MHPAEA Summary Form Instructions

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

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

The MHPAEA Summary Form includes the MHPAEA Data Report.

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

IND-PRIND Puerto Rico Indemnity Plan 2021

MHPAEA Summary Form

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

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

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

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

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

Behavioral Health Benefits
1 (800) 433-5768
24 hours a day, 365 days a year

Medical, Dental, Vision
1 (800) 244-6224
24 hours a day, 365 days a year

TTY/TDD Service (For callers who are deaf or hard of hearing)
Dial 711 and follow the prompts
24 hours a day, 365 days a year.

Overview:

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

1. Definition of Medical Necessity

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Services Subject to Medical Necessity: All inpatient and outpatient M/S services must be medically necessary. Services determined by Cigna not to be medically necessary would excluded under the terms of the plan. Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows: **Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent	**Services Subject to Medical Necessity:** All inpatient and outpatient MH/SUD services must be medically necessary. Services determined by Cigna not to be medically necessary would excluded under the terms of the plan. Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows: **Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent

therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the 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.	therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the 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.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Development of Clinical Criteria Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions. The Medical Technology Assessment Committee (MTAC)	**Development of Clinical Criteria** Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services.

establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits. **Factors** The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. MTAC's policy development processes entails assessing behavioral health technologies based upon the following factors: • Clinical efficacy	The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits. **Factors** The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. MTAC's policy development processes entails assessing behavioral health technologies based upon the following factors:

• Safety • Appropriateness of the proposed treatment	• Clinical efficacy • Safety • Appropriateness of the proposed treatment

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Sources and Evidentiary Standards Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009: • 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	**Sources and Evidentiary Standards** Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009: • 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.

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.	• 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.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions. The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate	Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services. The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.

consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.	Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.

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

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

An "in operation" review of Cigna's application of the medical necessity NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the operational analysis of the application of UM, Cigna reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.

2. <u>Prior Authorization Review Process</u>

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Prior authorization is not required for any Medical/Surgical services.	Prior authorization is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Prior authorization is not required for any Medical/Surgical services.	Prior authorization is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Prior authorization is not required for any Medical/Surgical services.	Prior authorization is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Prior authorization is not required for any Medical/Surgical services.	Prior authorization is not required for any Mental Health/Substance Use Disorder services.

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

Prior authorization is not required for any Medical/Surgical or MH/SUD services.

3. <u>Concurrent Review Process</u>

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Concurrent review is not required for any Medical/Surgical services.	Concurrent review is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Concurrent review is not required for any Medical/Surgical services.	Concurrent review is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Concurrent review is not required for any Medical/Surgical services.	Concurrent review is not required for any Mental Health/Substance Use Disorder services.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Concurrent review is not required for any Medical/Surgical services.	Concurrent review is not required for any Mental Health/Substance Use Disorder services.

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

Concurrent review is not required for any Medical/Surgical or MH/SUD services.

4. Retrospective Review Process

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Retrospective Medical Necessity Review is available for all M/S In-Patient and Outpatient services upon request of the enrollee *if* prior authorization was required and not obtained via the pre-service or concurrent care review process. Enrollees must meet timely filing requirements and have up to 365 from the date of services to request Retrospective review. **Process** Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the	Retrospective Medical Necessity Review is available for all MH/SUD In-Patient and Outpatient services upon request of the enrollee *if* prior authorization was required and not obtained via the pre-service or concurrent care review process. Enrollees must meet timely filing requirements and have up to 365 from the date of services to request Retrospective review. **Process** Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the

participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the services at issue, the services would be denied as not medically necessary. For denials, the enrollee would have the right to pursue the full internal and/or external appeal process.	participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the services at issue, the services would be denied as not medically necessary. For denials, the enrollee would have the right to pursue the full internal and/or external appeal process.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The factors used to determine that retroactive review NQTL will apply to M/S benefit is whether the prior authorization of the M/S services were obtained via the pre-service or concurrent care review process and an enrollee has requested such review.	The factors used to determine that retroactive review NQTL will apply to MH/SUD benefit is whether the prior authorization/precertification of the MH/SUD services were obtained via the pre-service or concurrent care review process and an enrollee has requested such review.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
• Enrollee Medical Records and Plan Documents • Clinical Criteria/Medical Necessity	• Medical Records and Plan Documents • Clinical Criteria/Medical Necessity

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

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits

(M/S)	(MH/SUD)
In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.	In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.

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

Retrospective Medical Necessity Review is a process, strategy or evidentiary standard designed to limit the scope or duration of benefits for services provided under an enrollee benefit plan. Retrospective Medical Necessity Review is available for both M/S and MH/SUD In-Patient and Outpatient services upon request of the enrollee *if* prior authorization was not obtained via the pre-service or concurrent care review process.

UM coverage determinations of M/S services and MH/SUD services use the same processes, strategies, and evidentiary standards and are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider.

Moreover, Cigna's methodology for determining which MH/SUD services within a classification of benefits are subject to retrospective review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to retrospective review.

An in operation review of Cigna's application of the Retrospective Review NQTL, specifically approvals and denial information, in the "Inpatient" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits.

An in operation review of Cigna's application of the Retrospective Review NQTL, specifically approvals and denial information, in the "Outpatient classification revealed higher denial rates for M/S benefits than for MH/SUD benefits across all determinations including coverage denial, denied as not medical necessary and denied as experimental, investigational or unproven.

When reviewing the average number of days approved upon retrospective review for inpatient services, the approval times were nearly identical with 7 days approved for MH/SUD services and 7.2 days approved for M/S services.

Lastly, a review of Level 1 appeals data revealed near identical rates of appeals denial, determinations upheld with MH/SUD reflecting 79.32% and 85.70% respectively for Inpatient and 77.97% and 82.76% for Outpatient. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. Cigna's methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits

5. <u>Emergency Services</u>

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Emergency Medical Condition Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. **Emergency Services**	**Emergency Medical Condition** Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. **Emergency Services**

Emergency services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; or a health care item or service furnished or required to evaluate and treat the Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient. In an emergency situation, you should call 911 for Maryland or other state, county, or local emergency medical services. Pre-authorization for this service is not required.	Emergency services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; or a health care item or service furnished or required to evaluate and treat the Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient. In an emergency situation, you should call 911 for Maryland or other state, county, or local emergency medical services. Pre-authorization for this service is not required.

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

Medical/Surgical Benefits (M/S)	**Mental Health/Substance Use Disorder Benefits (MH/SUD)**
Emergency medical/surgical services are not subject to prior authorization. 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:	Emergency MH/SUD services are not subject to prior authorization. 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; or • Serious dysfunction of any bodily organ or part.	• 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; or • Serious dysfunction of any bodily organ or part.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Emergency medical/surgical services are not subject to prior authorization. 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; or • Serious dysfunction of any bodily organ or part.	Emergency MH/SUD services are not subject to prior authorization. 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; or • Serious dysfunction of any bodily organ or part.

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

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

Emergency medical/surgical services are not subject to prior authorization. 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; or • Serious dysfunction of any bodily organ or part.	Emergency MH/SUD services are not subject to prior authorization. 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; or • Serious dysfunction of any bodily organ or part.

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

Cigna's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.

6. <u>Pharmacy Services</u>

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

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

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law. When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request. When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card. If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the	Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law. When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request. When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card. If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the

diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill. If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.	claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill. If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

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

Medical/Surgical Benefits (M/S)	**Mental Health/Substance Use Disorder Benefits (MH/SUD)**
When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost. The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest	When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost. The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the

net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information. The factors considered in deciding to apply a prior authorization requirement, including a quantity limit, to a drug include the risk of adverse safety issues, cost, or risk of inappropriate (i.e., wasteful) utilization. The evidentiary standard used to define whether a drug poses an adverse safety issue is the assessment by clinical experts of available clinical evidence, including, without limitation, FDA labeling, clinical guidelines or clinical literature. This evidence is reviewed in its totality by relevant experts, though certain attributes such as the status of a drug as a controlled substance will, if present, result in application or a prior authorization requirement on the basis of potentially serious adverse safety impacts to enrollees. Controlled substances subject to prior authorization or a quantity limit include ADHD stimulants, which are MH/SUD benefits, and other controlled substances used to treat Med/Surg conditions like opioids for pain management. For other drugs, the FDA's product label generally indicates whether a serious adverse safety risk exists for a drug, though sometimes, such as with opioids, other widely-accepted clinical guidelines such as CDC guidance may also dictate whether a prior authorization requirement will apply.	lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information. The factors considered in deciding to apply a prior authorization requirement, including a quantity limit, to a drug include the risk of adverse safety issues, cost, or risk of inappropriate (i.e., wasteful) utilization. The evidentiary standard used to define whether a drug poses an adverse safety issue is the assessment by clinical experts of available clinical evidence, including, without limitation, FDA labeling, clinical guidelines or clinical literature. This evidence is reviewed in its totality by relevant experts, though certain attributes such as the status of a drug as a controlled substance will, if present, result in application or a prior authorization requirement on the basis of potentially serious adverse safety impacts to enrollees. Controlled substances subject to prior authorization or a quantity limit include ADHD stimulants, which are MH/SUD benefits, and other controlled substances used to treat Med/Surg conditions like opioids for pain management. For other drugs, the FDA's product label generally indicates whether a serious adverse safety risk exists for a drug, though sometimes, such as with opioids, other widely-accepted clinical guidelines such as CDC guidance may also dictate whether a prior authorization requirement will apply.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest	The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the

net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.	lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The processes, factors, and standards are used to determine formulary placement to an MH/SUD or M/S drug are identical. The same formulary committee structure makes decisions with respect to MH/SUD or M/S drugs ensures appropriate expertise across MH/SUD and M/S treatment. Two Cigna committees perform different, but interrelated, functions when designing utilization management requirements like quantity limits: the Cigna Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Cigna Value Assessment Committee. Cigna uses one, combined set of policies to govern its formulary management practices across M/S and MH/SUD drugs, and, while uniformity in processes is not required by the NQTL requirements (only comparability), and uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written. The P&T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. The P&T Committee includes among its voting members a psychiatrist to help ensure that, like other medical specialties, appropriate expertise in MH/SUD treatment is represented when reviewing the clinical safety/efficacy of drugs that may be considered MH/SUD benefits. By including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process. While physicians,	The processes, factors, and standards are used to determine formulary placement to an MH/SUD or M/S drug are identical. The same formulary committee structure makes decisions with respect to MH/SUD or M/S drugs ensures appropriate expertise across MH/SUD and M/S treatment. Two Cigna committees perform different, but interrelated, functions when designing utilization management requirements like quantity limits: the Cigna Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Cigna Value Assessment Committee. Cigna uses one, combined set of policies to govern its formulary management practices across M/S and MH/SUD drugs, and, while uniformity in processes is not required by the NQTL requirements (only comparability), and uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written. The P&T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. The P&T Committee includes among its voting members a psychiatrist to help ensure that, like other medical specialties, appropriate expertise in MH/SUD treatment is represented when reviewing the clinical safety/efficacy of drugs that may be considered MH/SUD benefits. By including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is

regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions. In rendering clinical findings on drugs, the P&T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines. The Value Assessment Committee is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from Cigna's finance areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&T Committee - which drugs will be covered on the formularies offered by Cigna to plans and whether a utilization management requirement will apply to a drug. Cigna's formulary committees collectively consider the factors and evidentiary standards described in the narratives to Steps 2 and 3 in deciding whether to place a drug on the formulary and, if so, on which formulary tier. Cigna's review evidences that the written processes and standards used to determine formulary placement is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&T and Value Assessment Committee structure reviews M/S and MH/SUD	represented in the formulary decision-making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions. In rendering clinical findings on drugs, the P&T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines. The Value Assessment Committee is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from Cigna's finance areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&T Committee - which drugs will be covered on the formularies offered by Cigna to plans and whether a utilization management requirement will apply to a drug. Cigna's formulary committees collectively consider the factors and evidentiary standards described in the narratives to Steps 2 and 3 in deciding whether to place a drug on the formulary and, if so, on which formulary tier. Cigna's review evidences that the written processes and standards used to determine formulary placement is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&T

drugs for formulary placement pursuant to common policies and procedures, and the processes and aforementioned factors and evidentiary standards considered in formulary placement does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.	and Value Assessment Committee structure reviews M/S and MH/SUD drugs for formulary placement pursuant to common policies and procedures, and the processes and aforementioned factors and evidentiary standards considered in formulary placement does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.

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

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

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

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

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

7. Prescription Drug Formulary Design

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The plan offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.	The plan offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost. The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.	When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost. The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.	The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
The evidentiary standards for tier placement of MH/SUD and M/S drugs are comparable, and no more stringently applied to MH/SUD drugs. Essentially, the evidentiary standards for each factor that dictate placement of a drug on a particular tier function collectively as definitions for each formulary tier, that is, what qualifies a drug for placement on a particular tier. Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank's drug indicator file, and not by reference to the drug's status as an M/S or MH/SUD benefit. If the algorithm identifies a covered drug as a generic drug, then the drug is covered on Tier 1 of the formulary, whether an MH/SUD or M/S drug. If brand drug status is determined by application of the algorithm, a	The evidentiary standards for tier placement of MH/SUD and M/S drugs are comparable, and no more stringently applied to MH/SUD drugs. Essentially, the evidentiary standards for each factor that dictate placement of a drug on a particular tier function collectively as definitions for each formulary tier, that is, what qualifies a drug for placement on a particular tier. Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank's drug indicator file, and not by reference to the drug's status as an M/S or MH/SUD benefit. If the algorithm identifies a covered drug as a generic drug, then the drug is covered on Tier 1 of the formulary, whether an MH/SUD or M/S drug. If brand drug status is determined by application of

covered brand drug is typically placed on Tier 2 as a preferred brand drug if either it lacks available generic alternatives (inclusive of therapeutic equivalents and therapeutic alternatives) based on an assessment of First DataBank drug indicators and/or external information about alternative drugs in the same therapeutic class, or if a rebate arrangement exists for the brand drug. Conversely, a covered brand drug is typically placed on Tier 3 as a non-preferred brand drug if it either has available generic alternatives or there is no rebate arrangement for the brand drug. A minority of drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several factors that it doesn't warrant coverage on the formulary. If the formulary committee identifies that a given brand or generic drug has covered therapeutic alternatives available that project to have lower net cost(s) than the drug in question (inclusive of an assessment of projected ingredient cost expenditures as sourced from claims/reimbursement information and available rebate revenue), then the drug may be designated as non-formulary. Non-formulary drugs	the algorithm, a covered brand drug is typically placed on Tier 2 as a preferred brand drug if either it lacks available generic alternatives (inclusive of therapeutic equivalents and therapeutic alternatives) based on an assessment of First DataBank drug indicators and/or external information about alternative drugs in the same therapeutic class, or if a rebate arrangement exists for the brand drug. Conversely, a covered brand drug is typically placed on Tier 3 as a non-preferred brand drug if it either has available generic alternatives or there is no rebate arrangement for the brand drug. A minority of drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several factors that it doesn't warrant coverage on the formulary. If the formulary committee identifies that a given brand or generic drug has covered therapeutic alternatives available that project to have lower net cost(s) than the drug in question (inclusive of an assessment of projected ingredient cost expenditures as sourced from claims/reimbursement information and available rebate revenue), then the drug may be designated as non-formulary. Non-formulary drugs

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

With respect to parity compliance as-written, the same, and not just comparable, processes, factors, and standards are used to determine formulary placement to an MH/SUD or M/S drug.

With respect to the process by which the NQTL is designed and applied, the same formulary committee structure makes decisions with respect to MH/SUD or M/S drugs the ensures appropriate expertise across MH/SUD and M/S treatment. Two Cigna committees perform different, but interrelated, functions when designing utilization management requirements like quantity limits: the Cigna Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Cigna Value Assessment Committee. Cigna uses one, combined set of policies to govern its formulary management practices across M/S and MH/SUD drugs, and, while uniformity in processes is not required by the NQTL requirements (only comparability), uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written.

The P&T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. The P&T Committee includes among its voting members a psychiatrist to help ensure that, like other medical specialties, appropriate expertise in MH/SUD treatment is represented when reviewing the clinical safety/efficacy of drugs that may be considered MH/SUD benefits. By including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions. In rendering clinical findings on drugs, the P&T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines. The Value Assessment Committee is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from Cigna’s finance areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&T Committee - which drugs will be covered on the formularies offered by Cigna to plans and whether a utilization management requirement will apply to a drug. Cigna's formulary committees collectively consider the factors and evidentiary standards described in the narratives to Steps 2 and 3 in deciding whether to place a drug on the formulary and, if so, on which formulary tier.

Cigna's review evidences that the written processes and standards used to determine formulary placement is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&T and Value Assessment Committee structure reviews M/S and MH/SUD drugs for formulary placement pursuant to common policies and procedures, and the processes and aforementioned factors and evidentiary standards considered in formulary placement does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.

In terms of operational parity compliance, the formulary placement of MH/SUD and M/S drugs all conform to the aforementioned evidentiary standards established for Tier 1, Tier 2, and Tier 3.

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

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

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

In summary, the comparative analyses documented in the narratives to Steps 4 and 5, which themselves construe the application of the multi-tiered formulary design NQTL described in Steps 1 through 3, demonstrate the compliance in-writing and in-operation of the quantity limit/prior authorization NQTL. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. In this case, there were comparable and, in some cases more advantageous, outcomes for the placement and tiering of MH/SUD drugs as compared to M/S drugs based on the absolute number of, and incidence of, non-formulary v. formulary and, for on-formulary drugs, Tier 2 v. Tier 3 drugs. These comparable outcomes, along with the confirmation that the evidentiary standards and factors were actually applied consistently to MH/SUD drugs as compared to M/S drugs, evidence in-operation compliance in terms of comparability and equivalent stringency.

8. Case Management

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

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

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

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.	While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.	Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.	Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.	Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.

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

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

9. Process for Assessment of New Technologies

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:	Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

• not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed; • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed; • the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or • the subject of an ongoing phase I, II, III or IV clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan. In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following: • the national institutes of health (NIH); • an NIH cooperative group or an NIH center; • the FDA in the form of an investigational new drug application; • the federal department of veterans affairs; or • an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.	• not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed; • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed; • the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or • the subject of an ongoing phase I, II, III or IV clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan. In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following: • the national institutes of health (NIH); • an NIH cooperative group or an NIH center; • the FDA in the form of an investigational new drug application; • the federal department of veterans affairs; or • an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna considers the following factors in determining whether a services is experimental, investigational or unproven: • 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 the 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 as provided in the clinical trials section below.	Cigna considers the following factors in determining whether a services is experimental, investigational or unproven: • 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 the 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 as provided in the clinical trials section below.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources: • clinical literature • FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven. • FDA approval or clearance • English language peer reviewed publications including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.	In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources: • clinical literature • FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven. • FDA approval or clearance • English language peer reviewed publications including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes. Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.	Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes. Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.

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

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

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

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

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

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

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

10. Standards for Provider Credentialing and Contracting

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Since there is no provider network, this NQTL is not applicable.	Since there is no provider network, this NQTL is not applicable.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Since there is no provider network, this NQTL is not applicable.	Since there is no provider network, this NQTL is not applicable.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Since there is no provider network, this NQTL is not applicable.	Since there is no provider network, this NQTL is not applicable.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Since there is no provider network, this NQTL is not applicable.	Since there is no provider network, this NQTL is not applicable.

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

Since there is no provider network, this NQTL is not applicable.	Since there is n

11. Exclusions for Failure to Complete a Course of Treatment

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.

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

Cigna does not exclude benefits for failure to complete treatment for M/S or MH/SUD Benefits. Cigna's process is consistent between M/S and MH/SUD, so Cigna does not apply such an NQTL to MH/SUD benefits that warrants analysis under the NQTL requirement.

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

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.

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

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

13. Restrictions for Provider Specialty

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers are required to work within the scope of their licenses.	Providers are required to work within the scope of their licenses.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers are required to work within the scope of their licenses.	Providers are required to work within the scope of their licenses.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers are required to work within the scope of their licenses.	Providers are required to work within the scope of their licenses.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers are required to work within the scope of their licenses.	Providers are required to work within the scope of their licenses.

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

Cigna requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. Cigna does not, in writing or in operation, further restrict provision of MH/SUD benefits to

certain types of specialties so long as the rendering provider is acting within the scope of the provider's license, and, in terms of stringency, Cigna confirms that it does not waive for any M/S providers the requirement that the M/S provider act within the scope of the provider's license in order for services to be covered.

14. <u>Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)</u>

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers To calculate appropriate reimbursement levels for covered charges with providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the so-called "Maximum Reimbursable Charge" (MRC) for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated using one of two methodologies: MRC1 or MRC2. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S benefits. **Facilities** To calculate appropriate reimbursement levels for covered charges with providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the so-called "Maximum Reimbursable Charge" (MRC) for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated	**Providers** To calculate appropriate reimbursement levels for covered charges with providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the so-called "Maximum Reimbursable Charge" (MRC) for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated using one of two methodologies: MRC1 or MRC2. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S. **Facilities** To calculate appropriate reimbursement levels for covered charges with providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the so-called "Maximum Reimbursable Charge" (MRC) for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated

using one of two methodologies: MRC1 or MRC2. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S.	using one of two methodologies: MRC1 or MRC2. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers Maximum Reimbursable Charge – MRC1 Under MRC1, the plan applies to a covered inpatient or outpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC1 is as follows, and excerpted as relevant:	**Providers** Maximum Reimbursable Charge – MRC1 Under MRC1, the plan applies to a covered inpatient or outpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC1 is as follows, and excerpted as relevant:

"The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used. The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule." Maximum Reimbursable Charge – MRC2 Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment	"The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used. The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule." Maximum Reimbursable Charge – MRC2 Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment

(DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization. MRC2 rate updates occur in response to CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes. Plan sponsor clients can select the percentage of MRC2 paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna applies a reimbursement rate derived from a methodology similar to the ones used by Medicare. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC2 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentage of a schedule developed by CG that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.	(DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization. MRC2 rate updates occur in response to CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes. Plan sponsor clients can select the percentage of MRC2 paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna applies a reimbursement rate derived from a methodology similar to the ones used by Medicare. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC2 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentage of a schedule developed by CG that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • the 80th percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used." For emergency services, under either the MRC1 or MRC2 methodologies, and consistent with the Affordable Care Act, Cigna-administered plans agree to pay to an out-of-network provider the greatest of the following amounts: (1) The median amount negotiated with in-network providers for the emergency service; (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) The amount that would be paid under Medicare for the emergency service (minimum payment standards). **Facilities** Maximum Reimbursable Charge – MRC1 Under MRC1, the plan applies to a covered inpatient or outpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in	In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • the 80th percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used." For emergency services, under either the MRC1 or MRC2 methodologies, and consistent with the Affordable Care Act, Cigna-administered plans agree to pay to an out-of-network provider the greatest of the following amounts: (4) The median amount negotiated with in-network providers for the emergency service; (5) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (6) The amount that would be paid under Medicare for the emergency service (minimum payment standards). **Facilities** Maximum Reimbursable Charge – MRC1 Under MRC1, the plan applies to a covered inpatient or outpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in

question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC1 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used. The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule."	question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc. The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC1 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used. The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule."

Maximum Reimbursable Charge – MRC2 Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization. MRC2 rate updates occur in response to CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes. Plan sponsor clients can select the percentage of MRC2 paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna applies a reimbursement rate derived from a methodology similar to the ones used by Medicare.	Maximum Reimbursable Charge – MRC2 Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization. MRC2 rate updates occur in response to CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes. Plan sponsor clients can select the percentage of MRC2 paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna applies a reimbursement rate derived from a methodology similar to the ones used by Medicare.

The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC2 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentage of a schedule developed by CG that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • the 80th percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used." For emergency services, under either the MRC1 or MRC2 methodologies, and consistent with the Affordable Care Act, Cigna-administered plans agree to pay to a provider the greatest of the following amounts:	The standard benefit language incorporated into many plan sponsors' benefit plans to describe MRC2 is as follows, and excerpted as relevant: "The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • a policyholder-selected percentage of a schedule developed by CG that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the health care professional's normal charge for a similar service or supply; or • the 80th percentile of charges made by health care professionals of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database that is derived from charges for other for similar services may be used." For emergency services, under either the MRC1 or MRC2 methodologies, and consistent with the Affordable Care Act, Cigna-administered plans agree to pay to a provider the greatest of the following amounts:

(1) The median amount negotiated with in-network providers for the emergency service; (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or (3) The amount that would be paid under Medicare for the emergency service (minimum payment standards).	(4) The median amount negotiated with in-network providers for the emergency service; (5) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or The amount that would be paid under Medicare for the emergency service (minimum payment standards).

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of	**Providers** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT

rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan. **Facilities** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar	codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan. **Facilities** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar

geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.	geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.

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

Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)
Providers In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements	**Providers** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with an health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements

indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan. **Facilities** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with an health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by	indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan. **Facilities** In addition to calculating an MRC for a covered service, Cigna also identifies whether it has access to an acceptable arrangement with a health care provider whereby the health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by

virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.	virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates – which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available – vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the provider is, again, equal to the lesser of (I) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.

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

Providers Cigna has assessed the methodology for calculating reimbursement amounts, and has concluded that it is designed and applied comparably, and no more stringently, as-written and in-operation across MH/SUD and M/S benefits. Cigna's methodology for determining M/S provider reimbursement rates and MH/SUD provider reimbursement rates are comparable and applied no more stringently to MH/SUD providers than to M/S providers as-written. As described in the foregoing, the plans establish in their terms one methodology, including the percentile or percentage, if any, applied to the MRC for the service that uniformly applies to MH/SUD and M/S benefits. There are not different methodologies for identifying the charge, or, as applicable, the percentile applied to the charge,

used to calculate the amount the plan agrees to reimburse for the service rendered by a provider. The charges used to calculate MH/SUD benefits are subject to the same percentile or percentage as applies to M/S benefits (e.g., 80% of the MRC for the service). Likewise, enrollees enjoy the protection from balance-billing afforded by any indirect rate arrangement accessed by the plan, whether the provider with which the plan has an indirect rate arrangement renders MH/SUD services or M/S services to the enrollees. Cigna does not limit application of these rate arrangements to M/S services, and the indirect rate arrangements with MH/SUD providers leverage, just like M/S providers and where available, rates obtained by third party vendors and derived from third party databases that compile charges for the same or similar providers in the geographic area. Specifically, across MH/SUD and M/S providers the charges for services differ as-between inpatient and outpatient facilities and among different licensure/training levels, including physician and non-physician practitioners (e.g. MD/PhD v. psychologists), and across geographic areas.

In terms of operational NQTL parity compliance, Cigna assessed the application of the reimbursement program across Cigna-administered plans and has confirmed reimbursement methodology applied, in operation, comparably to MH/SUD benefits and no more stringently than M/S benefits received. Specifically, Cigna-administered plans cover and thus treat as payable as plan benefits the full billed charges submitted by the MH/SUD providers at a comparable and, indeed, a generally higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. This means that MH/SUD providers receive reimbursement for the full submitted charges at least as often, and in some instances more often, than M/S providers.

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 MH/SUD and M/S providers' billed charges, while such an advantageous result for MH/SUD benefits is not required by the NQTL requirement, it does evidence that the reimbursement methodology is actually operating in a manner that ensures enrollees accessing MH/SUD services from providers are receiving at least comparable benefits to enrollees accessing M/S services from providers. While not dispositive of NQTL compliance, these outcomes, in addition to the description of the foregoing process and standards for calculating reimbursement amounts, help evidence that the reimbursement methodologies applied under Cigna-administered plans are at least as generous for, and thus comparable and not more stringently applied to, MH/SUD inpatient and outpatient benefits in-writing and in-operation.

Facilities

Cigna has assessed the methodology for calculating reimbursement amounts, and has concluded that it is designed and applied comparably, and no more stringently, as-written and in-operation across MH/SUD and M/S benefits. Cigna's methodology for determining M/S provider reimbursement rates and MH/SUD provider reimbursement rates are comparable and applied no more stringently to MH/SUD providers than to M/S providers as-written. As described in the foregoing, the plans establish in their terms one methodology, including the percentile or percentage, if any, applied to the MRC for the service that uniformly applies to MH/SUD and M/S benefits. There are not different methodologies for identifying the charge, or, as applicable, the percentile applied to the charge, used to calculate the amount the plan agrees to reimburse for the service rendered by a provider. The charges used to calculate

MH/SUD benefits are subject to the same percentile or percentage as applies to M/S benefits (e.g., 80% of the MRC for the service). Likewise, enrollees enjoy the protection from balance-billing afforded by any indirect rate arrangement accessed by the plan, whether the provider with which the plan has an indirect rate arrangement renders MH/SUD services or M/S services to the enrollees. Cigna does not limit application of these rate arrangements to M/S services, and the indirect rate arrangements with MH/SUD providers leverage, just like M/S providers and where available, rates obtained by third party vendors and derived from third party databases that compile charges for the same or similar providers in the geographic area. Specifically, across MH/SUD and M/S providers the charges for services differ as-between inpatient and outpatient facilities and among different licensure/training levels, including physician and non-physician practitioners (e.g. MD/PhD v. psychologists), and across geographic areas.

In terms of operational NQTL parity compliance, Cigna assessed the application of the reimbursement program across Cigna-administered plans and has confirmed reimbursement methodology applied, in operation, comparably to MH/SUD benefits and no more stringently than M/S benefits. Specifically, Cigna-administered plans cover and thus treat as payable as plan benefits the full billed charges submitted by the MH/SUD providers at a comparable and, indeed, a generally higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. This means that MH/SUD providers receive reimbursement for the full submitted charges at least as often, and in some instances more often, than M/S providers.

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 MH/SUD and M/S providers' billed charges, while such an advantageous result for MH/SUD benefits is not required by the NQTL requirement, it does evidence that the reimbursement methodology is actually operating in a manner that ensures enrollees accessing MH/SUD services from providers are receiving at least comparable benefits to enrollees accessing M/S services from providers. While not dispositive of NQTL compliance, these outcomes, in addition to the description of the foregoing process and standards for calculating reimbursement amounts, help evidence that the reimbursement methodologies applied under Cigna-administered plans are at least as generous for, and thus comparable and not more stringently applied to, MH/SUD inpatient and outpatient benefits in-writing and in-operation.

MHPAEA Data Report for Calendar Year Ending December 31, 2021 (§15–144(f))

Health Plan	IND-PRIND Indemnity-PUERTO RICO INDEMNITY PLAN

Benefit	Classification	# of Authorization Requests Received	# of Authorization Requests Approved	# of Authorization Requests Denied	% Approved	% Denied
Mental Health Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	2	2	0	100%	0%
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
Substance Use Disorder Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	0	0	0	#DIV/0!	#DIV/0!
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
Medical /Surgical Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!
	RX	38	22	16	58%	42%
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!

MHPAEA Data Report for Calendar Year Ending December 31, 2021 (§15–144(f))

Health Plan	IND-PRIND Indemnity-PUERTO RICO INDEMNITY PLAN

Benefit	Classification	# of Claims Submitted	# of Claims Approved	# of Claims Denied	% Approved	% Denied	Reasons for Denial of Claims
Mental Health Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!	0
	RX	0	0	0	#DIV/0!	#DIV/0!	0
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!	0
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!	0
Substance Use Disorder Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	Emergency Services	0	0	0	#DIV/0!	#DIV/0!	0
	RX	0	0	0	#DIV/0!	#DIV/0!	0
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!	0
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!	0
Medical /Surgical Benefits	INN-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Inpatient	0	0	0	#DIV/0!	#DIV/0!	0
	Emergency Services	3	3	0	100%	0%	0
	RX	8	6	2	75%	25%	79,76
	INN-Outpatient-Office	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-Office	4	4	0	100%	0%	0
	INN-Outpatient-AllOther	0	0	0	#DIV/0!	#DIV/0!	0
	OON-Outpatient-AllOther	7	5	2	71%	29%	1231,720

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

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

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

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

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

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

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

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

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

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