc. Cigna also confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between cycles and, if applicable, is reviewed and approved by Cigna's Credentialing Committee. • A completed signed and dated application via Counsel for Affordable Quality Healthcare (CAQH) or state approved application • A completed, signed, and dated authorization and release form (if not included in the application form)	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. **Plan Standards for Non-Physicians** Non-physicians applying for participation in Cigna's network for M/S services follow the same standards/criteria to the physicians' standards, where applicable. Examples of non-physician practitioners include, but are not limited to, physician assistants, naturopaths, nurses, acupuncturists, and midwives (subject to state laws). The credentialing criteria for non-physicians is also determined by the National Committee for Quality Assurance (NCQA), state, and federal standards. Cigna's Credentialing Committee evaluates exceptions to the credentialing criteria on a case-by-case basis. Exceptions include, but are not limited to, hospital privileges for providers that do not typically admit, waiving DEA for providers who do not prescribe, etc. Cigna also confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between cycles and, if applicable, is reviewed and approved by Cigna's Credentialing Committee. • A completed signed and dated application via Counsel for Affordable Quality Healthcare (CAQH) or state approved application

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Documented work history for the past 5 years (initial cred only) • Current unrestricted license to practice • Verifiable education/training (if not board certified) • Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits • Acceptable history of professional liability claim experience from the National Practitioner Data Bank (NPDB) • Acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization.	• A completed, signed, and dated authorization and release form (if not included in the application form) • Documented work history for the past 5 years (initial cred only) • Current unrestricted license to practice • Verifiable education/training (if not board certified) • Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits • Acceptable history of professional liability claim experience from the National Practitioner Data Bank (NPDB) • Acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization.
What are the credentialing/contracting standards for unlicensed personnel? (e.g., home health aides, qualified autism service professionals and paraprofessionals)	Unlicensed providers may not be directly contracted but may render services under a fully contracted and credentialed individual (supervising provider) or entity.	Unlicensed providers may not be directly contracted but may render services under a fully contracted and credentialed individual (supervising provider) or entity.
Credentialing As Written, In Operation, Conclusion: **As Written:** Cigna's methodology for credentialing for M/S and MH/SUD physician providers are the same. Cigna credentialing standards for licensed physicians follow 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.		

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

<table>
<tr><th>Non-Quantitative Treatment Limitation (NQTL)</th><th>Mental Health/Substance Use Disorder Benefits (MH/SUD)</th><th>Medical/Surgical (M/S)</th></tr>
<tr><td colspan="3">In Operation:
In operation, M/S and MH/SUD credentialing have been evaluated and determined to be comparable because:

• Cigna maintains an open network and will contract with any M/S or MH/SUD provider or facility requesting admission to the network.
• Both M/S and MH/SUD utilize Network Admissions standards that are designed and maintained by the Quality Programs & Accreditation (“QP&A”) team. M/S and MH/SUD credentialing process steps are aligned.
• Cigna maintains one credentialing committee for the review of providers entering the M/S or MH/SUD networks.
• The metrics used to monitor performance are consistent
  ○ Average time to review a credentialing application
  ○ Average time to approve a credentialing application
  ○ Average time to deny a credentialing application
  ○ The number of appeals
  ○ The number of appeal denials

Conclusion:
Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, is 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.</td></tr>
<tr><th colspan="3">Exclusions for Failure to Complete a Course of Treatment</th></tr>
<tr><td>Does the plan exclude benefits for failure to complete a course of treatment?</td><td>Cigna does not exclude benefits for failure to complete treatment.</td><td>Cigna does not exclude benefits for failure to complete treatment.</td></tr>
<tr><td>Does the plan restrict the geographic location in which services can be received? (e.g., service area, within a specific State, within the U.S.)</td><td>Cigna will provide benefit coverage for services rendered by an appropriately licensed facility or provider, subject to benefit availability (INN/OON) and medical necessity. Cigna does not limit scope or duration based on provider/facility type. Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice.</td><td>Cigna will provide benefit coverage for services rendered by an appropriately licensed facility or provider, subject to benefit availability (INN/OON) and medical necessity. Cigna does not limit scope or duration based on provider/facility type. Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice.</td></tr>
<tr><th colspan="3">Restrictions that Limit Duration or Scope of Benefits for Services</th></tr>
<tr><td>Does the plan restrict the type(s) of facilities in</td><td>Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice.</td><td>Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice.</td></tr>
</table>

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
which enrollees can receive services?	Customers are only limited to in or out of network benefit limitations according to the subscriber plan. Cigna does not limit scope or duration based on provider/facility type, other than the standard licensing or board certifications required by NCQA credentialing standards and state licensing requirements.	Customers are only limited to in or out of network benefit limitations according to the subscriber plan. Cigna does not limit scope or duration based on provider/facility type, other than the standard licensing or board certifications required by NCQA credentialing standards and state licensing requirements.
Provider Specialties		
Does the plan restrict the types of provider specialties that can provide certain MH/SUD benefits?	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.
Provider Directory (In Network Benefit Classifications)		
	Factors: Network participation of a licensed health care provider, facility or ancillary provider. 1. Onboarding (contracting) 2. Approval (credentialing) **Sources for Factors:** 1. Onboarding (contracting): Executed Provider Agreement 2. Approval (credentialing): CAQH or other approved application form **Evidentiary Standards and Applicable Thresholds:** 1. Onboarding (contracting): Executed Provider Agreement, signed by both the provider and Cigna, representing their agreement to be bound by the terms and conditions of the contract. 2. Approval (credentialing): CAQH or other approved application form and primary source verification sites for education, licensure and sanctions. Credentialing criteria and verification sites will differ by type of Provider (i.e. hospital, Residential Treatment	**Factors:** Network participation of a licensed health care provider, facility or ancillary provider. 1. Onboarding (contracting) 2. Approval (credentialing) **Sources for Factors:** 1. Onboarding (contracting): Executed Provider Agreement 2. Approval (credentialing): CAQH or other approved application form **Evidentiary Standards and Applicable Thresholds:** 1. Onboarding (contracting): Executed Provider Agreement, signed by both the provider and Cigna, representing their agreement to be bound by the terms and conditions of the contract. 2. Approval (credentialing): CAQH or other approved application form and primary source verification sites for education, licensure and sanctions. Credentialing criteria

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Center, Practitioner). **Sources for Evidentiary Standards:** 1. Onboarding (contracting): Executed Provider Agreement 2. Approval (credentialing): Successful Credentialing Approval. Criteria will differ by type of Provider	and verification sites will differ by type of Provider (i.e. hospital practitioner, Ambulatory Surgical Center, etc.) **Sources for Evidentiary Standards:** 1. Onboarding (contracting): Executed Provider Agreement 2. Approval (credentialing): Successful Credentialing Approval. Criteria will differ by type of Provider

Provider Directory As Written, In Operation, and Conclusion:

As Written:
For both its M/S and MH/SUD provider directories, Cigna has aligned policies to establish and monitor appropriate Provider Directory display, search and navigation. Alignment includes (1) identical factors for providers to meet prior to being displayed in directories (executed contracted, approved credentialing); (2) processes for maintaining and auditing data; (3) integrated M/S and MH/SUD Provider Directory for enrollee ease of use. Policies are reviewed on at least an annual basis to ensure compliance with parity and all state/federal regulations. Additionally, results of directory outreach/audit are reviewed together. Where appropriate, corrective actions are aligned to ensure parity between M/S and MH/SUD results and action plans.

In Operation:
M/S and MH/SUD are evaluated on a similar cadence (every 90 days) and use similar mechanisms for validation. MH/SUD data is further evaluated for accuracy via a direct outreach to MH/SUD providers to validate with them directly, all of their demographic data elements displayed in the Provider Directory. For both M/S and MH/SUD providers, they are subject to suppression from the directory if they are non-responsive to all outreach/validation attempts made in a calendar year.

Cigna maintains a robust M/S and MH/SUD network of in-person and virtual providers, which are similarly displayed and searchable in a single, combined Provider Directory for enrollee use. Processes to bring a M/S and MH/SUD provider into the network, and available for Provider Directory display are aligned both in writing and operation.

Provider Shortages are deficiencies in the number or availability of in-network providers with appropriate training and expertise to sufficiently meet the needs of a carrier's members to obtain covered services without unreasonable delay or travel. Provider Shortages include determinations by a carrier that additional providers are required for the product's network based on factors and evidentiary standards used by the carrier to measure network composition or to address network deficiencies in addition to meeting network adequacy standards set by a state or federal regulator.

The Cigna and Evernorth networks are assessed for adequacy according to Provider Availability and Accessibility standards. Additionally, both networks are open to all interested providers who:

- Sign and agree to contract terms (including rates)

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
• Meet all credentialing requirements (which may vary based on provider type) Cigna and Evernorth utilize the following strategies when a provider shortage is noted to identify potential providers for network recruitment purposes: • Review out-of-network utilization • Review of competitor provider directories • If competitor provider directories show no other option available (i.e. Cigna/Evernorth has contracted with all available providers in the market), an internet search is conducted to see if there are any other non-participating providers that can be added for recruitment. Provider data accuracy monitoring is conducted on an ongoing basis and opportunities for improvement or efficiencies in the process are regularly sought out. For example, M/S Provider Directory data is currently able to be verified via First Level (external sources, automated logic). MH/SUD data is currently being piloted through a similar process to determine if this is a successful form of data validation for MH/SUD providers as well. If successful, Cigna hopes that this helps to further improve MH/SUD data accuracy while lessening the burden on providers of validating their data every 90 days and improving data update turnaround time. Cigna/Evernorth finds the processes applied to MH/SUD to be comparable and no more restrictive than those to M/S.		
Network Adequacy		
Explain how the plan ensures the provider network provides sufficient availability of providers within the service area	Cigna utilizes the following factors, sources, and evidentiary standards to determine In-network Inpatient, Outpatient office, and Outpatient all other services that are subject to the Network Adequacy NQTL. These factors are not weighted. No other factors have been considered and rejected. **Factors:** 1. State/Federal Law, as applicable 2. Provider Availability 3. Provider Accessibility to meet Appointment Wait Time Standards **Evidentiary Standards and Applicable Thresholds:** 1. State/Federal Law, as applicable 2. Provider Availability and other state/federal requirements as benchmarks. • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Quest Analytics conducts this reporting/analysis.	Cigna utilizes the following factors, sources, and evidentiary standards to determine In-network Inpatient, Outpatient office, and Outpatient all other services that are subject to the Network Adequacy NQTL. These factors are not weighted. No other factors have been considered and rejected. **Factors:** 1. State/Federal Law, as applicable 2. Provider Availability 3. Provider Accessibility to meet Appointment Wait Time Standards **Evidentiary Standards and Applicable Thresholds:** 1. State/Federal Law, as applicable 2. Provider Availability and other state/federal requirements as benchmarks.

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<td></td>
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Urban: Population density is >3,000 people per square mile
Suburban: Population density is 1,000-3,000 people per square mile
Rural Population density is <1,000 people per square mile

<table>
<tr><th colspan="3">Travel Distance Standards</th></tr>
<tr><th>Provider Type</th><th>Geography</th><th>Standard</th></tr>
<tr><td>Master’s Level Clinician</td><td>Urban/Suburban/Rural</td><td>15 miles/15 miles/25 miles</td></tr>
<tr><td>Psychologist</td><td>Urban/Suburban/Rural</td><td>15 miles/15 miles/25 miles</td></tr>
<tr><td>Prescriber</td><td>Urban/Suburban/Rural</td><td>15 miles/15 miles/25 miles</td></tr>
<tr><td>Inpatient Facility</td><td>Urban/Suburban/Rural</td><td>25 miles/30 miles/40 miles</td></tr>
<tr><td>Residential Facility</td><td>Urban/Suburban/Rural</td><td>25 miles/30 miles/40 miles</td></tr>
<tr><td>Ambulatory Facility</td><td>Urban/Suburban/Rural</td><td>25 miles/30 miles/40 miles</td></tr>
</table>
3. Provider Accessibility to meet Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys.
<table>
<tr><th colspan="2">Waiting Time Standards</th></tr>
<tr><td>Life-Threatening Emergency</td><td>Immediately</td></tr>
<tr><td>Non-Life-Threatening Emergency</td><td>6 hours</td></tr>
<tr><td>Urgent</td><td>48 hours</td></tr>
<tr><td>Routine Initial Visit</td><td>10 working days</td></tr>
<tr><td>Routine follow-up care</td><td>30 days</td></tr>
</table>
Sources for Evidentiary Standards:
1. State/Federal Law, as applicable
2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.
</td>
<td>

Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Quest Analytics conducts this reporting/analysis.

Urban: Population density is >3,000 people per square mile
Suburban: Population density is 1,000-3,000 people per square mile
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<tr><th colspan="3">Travel Distance Standards</th></tr>
<tr><th>Provider Type</th><th>Geography</th><th>Standard</th></tr>
<tr><td>Adult Primary Care Provider</td><td>Urban/Suburban/Rural</td><td>10/15/30 miles</td></tr>
<tr><td>Pediatric Primary Care Provider</td><td>Urban/Suburban/Rural</td><td>15/60/75 miles</td></tr>
<tr><td>Cardiology</td><td>Urban/Suburban/Rural</td><td>20/35/60 miles</td></tr>
<tr><td>Dermatology</td><td>Urban/Suburban/Rural</td><td>20/35/60 miles</td></tr>
<tr><td>OB/Gyn</td><td>Urban/Suburban/Rural</td><td>20/35/60 miles</td></tr>
<tr><td>Allergy & Immunology</td><td>Urban/Suburban/Rural</td><td>20/35/60 miles</td></tr>
<tr><td>Orthopedics</td><td>Urban/Suburban/Rural</td><td>20/35/60 miles</td></tr>
<tr><td>Hematology/Oncology</td><td>Urban/Suburban/Rural</td><td>30/45/60 miles</td></tr>
<tr><td>Infectious Disease</td><td>Urban/Suburban/Rural</td><td>40/75/90 miles</td></tr>
<tr><td>Nephrology</td><td>Urban/Suburban/Rural</td><td>40/75/90 miles</td></tr>
<tr><td>Neurology</td><td>Urban/Suburban/Rural</td><td>40/75/90 miles</td></tr>
<tr><td>Pulmonary Medicine</td><td>Urban/Suburban/Rural</td><td>40/75/90 miles</td></tr>
<tr><td>Hospital</td><td>Urban/Suburban/Rural</td><td>25/30/35 miles</td></tr>
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3. Provider Accessibility to meet Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys.
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<tr><td></td><td>

Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring
Customer and/or Client Requests
Customer Complaints
Quality Concerns
Out-of-Network Provider Utilization

3. Provider Accessibility is measured through a provider and customer.

Design and Application:
Cigna maintains an open network for MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria (“Credentialing Criteria”).

Cigna monitors Network Adequacy at least annually and regularly produces Network Adequacy Plans for MH/SUD individual plan type networks for submission to states, as required.
</td><td>
<table>
<tr><th colspan="2">Waiting Time Standards</th></tr>
<tr><td>Urgent care for medical services</td><td>24 Hours</td></tr>
<tr><td>Routine primary care</td><td>14 days</td></tr>
<tr><td>Preventive visit/well visit</td><td>14 days</td></tr>
<tr><td>Non-urgent specialty care</td><td>14 days</td></tr>
</table>
Sources for Evidentiary Standards:
1. State/Federal Law, as applicable
2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.

Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring
Customer and/or Client Requests
Customer Complaints
Quality Concerns
Out-of-Network Provider Utilization

3. Provider Accessibility is measured through provider and customer surveys.

Design and Application:
Cigna maintains an open network for M/S Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria (“Credentialing Criteria”).

Cigna monitors Network Adequacy at least annually and regularly produces Network Adequacy Plans for M/S individual plan type networks for submission to states, as required.
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<tr><td colspan="3">Network Adequacy: As Written, In Operation, Conclusion:

As Written:</td></tr>
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Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

Cigna maintains an open network for both M/S and MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria"). Cigna maintains NCQA Managed Behavioral Healthcare Organization ("MBHO") Accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).
 	
NCQA Requirements dictate that Cigna monitors M/S and MH/SUD provider availability and accessibility utilizing various elements including:
 	
• The use of ratios such as the number of each type of practitioners to number of customers or the number of primary care practices accepting new patients to number of customers.
• The geographic distribution of practitioners that are within an acceptable distance to a practitioner's office or within an acceptable drive time.
• A quantitative and qualitative analysis that includes initial measurements to analyze data, then subsequent remeasurements if quantitative analysis demonstrates that stated goals were not met.
 	
Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA.
 	
In Operation:
Cigna evaluates comparability for M/S and MH/SUD Network Adequacy via provider availability and accessibility monitoring.
• Monitoring is conducted on an ongoing basis, and an analysis is performed annually to ensure that established accreditation, state, and federal standards for reasonable geographical location, number of providers, appointment availability, and provision for emergency care are measured.
• Monitoring activities may include evaluation of satisfaction surveys, evaluation of complaint and appeal reports, and evaluation of provider to customer ratios.
• An assessment of the provider network is also performed to ensure that the network meets the cultural, ethnic, racial, and linguistic needs and preferences of customers.
• Specific deficiencies are addressed with a corrective action plan, and follow-up activities are conducted to reassess compliance.
 	
Cigna assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon:
• the same indicators including NCQA and National Association of Insurance Commissioners (NAIC), and
• federal/state, network adequacy and access standards focused on:
  ○ distribution of provider types within geographic regions (i.e. zip codes);
  ○ plan population density within geographic regions (i.e. zip codes);
  ○ time and/or distance to access provider type within urban, suburban and rural areas;		

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
○ appointment wait times for emergent, urgent and routine visits; ○ customer satisfaction surveys; ○ customer complaint data Cigna reviewed provider availability ratios between M/S and MH/SUD providers and found MH/SUD providers to be available at a higher standard than M/S providers. This allows the customer more availability to MH/SUD care which in turn is more favorable when comparing MH/SUD to M/S. Per the provider survey administered by Cigna, M/S urgent care and MH/SUD inpatient urgent care results were compared and found that MH/SUD services were typically available quicker than medical urgent care services. Additionally, standards for non-urgent care were able to be compared and found similar results, that MH/SUD care was, on average, available faster than M/S non-urgent care services. **Conclusion:** As a result of its comparative analysis Cigna concludes that its processes, both written and in operation, are comparable across M/S and MH/SUD networks: consideration of state and federal law, provider availability and provider accessibility, as defined by a number of factors and sources. The same processes and factors are applied to M/S and MH/SUD networks.		
In-Network Provider (including Facility) Reimbursement		
Explain the plan's reimbursement approach for contracted providers	**Inpatient Facility Factors:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty, i.e. Network Adequacy). Perceived or actual: reputation or name recognition, quality of services and bargaining power 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available	**Inpatient Facility Factors:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty, i.e. Network Adequacy). Perceived or actual: reputation or name recognition, quality of services and bargaining power 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Sources for Factors: 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. Medicare Inpatient Prospective Payment System (IPPS) 4. Internal analysis of market dynamics/network adequacy, including review of supply of facilities from state licensing sites and competitor directory review and demand-based utilization trends. Research related to the reputation or name recognition amongst the community. Quality of Care/Service complaint reviews or status. Bargaining power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate) 5. Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs 6. Types of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data 7. Internal Determination 8. Internal Cigna Claims Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Evidentiary Standards and Applicable Thresholds:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and	8. Utilization 9. Competitive insights, when available **Sources for Factors**: 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S providers are classified based on provider type/level of training based upon CMS methodology. 3. Medicare Inpatient Prospective Payment System (IPPS) 4. Internal analysis of market dynamics/network adequacy, including review of supply of facilities from state licensing sites and competitor directory review and demand-based utilization trends. Research related to the reputation or name recognition amongst the community. Quality of Care/Service complaint reviews or status. Bargaining power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate) 5. Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs 6. Types of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data 7. Internal Determination 8. Internal Cigna Claims Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Evidentiary Standards and Applicable Thresholds:**

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels may merit higher reimbursement. 3. Medicare baseline rates: a. Diagnosis Related Group ("DRG"): Patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. (citation: CMS.gov). Applicable to Facility Inpatient and Facility Outpatient benefit classifications. 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 as indicated on the claim form, such as patient age and diagnosis. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and "groups it" into the correct DRG. That DRG information is then used to calculate the reimbursement, based on the factor in the contract. Cigna's DRG base rates are calculated using the factors defined in Step 1. The base rates for DRG are listed in the contract. The base rate is then multiplied by the CMS DRG weighing to determine reimbursement. By way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement b. Resource-Based Relative Value Scale ("RBRVS"): 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 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	1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels may merit higher reimbursement. 3. Medicare baseline rates: a. Diagnosis Related Group ("DRG"): Patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. (citation: CMS.gov). Applicable to Facility Inpatient and Facility Outpatient benefit classifications. 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 as indicated on the claim form, such as patient age and diagnosis. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and "groups it" into the correct DRG. That DRG information is then used to calculate the reimbursement, based on the factor in the contract. Cigna's DRG base rates are calculated using the factors defined in Step 1. The base rates for DRG are listed in the contract. The base rate is then multiplied by the CMS DRG weighing to determine reimbursement. By way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement b. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement c. Percent of Charge – percent of covered billed charges d. Per Diem – a per day, all-inclusive reimbursement rate for all covered services provided on that day 4. Supply of providers is determined by using state licensing sites to verify licensure and existence of provider/facility. Competitor directories (i.e., Aetna, Blue Cross) are used to identify available providers/facilities. These external sources, along with Plan's internal sources (i.e., existing networks including adequacy, utilization history) establish the availability of providers. Demand can be determined by Plan's internal review of utilization/claims data. Reputation and Name Recognition is a qualitative determination based on the supply/demand analysis as well as volume of client/customer requests and customer reviews (i.e. internet reviews). Quality is determined by qualitative assessment of quality of care and/or quality of service. Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative, including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the	designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard 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: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement c. Percent of Charge – percent of covered billed charges d. Per Diem – a per day, all-inclusive reimbursement rate for all covered services provided on that day 4. Supply of providers is determined by using state licensing sites to verify licensure and existence of provider/facility. Competitor directories (i.e., Aetna, Blue Cross) are used to identify available providers/facilities. These external sources, along with Plan's internal sources (i.e., existing networks including adequacy, utilization history) establish the availability of providers. Demand can be determined by Plan's internal review of utilization/claims data. Reputation and Name Recognition is a qualitative determination based on the supply/demand analysis as well as volume of client/customer requests and customer reviews (i.e. internet reviews). Quality is determined by qualitative assessment of quality of care and/or quality of service.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	following: • Appropriateness of Care: Alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care: Appropriateness of care resulting in a disruption in treatment. Individuals in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain the appropriate care. • Refusal of Care: Denial of care by a healthcare professional or provider for such reasons as no identification card, late for appointment, healthcare professional missing scheduled appointment or no healthcare professional available. Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following: • Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit). • Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as: uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care	Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative, including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the following: • Appropriateness of Care: Alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care: Appropriateness of care resulting in a disruption in treatment. Individuals in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain appropriate care. • Refusal of Care: Denial of care by a healthcare professional or provider for such reasons as no identification card, late for appointment, healthcare professional missing scheduled appointment or no healthcare professional available. Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following: • Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit).

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	needs (i.e. too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far, healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff - dissatisfaction about business partner's staff being unaware of procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate. 5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon the CMS Hospital wage index. 6. 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 7. Medical cost budgets - MH/SUD medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally, new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. The threshold is not specifically numerically defined,	• Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as: uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care needs (i.e. too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far, healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff - dissatisfaction about business partner's staff being unaware of procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate. 5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon the CMS Hospital wage index. 6. 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

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	but rather a question of whether the proposed rates are within or outside of the established budget. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/customer preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences 9. Competitive insights: When available through Coordination of Benefits or Transparency data, is used to determine fair market reimbursement rates. **Sources for Evidentiary Standards:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic, and practitioner) and/or specialty (e.g., physician practitioners v. non-physician practitioner v. facility). 3. Medicare Inpatient Prospective Payment System (IPPS) 4. Internal analysis of market dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches. Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate). 5. Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs 6. Types of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data	network access requirements and/or increase membership. 7. Medical cost budgets - M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally, new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. The threshold is not specifically numerically defined, but rather a question of whether the proposed rates are within or outside of the established budget. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/customer preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. 9. Competitive insights: When available through Coordination of Benefits or Transparency data, it is used to determine fair market reimbursement rates. **Sources for Evidentiary Standards:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic, and practitioner) and/or specialty (e.g., physician practitioners v. non-physician practitioner v. facility). 3. Medicare Inpatient Prospective Payment System (IPPS) 4. Internal analysis of market dynamics/network adequacy,

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	7. Internal Determination 8. Internal Cigna claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Design and Application:** Cigna maintains an open network and will contract with any MH/SUD provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. MH/SUD negotiations are based upon provider and information availability at a single point in-time. Negotiations depend on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. **Outpatient-Office, Outpatient All Other Factors:** 1. State and/or Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered:	including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches. Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate). 5. Hospital Wage Index to adjust payments based on geographic differences in hospital labor costs 6. Types of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data 7. Internal Determination 8. Internal Cigna claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Design and Application:** Cigna maintains an open network and will contract with M/S provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. M/S negotiations are based upon provider and information availability at a single point in-time. Negotiations depend on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. It is important to

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty) Perceived or actual: reputation or name recognition, quality of services and bargaining power. 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available **Sources for Factors:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e. hospital, clinic and practitioner) and/or specialty (e.g. physician practitioners v. non-physician practitioner v. facility). 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches, Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate) 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market	note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. **Outpatient-Office, Outpatient All Other Factors:** 1. State and/or Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty) Perceived or actual: reputation or name recognition, quality of services and bargaining power. 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available. **Sources for Factors:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic

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	rate and payment type for provider type and/or specialty 6. Types of Service are identified by CPT and HCPC codes and Internal Cigna Data 7. Internal determination 8. Internal Cigna Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Evidentiary Standards and Applicable Thresholds:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. 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). 3. Resource-Based Relative Value Scale (“RBRVS”): 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 Medicare Resource Based Relative Value Scale (“RBRVS”), a CMS created reimbursement methodology to reimburse providers for customers 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:	and practitioner) and/or specialty (e.g. physician practitioners v. non-physician practitioner v. facility). 3. CMS Medicare Resources Based Relative Value” scale (“RBRVS") system. 4. Internal analysis of market dynamics /network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may enhance a provider’s/facility’s ability to negotiate) 5. Medicare Geographical Practice Cost Index (“GPCI”), i.e. market rate and payment type for provider type and/or specialty 6. Types of Service are identified by CPT and HCPC codes and Internal Cigna Data 7. Internal determination 8. Internal Cigna Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Evidentiary Standards and Applicable Thresholds:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable

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	[(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement 4. Supply of provider type and/or specialty (network adequacy): 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. Reputation and Name Recognition is a qualitative determination based on the supply/demand analysis as well as volume of client/customer requests and customer reviews (i.e. internet reviews). Quality is determined by qualitative assessment of quality of care and/or quality of service. Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative, including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the following: • Appropriateness of Care - alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care - appropriateness of care resulting in a	state or NCQA. Providers with higher degree levels may merit higher reimbursement, Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner). 3. Resource-Based Relative Value Scale (“RBRVS”): 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 Medicare Resource Based Relative Value Scale (“RBRVS”), a CMS created reimbursement methodology to reimburse providers for customers 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: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement 4. Supply of provider type and/or specialty (network adequacy): 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.

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	disruption in treatment. Individual in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain the appropriate care. • Refusal of Care – denial of care by a healthcare professional or provider for such reasons as no identification card, late appointment, healthcare professional missing scheduled appointment or no healthcare professional available. Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following: • Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit). • Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as: uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care needs (i.e. too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far, healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff -	Reputation and Name Recognition is a qualitative determination based on the supply/demand analysis as well as volume of client/customer requests and customer reviews (i.e. internet reviews). Quality is determined by qualitative assessment of quality of care and/or quality of service. Quality of Care Complaints (QOC): A complaint (including written or verbal expression of dissatisfaction) received from the Customer or the Customer's representative, including quality of care concerns that has or has potential to negatively impact the Customer's clinical outcome. An example may be one of the following: • Appropriateness of Care - alleging mismanagement of care, conflicting diagnoses, improper treatment or exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care caused complications leading to additional service or care. • Continuity of Care - appropriateness of care resulting in a disruption in treatment. Individuals in need of assistance in obtaining appropriate treatment from another healthcare professional/facility, business partner, or healthcare process. The primary issue is the need to obtain appropriate care. • Refusal of Care - denial of care by a healthcare professional or provider for such reasons as no identification card, late for appointment, healthcare professional missing scheduled appointment or no healthcare professional available.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	dissatisfaction about business partner's staff being unaware of procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate. 5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon Geographic Practice Cost Index ("GPCI"). 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 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) 6. 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. 7. Medical cost budgets - MH/SUD medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally, new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard	Quality of Service Complaint: An expression of dissatisfaction regarding the healthcare delivery process. An example may be one of the following: • Accessibility of Service - dissatisfaction about availability of care (i.e., too long to get appointment, healthcare professional never available, too long in office for scheduled appointments, individual does not feel they were given sufficient time during their visit). • Attitude of Practitioner/healthcare professional - dissatisfaction about attitude of a healthcare professional or their office staff, such as: uncaring, rude, short-tempered, or threatening, which may include issues of professionals not communicating test results. • Availability of Service - dissatisfaction about availability of providers in a geographical area to meet the Customer's care needs (i.e. too few healthcare professionals resulting in timely scheduling problems in an area, drive is too far, healthcare professional not accepting new patients). This would include provider not available after hours. • Facility Environment - dissatisfaction about healthcare professional's office environment (i.e., unclean, too few chairs, no parking.) • Uneducated Healthcare Practitioner/Practitioner Staff - dissatisfaction about business partner's staff being unaware of procedures to follow to access care. • Healthcare process - dissatisfaction with elements of the healthcare process, attitude/behavior of the Healthcare staff. Bargaining Power is a qualitative combination of provider supply, reputation/name recognition, and quality which may enhance a provider's/facility's ability to negotiate.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	rates, but do not create specific limits or exclusions applicable to providers. The threshold is not specifically numerically defined, but rather a question of whether the proposed rates are within or outside of the established budget. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/customer preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. 9. Competitive insights, when available through Coordination of Benefits or Transparency data, are used to determine fair market reimbursement rates. **Source for Evidentiary Standards:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market dynamics /network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may enhance a provider's and or facility's ability to negotiate) 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty	5. Geographic market (i.e., market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon Geographic Practice Cost Index ("GPCI"). 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 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) 6. 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. 7. Medical cost budgets - M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally, new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. The threshold is not specifically numerically defined, but rather a question of whether the proposed rates are within or outside of the established budget. 8. Utilization: Utilization/claims history is used to determine

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	6. Types of Service are identified by CPT and HCPC codes and Internal Cigna Data 7. Internal Determination 8. Internal Cigna claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available **Design and Application:** Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD providers. Network adequacy deficiencies (Network Need) are always considered when negotiating reimbursement rates. Reimbursement rates for in-network MH/SUD outpatient services are determined as follows: • CMS (Medicare) RVU (relative value units); • Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; • Clinical Lab and Pathology codes, where applicable; • Site of Service (SOS) (e.g. office, facility); • Geographic market, which may be adjusted based upon the Medicare Geographical Practice Cost Index (GPCI). For MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be: • billed charges for the service;	need of provider related to meeting network access/customer preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences 9. Competitive insights, when available through Coordination of Benefits or Transparency data, is used to determine fair market reimbursement rates. **Sources for Evidentiary Standards:** 1. State/Federal Law, as applicable Where State/Federal law is not applicable, the following factors are also considered: 2. M/S providers are classified based on provider type/level of training based upon CMS methodology. 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market dynamics /network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. Name Recognition/Reputation: customer/client requests, internet reviews/searches Quality: internet reviews/searches (actual and/or perceived), complaints. Bargaining Power (is a combination of provider supply, reputation/name recognition, and quality which may enhance a provider's and or facility's ability to negotiate). 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Types of Service are identified by CPT and HCPC codes and Internal Cigna Data 7. Internal Determination

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• negotiated discount off of billed charges for the service during the contracting process.	8. Internal Cigna claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available. **Design and Application:** Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for M/S providers. Network adequacy deficiencies (Network Need) are always considered when negotiating reimbursement rates. Reimbursement rates for in-network M/S outpatient services are determined as follows: • CMS (Medicare) RVU (relative value units); • Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; • Clinical Lab and Pathology codes, where applicable; • Site of Service (SOS) (e.g. office, facility); • Geographic market, which may be adjusted based upon the Medicare Geographical Practice Cost Index (GPCI). For M/S services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be: • billed charges for the service; • negotiated discount off of billed charges for the service during the contracting process.

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

In-network Provider (including Facility) Reimbursement As Written, In Operation, Conclusion:

As Written:
Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for M/S and MH/SUD.
Standard and Non-Standard (negotiated) fee schedules are developed based upon the provider or facility's negotiation request. Per internal protocol, for both M/S and MH/SUD non-standard reimbursement the following factors are considered in all negotiations, where applicable:

1. State/Federal Law, as applicable
   Where State/Federal law is not applicable, the following factors are also considered:
2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.
3. Medicare Baseline Rates
4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty i.e. Network Adequacy). Perceived or actual: reputation or name recognition, quality of services and bargaining power
5. Geographic Market
6. Scope and Type of services
7. Medical Cost Budget
8. Utilization
9. Competitive insights, when available

In determining any rate in both the M/S and MH/SUD provider and facility agreements, Cigna assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. Cigna's reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for M/S and MH/SUD providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area.

In Operation:
Inpatient:
Cigna conducted a comparison of DRG reimbursement for in-network M/S facilities compared to per diem for MH/SUD in-network facility-based services.
In order to complete the comparison, Cigna calculated the daily average rate based on the DRG expected length of stay. Once the DRG daily rate was determined, Cigna compared it to the MH/SUD reimbursement for a hospital bed day. The facility reimbursement comparative analysis reflects that, on average, Cigna applied a comparable and no more stringent discount for MH/SUD services than those applied to M/S services.

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Outpatient: Cigna has assessed the reimbursement rates paid across its Commercial book-of-business by reference to reimbursement data in 2024. For purposes of the comparison, Cigna has compared medical primary care MD to mental health MD psychiatrists. For non-MDs, Cigna has compared medical mid-level to mental health providers, psychologists and LCSWs. For comparison of the rendered services, Cigna chose CPT codes 99203 and 99213, patient diagnosis evaluation and management, for medical and psychiatrists, and CPT codes 90791 and 90832, also representing patient diagnosis and management, for mental health non-physicians. These codes comprise the majority of services these provider types render, and more importantly they are specific to medical and mental health billing practices, respectively. Cigna finds the primary care physician reimbursement rates relative to those of psychiatrists. Similarly, the medical mid-level providers reimbursement rates are relative to the psychologist and LCSWs. **Conclusion:** The review and evaluation of Cigna's underlying processes, strategies, evidentiary standards and factors used to apply the network reimbursement NQTL to MH/SUD benefits and to M/S surgical benefits have resulted in the conclusion that Cigna is in compliance with MHPAEA. Specifically, reimbursement rates for both M/S and MH/SUD providers and facilities for inpatient and outpatient services are the result of a negotiation between Cigna and each network provider. Each negotiation is handled on a case-by-case basis, and Cigna considers and applies these factors in each negotiation: the Federal Law, Provider Type, Medicare Baseline Rates, Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty), Geographic Market, Scope and Type of services, Medical Cost Budget, Utilization, and Competitive Insights. Whether for initial negotiation or renegotiation, Cigna's Network Provider reimbursement methodologies for M/S and MH/SUD Network Providers are based upon these same nine factors. Due to the highly variable nature of each negotiation, consistent outcomes are not always achieved. While comparable outcomes can be evidence of NQTL compliance, operational outcomes are not determinative of such compliance. Although assessment of reimbursement rates as paid, per claims data, identified disparities (noted in step 5 such as: variances in provider type practice differences between M/S and MH/SUD) between the reimbursement rates for M/S and MH/SUD providers, differences in end-state reimbursement rates alone are not the basis for a parity violation provided they are the outcome of comparable processes, factors, and standards for negotiation of provider reimbursement rates. Based upon its analysis, Cigna has concluded that the processes, strategies, evidentiary standards, and other factors used to determine reimbursement rates for MH/SUD services subject to in-network inpatient and outpatient reimbursement requirements are comparable to, and applied no more stringently than, those used to determine reimbursement rates for M/S services in all benefit classifications.		
Usual, Customary & Reasonable Charges		
Explain the plan's method for determining usual,	**OON IP Facility Factors:** 1. State/Federal Law, as applicable • No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the	**OON IP Facility Factors:** 1. State/Federal Law, as applicable • No Surprises Act (NSA) (45 CFR 149.420; Section 104

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
customary and reasonable charges	No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the customer did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) **Sources for Factors:** 1. Emergency inpatient admissions will be subject to the No Surprises Act (NSA). 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • Cigna initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • For plans that elect MRC1, Cigna uses FAIR Health data for professional services • For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value" scale ("RBRVS") system for professional services. For facility services, Cigna leverages the Optum Medicare database **Evidentiary Standards and Applicable Thresholds:** 1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the customer did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program provided by external pricing partners that utilize methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following:	of the No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the customer did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) **Sources for Factors:** 1. Emergency inpatient admissions will be subject to the No Surprises Act (NSA). 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • Cigna initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • For plans that elect MRC1, Cigna uses FAIR Health data for professional services • For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value" scale ("RBRVS") system for professional services. For facility services, Cigna leverages the Optum Medicare database **Evidentiary Standards and Applicable Thresholds:** 1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the customer did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program provided by external pricing partners that utilize methods to establish reimbursement levels for covered charges with out-of-

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. When Out of Network Protection Program does not apply Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount: • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients select an MRC2 percentage between 100 and 500. **Sources for Evidentiary Standards:** 1. Inpatient emergency admission facility claims are subject to the No Surprises Act (NSA): Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). QPA is	network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. When the Out of Network Protection Program does not apply, provider reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount. • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 500. **Sources for Evidentiary Standards:**

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	defined as the median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for 2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region. 2. Out of Network Protection Programs • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility • Cigna uses in-network rates as a basis for negotiation 3. Maximum Reimbursable Charge (MRC) • MRC1 - For plans that elect MRC1, Cigna uses FAIR Health data for professional services • MRC2 – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. Cigna leverages the Optum Medicare database for facility services. **Design and Application:** Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. Cigna's Out of Network Reimbursement process first identifies out-of-network claims (OON) then sends the claim for external claim pricing. Claims are priced using the following methods:	1. Inpatient emergency admission facility claims are subject to the No Surprises Act (NSA): Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). QPA is defined as the median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for 2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region. 2. Out of Network Protection Program • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility • Cigna uses in-network rates as a basis for negotiation 3. Maximum Reimbursable Charge (MRC) • MRC1 - For plans that elect MRC1, Cigna uses FAIR Health data for professional services • MRC2 – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. Cigna leverages the Optum Medicare database for facility services. **Design and Application:**

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• Network Savings Program (NSP): Savings obtained through the Claritev (formerly Multiplan) network, as identified on the customer's medical ID card. • Bill Negotiation Services (BNS): A suite of pricing techniques that attempt to achieve savings. • Maximum Reimbursable Charge (MRC): Claim processing based on applicable benefit plan elections (MRC) or billed charges. Cigna may enhance covered Out-of-Network services to the In-network benefit level. Some of these instances are (not all-inclusive): • Emergency services (i.e. ground ambulance): Cigna may determine that it is appropriate to process emergency services not covered under the No Surprises Act at the in-network benefit. • Network Adequacy Provision Policy (UM-20): Cigna understands there are times when it may be prudent for a customer to seek care from an out-of-network practitioner/facility. These instances may be due to customer in need of medically necessary specialized care where an out-of-network practitioner/facility is able to produce a better outcome due to the specific unique need of the patient, or in situations where a customer is unable to receive care at an in-network health care professional or facility within reasonable appointment availability timeframes or drive times from their home, for example. These claims may be processed according to the customers' in-network benefit, if the criteria is met per this policy. **OON Outpatient-Office, Outpatient All Other:** **Factors:** 1. State/Federal Law, as applicable 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) 4. Medicare Gap Fill for procedures that are not covered by	Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. Cigna's Out of Network Reimbursement process first identifies out-of-network claims (OON) then sends the claim for external claim pricing. Claims are priced using the following methods: • Network Savings Program (NSP): Savings obtained through the Claritev (formerly Multiplan) network, as identified on the customer's medical ID card. • Bill Negotiation Services (BNS): A suite of pricing techniques that attempt to achieve savings. • Maximum Reimbursable Charge (MRC): Claim processing based on applicable benefit plan elections (MRC) or billed charges. Cigna may enhance covered Out-of-Network services to the In-network benefit level. Some of these instances are (not all-inclusive): • Emergency services (i.e. ground ambulance): Cigna may determine that it is appropriate to process emergency services not covered under the No Surprises Act at the in-network benefit. • Network Adequacy Provision Policy (UM-20): Cigna understands there are times when it may be prudent for a customer to seek care from an out-of-network practitioner/facility. These instances may be due to customer in need of medically necessary specialized care

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Medicare or do not have a CMS Medicare Resources Based Relative Value Scale (“RBRVS") **Sources for Factors:** 1. No Surprises Act (NSA) qualifying services will be subject to NSA (e.g., emergency, non-participating providers rendering in a participating facility). 2. Out-of-Network Protection Program • External pricing partner network rate. • External pricing partner direct negotiation • Cigna-initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • MRC1 rate developed from the external pricing partner claims database. • For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value” scale (“RBRVS") system for professional services. For facility services, Cigna leverages the Optum Medicare database. 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board **Evidentiary Standards and Applicable Thresholds:** 1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) 2. Out of Network Protection Program provided by an external pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its	where an out-of-network practitioner/facility is able to produce a better outcome due to the specific unique need of the patient, or in situations where a customer is unable to receive care at an in-network health care professional or facility within reasonable appointment availability timeframes or drive times from their home, for example. These claims may be processed according to the customer's in-network benefit, if the criteria is met per this policy. **OON Outpatient-Office, Outpatient All Other:** **Factors:** 1. State/Federal Law, as applicable 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) 4. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale (“RBRVS") **Sources for Factors:** 1. No Surprises Act (NSA) qualifying services will be subject to NSA (e.g., emergency, non-participating providers rendering in a participating facility). 2. Out-of-Network Protection Program • External pricing partner network rate. • External pricing partner direct negotiation • Cigna-initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • MRC1 rate developed from the external pricing partner claims database. • For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value” scale (“RBRVS") system for professional services. For facility services, Cigna leverages the

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner offers a market rate reimbursement, as determined by the pricing partner company. Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. When the Out of Network Protection Program does not apply, Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 500. 4. • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. • Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC	Optum Medicare database. 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board **Evidentiary Standards and Applicable Thresholds:** 1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) 2. Out of Network Protection Program provided by an external pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner offers a market rate reimbursement, as determined by the pricing partner company. Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. When Out of Network Protection Program does not apply Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in each geographical

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate rate and code, if available. **Sources for Evidentiary Standards:** 1. No Surprises Act (NSA) Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). QPA is defined as the median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for 2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region. 2. Out of Network Protection Programs Savings through Claritev (formerly Multiplan) and Zelis • This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Commercial benchmarks, CMS data, Contractual allowable, Historical claims, Provider insights, Geographic adjustments 3. Maximum Reimbursable Charge (MRC) • MRC1 - Cigna uses FAIR Health data for professional services • MRC2 – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value scale ("RBRVS") system for professional services. Cigna leverages the Optum Medicare database for facility services 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy	area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 500 4. • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. • Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate rate and code, if available. **Sources for Evidentiary Standards:** 1. No Surprises Act (NSA) Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). QPA is defined as the median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Review Board **Design and Application:** Cigna reimburses out of network providers either through its Out-of-Network Protection Programs, or the client-elected Maximum Reimbursable Charge (MRC). Cigna's Out-of-Network Protection Program reimbursement methodologies include: • Fee Negotiation Service – Negotiates charge reductions ending in a signed agreement with the Provider/Facility; • Supplemental Network – Additional regional networks of Provider/Facility's contracted with vendor partners, concluding with a signed agreement; • Repricing – similar to bill negotiation where there is an offer and settlement and where the initial reimbursement on the claim is not a signed agreement but a part of the repricing process. The vendors apply a reasonable allowed amount based on the service and geographic location of the Provider/Facility. The Provider/Facility can decide not to accept the offer; • Cigna-initiated direct negotiation -Cigna may initiate direct negotiations with a provider. This is a negotiated agreement where the provider remains non-contracted with Cigna but agrees not to balance bill the customer. The calculation of the MRCs for the range of MH/SUD services is derived from databases that compile charges and rates from providers in the same geographic area for the same/similar services across MH/SUD (i.e., Fair Health for MRC1). As such, the MRC methodology has been deemed to be comparable in their application across MH/SUD services.	2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region. 2. Out of Network Protection Programs Savings through Claritev (formerly MultiPlan) and Zelis • This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Commercial benchmarks, CMS data, Contractual allowable, Historical claims, Provider insights, Geographic adjustments 3. Maximum Reimbursable Charge (MRC) • MRC1 - Cigna uses FAIR Health data for professional services • MRC2 – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value scale ("RBRVS") system for professional services. Cigna leverages the Optum Medicare database for facility services 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board **Design and Application:** Cigna reimburses out of network providers either through its Out-of-Network Protection Programs, or the client-elected Maximum Reimbursable Charge (MRC). Cigna's Out-of-Network Protection Program reimbursement methodologies include:

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
		• Fee Negotiation Service – Negotiates charge reductions ending in a signed agreement with the Provider/Facility; • Supplemental Network – Additional regional networks of Provider/Facility's contracted with vendor partners, concluding with a signed agreement; • Repricing – similar to bill negotiation where there is an offer and settlement and where the initial reimbursement on the claim is not a signed agreement but a part of the repricing process. The vendors apply a reasonable allowed amount based on the service and geographic location of the Provider/Facility. The Provider/Facility can decide not to accept the offer; • Cigna-initiated direct negotiation -Cigna may initiate direct negotiations with a provider. This is a negotiated agreement where the provider remains non-contracted with Cigna but agrees not to balance bill the customer. The calculation of the MRCs for the range of M/S services are derived from databases that compile charges and rates from providers in the same geographic area for the same/similar services across M/S (i.e., Fair Health for MRC1). As such, the MRC methodology has been deemed to be comparable in their application across M/S services.
Out-of-Network Provider Reimbursement: As written, In Operation, Conclusion: Cigna reimburses out of network providers either through its Out-of-Network Protection Programs, or the client-elected Maximum Reimbursable Charge (MRC). **As Written:** Cigna reimburses providers either through its Out-of-Network Protection Programs, lesser of the covered billed charges, or the client-elected Maximum Reimbursable Charge (MRC). Cigna's Out of Network Protection Programs can supplement both the M/S and MH/SUD contracted networks. For clients that elect to use the Out-of-Network Protection Programs, M/S and MH/SUD claims may be priced using the vendor's network rates or direct negotiation with the provider. The type of Out of Network Provider Reimbursement in Cigna's Out-of-Network Protection Program includes claims repricing, the use of a supplemental network, direct negotiation, or MRC. Reimbursement methodologies include:		

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

- Fee Negotiation Service – Negotiates charge reductions ending in a signed agreement with the Provider/Facility;
- Supplemental Network – Additional regional networks of Provider/Facility's contracted with vendor partners, concluding with a signed agreement. Maximum Reimbursable Charge (MRC) - MRC represents the maximum reimbursement the medical plan will pay for a covered OON service.
- MRC can be based on a percentile of charges (MRC1) or a percentage of Cigna's Medicare-based fee schedule (MRC2). The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:
- MRC1
  - Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change.
  - Clients select an MRC1 percentile between 50 and 95
- MRC2
  - Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area.
  - Clients select an MRC2 percentage between 100 and 500.

The customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.

Cigna annually assesses the comparability of reimbursement rates using data assessments to determine if there are any disparities as-between M/S and MH/SUD benefits warranting further analysis. In no event has Cigna identified significant disparities in outcomes, that is, disparities in the application of the reimbursement methodology, including significant disparities in the proportion of MH/SUD claims for which enrollees are subject to balance billing, that warrant revision to the methodology by which Cigna calculates reimbursement rates for out-of-network benefits. Because the calculation of the MRCs for the range of M/S and MH/SUD services is derived from databases that compile charges and rates from providers in the same geographic area for the same/similar services across M/S and MH/SUD services (i.e., Fair Health for MRC1), the MRC methodology has been deemed to be comparable in their application across M/S and MH/SUD services.

In Operation:
Cigna has assessed the application of the Out-of-Network Protection Program across Cigna-administered plans and has confirmed Out-of-network reimbursement methodology applied comparably to MH/SUD benefits and no more stringently than M/S benefits received out-of-network.

- Zelis and Claritev (formerly Multiplan) negotiation processes and strategies are aligned between M/S and MH/SUD health care professionals and/or facilities.
- Cigna has reviewed the Zelis and Claritev (formerly Multiplan) comparative analysis documentation and confirmed policy alignment across M/S and MH/SUD.
- Cigna performs multiple audits to ensure reimbursement accuracy.
- Cigna administered plans reimburse MH/SUD out-of-network providers for the full submitted charges at least as often, and in some instances more often, than M/S out-of-network providers.

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
Conclusion: Cigna has concluded that it pays on average to MH/SUD providers a higher reimbursement amount than M/S providers as measured as a discount off the respective M/S and MH/SUD providers' billed charges, while such an advantageous result for MH/SUD benefits is not required by the NQTL requirement, it does evidence that the out-of-network reimbursement methodology is actually operating in a manner that ensures enrollees accessing MH/SUD services from out-of-network providers are receiving at least comparable benefits to enrollees accessing M/S services from out-of-network providers. While not dispositive of NQTL compliance, these outcomes, in addition to the description of the foregoing process and standards for calculating out-of-network reimbursement amounts, help evidence that the out-of-network reimbursement methodologies applied under Cigna-administered plans are at least as generous for, and thus comparable and not more stringently applied to, MH/SUD outpatient benefits in-writing and in-operation.		
Restrictions on Provider Specialty		
Explain any restrictions the plan places on provider billing codes	Cigna does not place restrictions on provider billing codes or place restrictions on MH/SUD providers that would limit the scope of their practice. Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare & Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.	Cigna does not place restrictions on provider billing codes or place restrictions on M/S providers that would limit the scope of their practice. Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare & Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.
Explain any restrictions the plan places on services provided by specialty providers.	Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice. Customers are only limited to in or out of network benefit limitations according to the subscriber plan.	Benefit determinations are strictly based on medical necessity, in accordance with generally accepted standards of medical practice. Customers are only limited to in or out of network benefit limitations according to the subscriber plan.
Post Claim Payment Retrospective Review (Fraud, Waste, and Abuse)		
	The **post-payment retrospective review** NQTL concerns retrospective or retroactive review of services where the claims have already been paid. Cigna utilizes various forms of post-payment retrospective review, which include the following: • Fraud, waste, and abuse investigations that occur post-claim	The **post-payment retrospective review** NQTL concerns retrospective or retroactive review of services where the claims have already been paid. Cigna utilizes various forms of post-payment retrospective review, which include the following: • Fraud, waste, and abuse investigations that occur post-

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	payment ("FWA"); and • Other post-payment retrospective review concepts Cigna applies, such as overpayment recovery ("Other"). Cigna's fraud, waste, and abuse efforts apply to all MH/SUD services that are covered under the plan. Therefore, the list of specific CPT or revenue codes potentially subject to an SIU investigation encompasses all codes payable under the plan. **Factors:** 1. Internal Referrals: Notification within Cigna's SIU of suspected fraudulent behavior of a provider or customer. 2. External Referrals: Notification by an individual or organization outside of Cigna SIU of suspected fraudulent behavior of a provider or customer. 3. Analytics: Programs utilized to identify suspect billing behavior **Sources for Factors:** 1. Internal Referrals Sources: • Cigna SIU Internal Analytics • Vendor partner identification via algorithms • Frontline claim and call team • Cigna account manager notification of a client concern • SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Cigna.com 2. External Referral Sources: • SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Cigna.com • https://www.cigna.com/legal/members/report-fraud • Federal and state law enforcement agencies • Vendor identification via algorithms • NHCAA (SIRIS database)	claim payment ("FWA"); and • Other post-payment retrospective review concepts Cigna applies, such as overpayment recovery ("Other"). Cigna's fraud, waste, and abuse efforts apply to all M/S services that are covered under the plan. Therefore, the list of specific CPT or revenue codes potentially subject to an SIU investigation encompasses all codes payable under the plan. **Factors:** 1. Internal Referrals: Notification within Cigna's SIU of suspected fraudulent behavior of a provider or customer 2. External Referrals: Notification by an individual or organization outside of Cigna SIU of suspected fraudulent behavior of a provider or customer. 3. Analytics: Programs utilized to identify suspect billing behavior **Sources for Factors:** 1. Internal Referrals Sources: • Cigna SIU Internal Analytics • Vendor partner identification via algorithms • Frontline claim and call team • Cigna account manager notification of a client concern • SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Cigna.com 2. External Referral Sources: • SIU hotline – 800-667-7145 • SIU e-mail – specialinvestigations@Cigna.com • https://www.cigna.com/legal/members/report-fraud • Federal and state law enforcement agencies • Vendor identification via algorithms

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	• HFPP (Healthcare Fraud Prevention Partnership) 3. Analytics Sources: • Claims data • SIU Internal analytics team • Vendor analytics: ○ Dedicated Data-Mart (Healthcare Fraud Shield) Claim detail for over 12 million medical customers (over 1 billion claim lines) are loaded on a weekly basis for risk scoring based on over 1,200 rules-based alerts. In addition, unsupervised learning, also referred to as Artificial Intelligence (AI), is used to identify aberrant behavior that may not be overtly detected in a rules-based approach. ○ Geospatial Analytics (ArcGIS) Data is modeled for probability risks, i.e., events that are unlikely to be appropriate. Examples in this space include billing from disaster zones (wildfires, hurricanes, etc.) and prescribing from long distances. ○ Link Analysis (i2) Public record information for subjects of investigations, couple with internal data points, are loaded to IBM's i2 link analysis software to more clearly identify the extent of fraud activity. Examples include linkages of registered agents, telephone numbers, addresses, relationships, etc. This software is often used to expand an investigation through finding additional individuals or entities of interest. ○ IBM i2 - Link analysis software leveraging Thompson Reuters CLEAR public record information, together with proprietary investigative work and data to identify additional parties of interest of interest. ○ Multiple Control Models (Python, R, SAS EG, SQL)	• NHCAA (SIRIS database) • HFPP (Healthcare Fraud Prevention Partnership) 3. Analytics Sources: • Claims data • SIU Internal analytics team • Vendor analytics: ○ Dedicated Data-Mart (Healthcare Fraud Shield) Claim details for over 12 million medical customers (over 1 billion claim lines) are loaded on a weekly basis for risk scoring based on over 1,200 rules-based alerts. In addition, unsupervised learning, also referred to as Artificial Intelligence (AI), is used to identify aberrant behavior that may not be overtly detected in a rules-based approach. ○ Geospatial Analytics (ArcGIS) Data is modeled for probability risks, i.e., events that are unlikely to be appropriate. Examples in this space include billing from disaster zones (wildfires, hurricanes, etc.) and prescribing from long distances. ○ Link Analysis (i2) Public record information for subjects of investigations, couple with internal data points, are loaded to IBM's i2 link analysis software to more clearly identify the extent of fraud activity. Examples include linkages of registered agents, telephone numbers, addresses, relationships, etc. This software is often used to expand an investigation through finding additional individuals or entities of interest. ○ IBM i2 - Link analysis software leveraging Thompson Reuters CLEAR public record information, together with proprietary investigative work and data to identify additional parties of interest of interest. ○ Multiple Control Models (Python, R, SAS EG, SQL)

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	Many models are run on an ongoing basis. Examples in this space include tracking all data elements associated with individuals or entities suspected of inappropriate billing, and monitoring claim activity for any potential data matches. ○ RatStats - Statistical sampling software. ○ Prest & Associates - Performs medical reviews for investigations focused on behavioral services. A medical doctor with a behavioral focus reviews full medical records for a number of customers of a particular provider/facility to validate services are appropriate and consistent with standards. Results are aggregated and reviewed in detail as a part of the investigative process. ○ Other Enabling Technologies - Teradata Studio, Toad, CA Workstation, Tableau, Cognos, etc. ○ Tata Consultancy Services ("TCS") - Reporting and data acquisition is supported in part by TCS as a vendor. A total of eight outsourced full-time employees (FTEs) support this body of work. **Evidentiary Standards and Applicable Thresholds:** 1. Irrespective of specialty (MH/SUD), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. 2. Irrespective of specialty (MH/SUD), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of	Many models are run on an ongoing basis. Examples in this space include tracking all data elements associated with individuals or entities suspected of inappropriate billing, and monitoring claim activity for any potential data matches. ○ RatStats – Statistical sampling software. ○ Other Enabling Technologies – Teradata Studio, Toad, CA Workstation, tableau, Cognos, etc. ○ Tata Consultancy Services (TCS) - Reporting and data acquisition is supported in part by TCS as a vendor. A total of eight outsourced full-time employees (FTEs) support this body of work. **Evidentiary Standards and Applicable Thresholds:** 1. Irrespective of specialty (M/S), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. 2. Irrespective of specialty (M/S), analytics review claims for risk via a datamart of over a billion claim lines based on multiple perspectives of the data. Elements of modeling include the use of over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider's billing behavior to their peers and those who score differently are reviewed to determine if an

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	over 1,000 individual alerts in a rules-based model, as well as models focused on billing intensity, frequency, density, spikes, trends, and billing code (procedure and diagnosis codes) differences. The models compare a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. 3. a. Red Flags non-exhaustive list: Cigna's Special Investigations Unit (SIU) identifies the following "red flags" as potential indicators of fraud, waste, and abuse. Red flags are also known as anomalies and may cover procedure codes, revenue and diagnosis: • Treatment does not match diagnosis. • Treatment inconsistent with patient's age or gender. • Same or like diagnosis for all health care professionals' patients. • A large geographic difference in the location of the patient's home and the health care professional's office. • Treatment dates closely follow enrollment period. • Claimant/individual customer's address matches the health care professional's address. • Immediate claimant/individual customer pressures for payment of claims. • Resubmission of previously denied claim with modified information. • Unusual delay in submission of claims. • Multiple health care professional claims for the same customer on the same date of service. • Information on the claim form does not match eligibility information in claim system. • Unusually high number of patients coded as new patients to gain higher reimbursement. • Call history that customer has frequently requested	investigation is warranted. 3. a. Red Flags non-exhaustive list: Cigna's Special Investigations Unit (SIU) identifies the following "red flags" as potential indicators of fraud, waste, and abuse. Red flags are also known as anomalies and may cover procedure codes, revenue and diagnosis: • Treatment does not match diagnosis. • Treatment inconsistent with patient's age or gender. • Same or like diagnosis for all health care professionals' patients. • A large geographic difference in the location of the patient's home and the health care professional's office. • Treatment dates closely follow enrollment period. • Claimant/individual customer's address matches the health care professional's address. • Immediate claimant/individual customer pressures for payment of claims. • Resubmission of previously denied claim with modified information. Unusual delay in submission of claims. • Multiple health care professional claims for the same customer on the same date of service. • Information on the claim form does not match eligibility information in claim system. • Unusually high number of patients coded as new patients to gain higher reimbursement. • Call history that customer has frequently requested overrides • Physician, pharmacy or family member calls

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)
	overrides • Physician, pharmacy or family member calls concerned about individual customer's prescription drug abuse • Customer calls frequently regarding controlled substances • Multiple pharmacies used to fill controlled substances for one customer • Multiple physicians prescribing controlled substances for one customer • Customer calls about medications billed against his account that he does not take b. Dashboards and alerts that assess MH/SUD codes **Sources for Evidentiary Standards:** 1. Cigna claim data 2. Cigna claim data; Vendor data 3. a. Red flags include: claims data, internal analytics, and vendor analytics b. Healthcare Fraud Shield **Design and Application:** The procedural steps include an initial review and information gathering. Potential outcomes of an investigation may include: • Issue Closure when appropriate billing is verified • Watch List when determined additional monitoring may be required • Provider Education when a small variance is identified • Prepay Review when material fraud concerns are validated	concerned about • individual customer's prescription drug abuse • Customer calls frequently regarding controlled substances • Multiple pharmacies used to fill controlled substances for one customer • Multiple physicians prescribing controlled substances for one customer • Customer calls about medications billed against his account that he does not take b. Dashboards and alerts that assess M/S codes **Sources for Evidentiary Standards:** 1. Cigna claim data 2. Cigna claim data; Vendor data 3. a. Red flags include: claims data, internal analytics, and vendor analytics b. Healthcare Fraud Shield **Design and Application:** The procedural steps include an initial review and information gathering. Potential outcomes of an investigation may include: • Issue Closure when appropriate billing is verified • Watch List when determined additional monitoring may be required • Provider Education when a small variance is identified • Prepay Review when material fraud concerns are validated
Post Claim Payment Retrospective Review: As Written, In Operation, Conclusion: **As Written:** Cigna's SIU is responsible for:		

Non-Quantitative Treatment Limitation (NQTL)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Medical/Surgical (M/S)

- conducting investigations and analyzing cases to determine the scope of potential fraud
- flagging providers/facilities/customers in the claim systems to ensure payments suspected of fraud are addressed prior to releasing funds
- obtaining evidence for referrals to law enforcement, regulatory agencies, and associations
- pursuing civil recoveries
- delivering antifraud training and communication of current fraud schemes to Cigna employees
- using advanced technology and data-mining techniques to identify suspect behavior or patterns of possible fraudulent providers/facilities
- serving as a founding member of the National Health Care Anti-Fraud Association (NHCAA), an organization consisting of health care experts from both the public and private sectors
- working with clients and customers who inform us of discrepancies that may reveal potential fraud

The overall process for identifying potentially fraudulent claims is identical for both MH/SUD and M/S services.

Analytics are designed to identify potential bad actors by reviewing over a billion pieces of data which include:

- Claims
- Purchased public records
- Industry anti-fraud databases; and
- Social network

In Operation:
Upon review, Cigna has determined comparability of M/S and MH/SUD fraud, waste, and abuse process:

- Cigna applies general fraud, waste, and abuse policies without regard to whether a given service is a MH/SUD or M/S service.
- Special Investigations Unit has consistently investigated a larger number of potentially fraudulent M/S cases as compared to MH/SUD cases.
- Potential fraud is identified via an internal, external and or analytics referral/alert process regardless of MH/SUD or M/S.

Conclusion:
Cigna applies the same processes and factors with respect to identifying and investigating potentially fraudulent, wasteful, or abusive provider claims practices, without regard to whether the provider is considered an MH/SUD or M/S provider or facility. The operation of Cigna's Special Investigations Unit (SIU), which results in post-payment retrospective review of claims, is identical for both M/S and MH/SUD claims and therefore meets the comparability requirement. In operation, the SIU program is applied no more stringently to MH/SUD benefits as it is to M/S benefits, as evidenced by the significantly higher number of claims investigated for M/S services as compared to MH/SUD services.

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Appendix A – Definitions		

Utilization Management Definitions:

1. The ASAM Criteria®: Objective guidelines developed and published by American Society of Addiction Medicine that help clinicians standardize treatment planning and determine where patients are placed in treatment, and how to provide continuing, integrated care and ongoing service planning.
2. Behavioral Fast Certification (FastCert): A non-clinical streamlined MH/SUD prior authorization/concurrent review process which allows for a determination based on pre-set criteria.
3. Clinical Criteria: Clinical criteria are specific standards or guidelines used in healthcare to make decisions about customer care, such as diagnosis, treatment, and utilization management. These criteria help ensure that care is medically necessary and appropriate.
4. Concurrent Review: A request for service that occurs after admission or treatment has begun even if it is the initial request.
5. Coverage Policies – coverage policies are tools to assist in interpreting standard health coverage plan provisions. They assist with decisions about diagnosis, management and treatment in areas of health care.
6. Emergency/Emergent Care: Cigna defines an Emergency as a Medical or Behavioral health condition manifesting itself by acute symptoms of sufficient severity such that a prudent person could reasonably expect the absence of immediate medical or BH assessment or/and stabilization to result in:
   - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
   - Serious impairment to bodily functions
   - Serious dysfunction of any bodily organ or part
   - Imminent harm to self or others
7. MCG™: unbiased, evidence-based clinical decision support to identify safe and effective treatments and guide the appropriate level of care
8. Medical Fast Certification (“FastCert”): A non-clinical streamlined M/S prior authorization process which allows for a determination based on pre-set criteria.
9. Medical Necessity: Typically, Cigna considers medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, or devices to be medically necessary of the following criteria are met:
   - 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 professional.
   - 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 the member’s 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.
10. Mental Health/Substance Use Disorder (MH/SUD): Means benefits with respect to items or services for mental health conditions or substance use disorders that are included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as defined under the term of the Plan and in accordance with applicable federal and state law. Any condition defined by the Plan as being or as not being a mental health condition must be defined to be consistent with generally

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recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

11. Medical/Surgical (M/S): Means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the Plan and in accordance with applicable federal and state law but does not include mental health or substance use disorder benefits. Any condition defined by the Plan being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).
12. Non-Clinical Staff: Any staff that do not hold a license or certification including advocates and care coordinators.
13. Non-Urgent: A situation that is considered routine in nature. For non-urgent inpatient care, both M/S and MH/SUD always follow the pre-service non-urgent timeframe.
14. Pre-service appeal: means a request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the Customer obtaining care or services. A Customer's request for an appeal of a denial for service excluded from the organization's benefits package is a pre-service appeal if the Customer has not received the requested services.
15. Post-service appeal: means a request to change an adverse determination for care or services that have already been received by the Customer.
16. Peer Reviewer (for behavioral health): an independently licensed behavioral health practitioner from appropriate specialty areas. Peer-reviewers may be a doctorate level psychologists, addictionologists, or board-certified psychiatrists depending on the credentials of the practitioner requesting the service. Peer-reviewers may review with clinical peers regardless of sub-specialty (Child & Adolescent). Behavioral Health's psychologists shall not make denial determinations regarding reimbursement for inpatient care or reimbursement for prescription drugs.
17. Peer Reviewer (for medical): an independently licensed medical director.
    A medical director must:
    - Hold an active unrestricted license or certification to practice medicine in a state or territory of the United States
    - Unless expressly allowed by state or federal regulations, are located in a state or territory of the United States when conducting a peer clinical review
    - Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review
    - Hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine.
18. Prior Authorization: The requirement that a provider (physician, hospital, etc.) obtain approval from Cigna *before* performing a particular procedure. Prior authorization may also be referred to as precertification, predetermination, and pre-approval
19. Prior Authorization Filter Lever (PAFL): A type of prior authorization process for M/S benefits that includes an enhanced set of non-clinical Information Technology business rules that can auto-approve if a combination of data criteria is met. These data criteria include service code and/or diagnosis code, age, or state.
20. Provider/Practitioner: A licensed physician, non-physician health care practitioner, hospital or other facility, supplier, or other individual or entity involved in the delivery of health care services or benefits
21. Retrospective Review (aka post-service): A review performed when care or service has already been completed, or a discharge has occurred prior to an authorization of a coverage request.
22. Safety Protocols: consider the study's enrollment criteria including:
    - background risks associated with the disease or condition studied,

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- previous knowledge of toxicities (assessed and graded according to a standardized grading scale relevant to the studied population),
- warnings and precautions described in the product/procedure's label/protocol and is collected, recorded, and reported in a consistent manner.

23. Urgent: Any request for medical care or treatment where a delay in making non-urgent care determination:
    - Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on prudent layperson's judgement, or could seriously jeopardize the life, health, or safety of the member/customer or others, due to the member's/customer's psychological state
    - In the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

Network and Credentialing/Reimbursement Definitions:

1. Classification: Benefits Classifications for MH/SUD and M/S are Inpatient, Outpatient, All Other Outpatient, Prescription Drugs and Emergency care.
    - Inpatient services are provided by a hospital while Confined in a Hospital, Inpatient Rehab, Skilled Nursing facility or MH/SUD Residential facility.
    - Outpatient services are provided in an Outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.
2. Demand for provider type: The number of members/customers requiring a particular service/level of care in a particular geographic area. Factors applicable to provider demand include:
    - internal claims experience, the evidentiary source of which is Cigna's historical claims data and
    - external GeoAccess reports the evidentiary source of which is network access assessments that measure the distance between customers and providers. These assessments can be leveraged to determine how to adequately support its existing membership and the potential market if a strategic growth/network fortification plan is undertaken, as required to meet any applicable regulatory access standards.
3. Inpatient Benefit Classification: is defined as care provided in a hospital or other type of inpatient facility, where you are admitted, and spend at least one night.
    - Services that are provided by a hospital while Confined in a Hospital, Inpatient Rehab, Skilled Nursing facility or MH/SUD Residential facility.
4. Lack of access: The lack of an appropriately qualified, participating health care professional is not available to provide medically necessary services within a reasonable distance from the customer's home or within a reasonable appointment availability timeframe.
5. Mental Health or Substance Use Disorder (MH/SUD): Behavioral Health defines MH/SUD conditions as those included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the International Classification of Diseases
6. Medical/Surgical: Cigna defines the Medical/Surgical benefit as items or services for medical conditions or surgical procedures, as defined under the terms of the Plan and in accordance with applicable federal and state law but does not include mental health or substance use disorder benefits. Any condition defined by the Plan being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).
7. Outpatient Benefit Classification: Outpatient is defined as care that does not require a hospital stay.
    - Outpatient services are provided in an Outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.
8. Participating Provider/In-Network Provider means: Hospitals, Physicians, and Other Health Care Facilities or Professionals which are: (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna to provide services to Customers; or For the

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purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna to arrange, through contracts with Providers for the provision of any services and/or supplies, the charges for which are Covered Expenses. Provider agreement in effect with Cigna for this EOC at the time services are rendered.

9. Provider/Practitioner: A licensed physician, non-physician health care practitioner, hospital or other facility, supplier, or other individual or entity involved in the delivery of health care services or benefits
10. Subclassification: Cigna subclassifies “Office Visit” and “Outpatient All Other” within the Outpatients classification. For purposes of this analysis, the term subclassification is limited to Outpatient Services.
11. Supply of providers: The number of available providers of a particular type/license in a particular geographic area. Factors in determining the supply of providers include (1) the evaluation of Cigna’s existing network, the evidentiary source of which is Cigna’s internal provider contracting and credentialing data sources; and (2) the evaluation of other payers’ networks, the evidentiary source of which is third party data comprising of competitor intel, i.e., directories, licensing and NPI registry.

Fraud, Waste, and Abuse Definitions:

1. Abuse: Actions that may, directly or indirectly, result in unnecessary costs such as paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment
2. Anomaly - Diagnosis Code: A significant amount of revenue generated from unusual diagnosis codes
3. Anomaly - Procedure Code: A significant amount of revenue generated from an unusual procedure code
4. Anomaly – Procedure Combination: A significant amount of revenue generated from unusual combinations of procedures codes
5. Anomaly – Revenue Code: A significant amount of revenue generated from unusual revenue codes
6. Billing Error: Unintended billing mistake made by the provider
7. Data Mining: The process of sorting through large data sets to identify patterns and relationships that can help solve business problems through data analysis.
8. Density: Services and payments unusually concentrated within certain types of procedures
9. Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
10. Frequency: An abnormal frequency of services visits, units
11. Intensity: The level of service provided is abnormal when considered against defining attributes that include, without limit, age, gender and diagnoses
12. Internal Investigations: The Unit within Cigna's Compliance organization that is responsible for investigating violations related to the Code of Ethics and Principles of Conduct
13. Red Flag: Observed anomalies in either paper or electronic transaction environments whose unusual pattern or characteristics are essential for generating additional reviews or investigations
14. Special Investigations Unit: The Unit within Cigna's Corporate Audit Department tasked with the responsibility for conducting investigations of potential fraudulent, wasteful, or abusive activities
15. Spike: Sudden increases in paid volume
16. Trend: The trend in activity is increasing over time.
17. Waste: Practices that, directly or indirectly, result in unnecessary costs to plans, such as overusing services. Waste is generally considered a misuse of resources.

Mental Health Parity and Addiction Equity Act (MHPAEA)
Non-Quantitative Treatment Limitations (NQTLs) Summary Document