Mental Health Parity and Addiction Equity Act (MHPAEA)

<table>
<tr><td>Cigna Health and Life Insurance Company</td><td>Date: January 1, 2018</td></tr>
<tr><td colspan="2">Health Plan Product Offerings: Open Access Plus (OAP), Preferred Provider Organization (PPO), Network Point of Service (NPOS), Point of Service Open Access (NPOSOA), Point of Service (POS), HMO Point of Service (HMOPOS)</td></tr>
<tr><td colspan="2">Funding Arrangement Types(s): Fully Insured and Self-Insured</td></tr>
<tr><td colspan="2">This document provides a summary of Cigna's methodologies and processes for ensuring financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations administered by Cigna comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
nqtl_oap_ppo_npos_nposoa_pos_um_ip_op</td></tr>
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Defining Plan Benefits		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Definitions of Medical/Surgical Benefits and Mental Health and Substance use Disorder Benefits: Med_MHSUD_Def_2018_001	Cigna defines medical/surgical benefits as benefits for the treatment of medical/surgical conditions included in the current edition of the International Classification of Diseases (ICD) with the exception of the mental disorders classification.	Cigna defines mental health and substance use disorder (MH/SUD) benefits as benefits for the treatment of MH/SUD conditions included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This includes services rendered by licensed medical specialists for the treatment of MH/SUD conditions such as: • Nutritional counseling services rendered for the treatment of eating disorders; and • Speech therapy, physical therapy and occupational therapy rendered for the treatment of autism spectrum disorder.

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<table>
<tr><th colspan="3">Assignment of Health Care Services to the Classification of Benefits</th></tr>
<tr><td colspan="3">Assignment of Health Care Services to Inpatient Classification(s) of Benefits</td></tr>
<tr><td></td><td>Medical/Surgical</td><td>Mental Health and Substance Use Disorder (MH/SUD)</td></tr>
<tr><td>Inpatient Classification(s) of Benefits:</td><td>Non-emergent medical/surgical services, rendered by a hospital or facility to health plan enrollees who are confined overnight to the hospital or facility, are assigned to the inpatient classifications of benefits. This includes:
Services rendered by acute care hospitals and facilities licensed in accordance with the laws of the legally appropriate state agency and/or certified by a national accrediting body such as the Joint Commission (JC) which provide diagnostic services and treatment to the sick and injured by or under the supervision of physicians and 24-hour nursing services under the supervision of registered nurses; and
Services rendered by subacute care hospitals and facilities licensed in accordance with the laws of the legally appropriate state agency and/or certified by a national accrediting body such as the Joint Commission (JC) or Commission on Accreditation of Rehabilitation Facilities (CARF) including skilled nursing facilities and physical rehabilitation hospitals.
<table><tr><th>Medical/Surgical Inpatient Services Include:</th></tr><tr><td>Acute Inpatient Services</td></tr><tr><td>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.</td></tr><tr><td>Inpatient Professional Services</td></tr></table></td><td>Non-emergent MH/SUD services, rendered by a hospital or facility to health plan enrollees who are confined overnight to the hospital or facility, are assigned to the inpatient classifications of benefits. This includes:
Services rendered by acute care institutions licensed in accordance with the laws of the legally appropriate state agency and/or certified by a national accrediting body such as the Joint Commission (JC) which provide diagnostic services by or under the supervision of physicians and 24-hour nursing services under the supervision of registered nurses; and
Services rendered by subacute care institutions licensed in accordance with the laws of the legally appropriate state agency and/or certified by a national accrediting body such as the Joint Commission (JC) or Commission on Accreditation of Rehabilitation Facilities (CARF) including residential treatment facilities:
<table><tr><th>MH/SUD Inpatient Services Include:</th></tr><tr><td>Mental Health Acute Inpatient</td></tr><tr><td>Mental Health Subacute Residential Treatment</td></tr><tr><td>Mental Health Inpatient Professional Services</td></tr><tr><td>SUD Acute Inpatient Detoxification</td></tr><tr><td>SUD Acute Inpatient</td></tr><tr><td>SUD Subacute Residential Treatment</td></tr><tr><td>SUD Inpatient Professional Services</td></tr></table></td></tr>
</table>

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Assignment of Health Care Services to Inpatient Classification(s) of Benefits		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Inpatient Classification(s) of Benefits (Continued): InPat_Class_2018_001	Network Status • If the institution rendering the above referenced services is contracted with a Cigna provider network, the services are assigned to the **Inpatient, In-Network classification of benefits**. • If the institution rendering the above referenced services is not contracted with a Cigna provider network, the services are assigned to the **Inpatient, Out-of-Network classification of benefits**.	Network Status • If the institution rendering the above referenced services is contracted with Cigna Behavioral Health, Inc.'s network, the services are assigned to **the Inpatient, In-Network classification of benefits**. • If the institution rendering the above referenced services is not contracted with Cigna Behavioral Health, Inc.'s network, the services are assigned to the **Inpatient, Out-of-Network classification of benefits**.

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Assignment of Health Care Services to Outpatient Classification(s) of Benefits		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Outpatient Classification(s) of Benefits:	Non-emergent ambulatory medical/surgical services, rendered to health plan enrollees not confined overnight to an institution or facility, are assigned to the outpatient classifications of benefits. This includes:	Non-emergent ambulatory MH/SUD services, rendered to health plan enrollees not confined overnight to an institution or facility, are assigned to the outpatient classification of benefits:

Medical/Surgical Outpatient Services Include:
Office Visits with primary care physicians (PCPs)
Medical/Surgical Outpatient Services (Continued):
Office Visits with Specialists
Lab Services
Radiology Services
Advanced Radiology (MRI/CT/PET)
Outpatient Surgery
Outpatient Facility
Outpatient Professional Services
Speech Therapy
Physical Therapy
Occupational Therapy
Chiropractic Services
Neuropsychological Testing
Home Health Care
Hospice – Outpatient services
Durable Medical Equipment
Breast Feeding Equipment and Supplies
Urgent Care

MH/SUD Outpatient Services Include:
Individual Psychotherapy Services
Family Psychotherapy Services
MH/SUD Outpatient Services (Continued):
Group Psychotherapy Services
Mental Health Counseling Services
Medication Management
Psychological Testing
Electroconvulsive Therapy (ECT)
Partial Hospitalization
Outpatient Professional Services
Intensive Outpatient Services
Applied Behavior Analysis
Transcranial Magnetic Stimulation

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Assignment of Health Care Services to Outpatient Classification(s) of Benefits		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Outpatient Classification(s) of Benefits (Continued): OutPat_Class_2018_001	Network Status • If the provider rendering the above referenced ambulatory services is contracted with a Cigna provider network, the services are assigned to the **Outpatient, In-Network classification of benefits**. • If the provider rendering the above referenced ambulatory services is not contracted with a Cigna provider network, the services are assigned to the **Outpatient, Out-of-Network classification of benefits**.	Network Status • If the provider rendering the above referenced ambulatory services is contracted with Cigna Behavioral Health, Inc.'s network, the services are assigned to **the Outpatient, In-Network classification of benefits**. • If the provider rendering the above referenced services is not contracted with Cigna Behavioral Health, Inc.'s network, the services are assigned to the **Outpatient, Out-of-Network classification of benefits**.
Assignment of Sub-Classification of Outpatient, In-Network		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Sub-Classification of Outpatient, In-Network: Sub_Class_INN_2018_001	For Cigna Copay plans, Cigna sub-classifies the medical/surgical Outpatient, In-Network classification of benefits into in-network "Office Visits" and "All Other Outpatient Services." • Routine outpatient services typically rendered in an office setting by an independently licensed practitioner are assigned to the in-network "Office Visits" sub-classification of benefits. This includes routine outpatient services rendered by a Primary Care Physician (PCP) and medical specialists. • All other outpatient services (a/k/a non-routine outpatient services typically subject to higher cost and/or utilization) are assigned to the in-network "All Other Outpatient Services" sub-classification of benefits. This includes outpatient surgery, outpatient facility services, lab, radiology, advanced radiology, home health care, speech therapy, physical therapy, occupational therapy, etc.	For Cigna Copay plans, Cigna sub-classifies the MH/SUD Outpatient, In-Network classification of benefits into in-network "Office Visits" and "All Other Outpatient Services." • Routine outpatient services typically rendered in an office setting by an independently licensed practitioner are assigned to the in-network "Office Visits" sub-classification of benefits. This includes individual, family, and group psychotherapy; mental health counseling; and medication management services. • All other outpatient services (a/k/a non-routine outpatient services typically subject to higher cost and/or utilization) are assigned to the in-network "All Other Outpatient Services" sub-classification of benefits. This includes partial hospitalization, intensive outpatient services, Applied Behavior Analysis, Transcranial Magnetic Stimulation, etc.

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Assignment of Health Care Services to Emergency Classification of Benefits		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Emergency Care Classification of Benefits: ER_Class_2018_001	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 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.

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Quantitative Analysis of Financial Requirements

Under MHPAEA, a health plan may not impose a financial requirement (a/k/a member cost share) to a MH/SUD classification of benefits that is more restrictive than the predominant type and level of cost share applied to substantially all medical/surgical benefits within the same classification of benefits. [29 C.F.R. 2590.712(c)(2)(i)] A type of cost share is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification of benefits. If a type of cost share does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type of cost share may not be applied to the corresponding MH/SUD classification of benefits. [29 C.F.R. 2590.712(c)(3)(i)(A)].

Moreover, if a type of cost share applies to at least two-thirds of all medical/surgical benefits in a classification of benefits, but the plan applies more than one level of that type of cost share, the plan must apply the predominant cost share level to the corresponding MH/SUD classification of benefits. The predominant cost share level is the level that applies to more than one-half of the medical/surgical benefits within the classification of benefits. [29 C.F.R. 2590.712(c)(3)(i)(B)].

The determination of whether a type of cost share is subject to "substantially all" (at least two-thirds) of the medical/surgical benefits within a classification of benefits is based upon the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year. The MHPAEA regulations set forth "Any reasonable method may be used" to determine the dollar amount of medical/surgical benefits subject to a type of cost share expected to be paid under the plan for a plan year. [29 C.F.R. 2590.712(b)(4)]

According to sub-regulatory guidance published by the federal tri-agencies (DOL/HHS/DOT) on October 27, 2016, a plan or issuer must consider using plan-level claims data to perform the "substantially all" and "predominant (level)" testing if the data is credible for performing the required projections. If the plan or issuer's actuary determines using plan-level claims data is insufficient for making reasonable projections of future claims costs for the "substantially all" and "predominant (level) analyses, then the plan or issuer may use other reasonable claims data from other similarly-structured products or plans with similar demographics in conducting its actuarially-appropriate analyses. (See FAQ Q3: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf)

Methodology for Conducting MHPAEA Cost-Share Testing:

For plans with less than 20,000 covered lives, Cigna conducts its quantitative analysis (a/k/a cost share testing) using recent claim experience at the product level (a larger and more statistically stable data set) to determine the dollar amount of all plan payments expected to be paid for the plan year because using plan-level claims data was determined to be insufficient for producing actuarially reasonable outcomes. For plans with 20,000 or more covered lives, Cigna conducts its quantitative analysis using recent claim experience at the plan level to determine the dollar amount of all plan payments expected to be paid for the plan year. Cigna then assigns the allowed amounts (paid amount plus member cost share) for the medical/surgical services to the classifications of benefits covered under the plan (inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drug).

"Substantially All" Testing

Cigna analyzes the assigned allowed amounts by classification of benefits to assess whether a particular type of cost share (e.g. copay, coinsurance or deductible) applies to "substantially all" (at least two-thirds or 66.67%) medical/surgical benefits within each classification of benefits. If so, that type of cost share may be applied to the corresponding MH/SUD classification of benefits. If the testing reveals a type of cost share (e.g. copay, coinsurance or deductible) does not apply to "substantially all" medical/surgical benefits within a classification of benefits, then that type of cost share may not be applied to the corresponding MH/SUD classification of benefits.

Predominant Level Testing

If the health plan applies more than one level of the type of cost share applied to "substantially all" medical/surgical benefits within a classification (or sub-classification) of benefits, then Cigna assesses whether a particular level applies to more than 50% of the medical/surgical benefits within the classification (or sub-classification) of benefits. If so, that level is deemed the predominant level that may be applied to the corresponding MH/SUD classification (or sub-classification) of benefits.

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Quantitative Analysis of Financial Requirements (Continued)

Cigna updates its claim experience annually and continues to evaluate its cost share testing on an ongoing basis to consider changes in utilization patterns and benefit and cost share structures to ensure the sufficiency of data used. Financial_Req_2018_001

Quantitative Analysis of Quantitative Treatment Limitations (QTLs) a/k/a day and visit limits

A quantitative treatment limitation (QTL) is a technique used by a health plan to limit the scope of benefit coverage or the duration of treatment which is expressed numerically, e.g. day limits imposed upon inpatient benefits and visit limits imposed upon outpatient benefits. [29 C.F.R. 2590.712(a)] Cigna applies the same methodology referenced above when conducting its quantitative analysis of quantitative treatment limitations. Because Cigna's testing of its health plans reflects no quantitative treatment limitation is applied to “substantially all” (at least two-thirds or 66.67%) of all medical/surgical benefits within any classification (or sub-classification) of benefits, MH/SUD services within the covered classifications of benefits are not subject to day or visit limits. QTL_Req_2018_001

Non-Quantitative Treatment Limitations (NQTLs)

A non-quantitative treatment limitation (NQTL) is a technique used by a health plan that limits the scope of benefit coverage or the duration of treatment covered under the plan that is not expressed numerically. Examples of NQTLs include benefit exclusions; utilization management (a/k/a prior authorization) requirements; network admission (a/k/a credentialing/re-credentialing) requirements; and a plan’s methodology for determining in-network and out-of-network provider reimbursements.

Cigna uses comparable “processes, strategies, evidentiary standards or other factors” when determining whether, and to what extent, medical/surgical services and MH/SUD services are subject to an NQTL and does not apply NQTLs more stringently across MH/SUD services within a classification of benefits than they are applied to medical/surgical services within the same classification of benefits. NQTL_Def_2018_001

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Benefit Exclusion for Experimental, Investigational and Unproven Services		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Benefit Exclusion for Experimental, Investigational and Unproven Services: EIU_Def_2018_001	Medical/surgical services determined to be experimental, investigational and unproven are excluded from coverage. Experimental, investigational and unproven services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be: • 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; • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency 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 "Clinical Trials" section(s) of this plan; or • the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.	MH/SUD services determined to be experimental, investigational and unproven are excluded from coverage. Experimental, investigational and unproven services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be: • 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; • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency 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 "Clinical Trials" section(s) of this plan; or • the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

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Medical Necessity		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Medical Necessity Definition: MedNecDef_2018_001	When conducting medical necessity reviews of medical/surgical services, 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** Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be: • 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; and • rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.	When conducting medical necessity reviews of MH/SUD services, 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** Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be: • 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; and • rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

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	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Development of Medical Necessity Criteria:	Cigna utilizes its own internally developed Coverage Policies (a/k/a medical necessity criteria) and the Milliman Care Guidelines (MCG) when conducting medical necessity reviews of medical/surgical services, procedures, devices, equipment, imaging, diagnostic interventions, etc. 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 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.	Cigna utilizes its own internally developed Coverage Policies and its own internally developed "Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders" when conducting medical necessity reviews of MH/SUD services and technologies. 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 of any kind. Also systematic reviews and meta-analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.

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	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Development of Medical Necessity Criteria (Continued): MedNecCriteria_2018_001	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 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.	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. **Development of Cigna's *Medical Necessity Criteria for Treatment of Mental Health and Substance use Disorders*:** In addition, Cigna has developed its own *Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders* used to evaluate the medical necessity of MH/SUD services. Such criteria incorporates clinical care guidelines of the American Psychiatric Association; the American Association of Pediatrics; and the National Institute on Alcohol Abuse and Alcoholism due to their national acceptance as the best of evidence-based practice for mental health and substance use disorders. In addition, when developing its “Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders”, Cigna solicits, evaluates and incorporates feedback from patients, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association, American Psychological Association, NASW, AAMFT, and ASAM), psychiatrists, psychologists, and therapists across the country. At least annually, practitioners participating in the Behavioral Health Quality Committee (BHQC), as well as practitioners from local communities, provide feedback on the proposed medical necessity criteria which is reviewed, revised (as needed) and adopted by the BHQC.

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Utilization Management a/k/a Prior Authorization Requirements		
Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Methodology for determining which Inpatient Benefits are subject to Pre-Service Review (a/k/a Prior Authorization): PSR_Inpat_methods_2018_001	When determining which medical/surgical inpatient benefits are subject to pre-service medical necessity review (a/k/a prior authorization/precertification), Cigna conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (a/k/a prior authorization).	When determining MH/SUD inpatient benefits are subject to pre-service medical necessity review (a/k/a prior authorization/precertification), Cigna conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (a/k/a prior authorization).

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Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
List of Inpatient Benefits Subject to Pre-Service Review (a/k/a Prior Authorization): PSR_Inpat_list_2018_001	All non-emergent medical/surgical inpatient services are subject to pre-service medical necessity review (a/k/a prior authorization).	All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (a/k/a prior authorization).

Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Pre-Service Review Process: PSR_Inpat_process_2018_001	The customer's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a nurse reviewer who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the customer meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer assesses the customer does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets medical necessity criteria for the inpatient level of care at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 medical/surgical inpatient days upon pre-service review.	The customer's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a Care Manager (a licensed behavioral health clinician) who collects and reviews the supporting clinical information for medical necessity. If the Care Manager determines the customer meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the Care Manager assesses the customer does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets medical necessity criteria for the inpatient level of care at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 MH/SUD inpatient days upon pre-service review.

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<tr><td>Methodology for determining which Inpatient benefits are subject to Concurrent Care Review:
CSR_Inpat_methods_2018_001</td><td>When determining which medical/surgical inpatient benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors:
• Cost of treatment/procedure
• Whether treatment type is a driver of high cost growth
• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region
• Annualized claim volume for treatment type including total paid and denied claims
• Treatment types subject to a higher potential for fraud, waste and/or abuse
• Cost of UM and appeals for treatment type if subject to concurrent care review
• Projected return on investment and/or savings if treatment type is subjected to concurrent care review
If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review.</td><td>When determining which MH/SUD inpatient benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors:
• Cost of treatment/procedure
• Whether treatment type is a driver of high cost growth
• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region
• Annualized claim volume for treatment type including total paid and denied claims
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<tr><td>List of Inpatient Benefits Subject to Concurrent Care Review:
CSR_Inpat_list_2018_001</td><td>All non-emergent medical/surgical inpatient services reimbursed on a per diem basis are subject to concurrent care medical necessity review.
Note: In-network medical/surgical inpatient services reimbursed on a DRG or case rate basis authorized upon pre-service review are not subject to concurrent care review.</td><td>All non-emergent MH/SUD inpatient services reimbursed on a per diem basis are subject to concurrent care medical necessity review.</td></tr>
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Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Concurrent Care Review Process: CSR_Inpat_process_2018_001	Concurrent care reviews are typically initiated by a nurse reviewer telephonically a day or two before the last covered/authorized day. The nurse reviewer collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer determines the customer meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer assesses the customer does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 medical/surgical inpatient days upon concurrent care review.	Concurrent care reviews are typically initiated by a Care Manager (licensed behavioral health clinician) telephonically a day or two before the last covered/authorized day. The Care Manager collects the updated clinical information and/or reviews it for medical necessity. If the Care Manager determines the customer meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Care Manager assesses the customer does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 MH/SUD inpatient/residential days upon concurrent care review.

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Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Retrospective Review: Retro_Inpat_Review_2018_001	Medical/surgical inpatient services are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Customers 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 customer 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 in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the customer met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the customer harmless for the services at issue. For denials of out-of-network services, the customer would have the right to pursue the full internal and/or external appeal process.	MH/SUD inpatient services are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Customers 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 Care Manager (licensed behavioral health clinician) for review. If the Care Manager determines the customer met criteria for the services at issue, he/she authorizes the services at issue. If the Care Manager assesses the customer 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 in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the customer met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the customer harmless for the services at issue. For denials of out-of-network services, the customer would have the right to pursue the full internal and/or external appeal process.

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Utilization Management a/k/a Prior Authorization Requirements		
Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Methodology for determining which Outpatient benefits are subject to Pre-Service Review (a/k/a Prior Authorization): PSR_Outpat_methods_2018_001	When determining which medical/surgical outpatient benefits are subject to pre-service medical necessity review (a/k/a prior authorization/precertification), Cigna conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (a/k/a prior authorization).	When determining MH/SUD outpatient benefits are subject to pre-service medical necessity review (a/k/a prior authorization/precertification), Cigna conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (a/k/a prior authorization).

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Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
List of Outpatient Benefits Subject to Pre-Service Review (a/k/a Prior Authorization): PSR_Outpat_list_2018_001	Based upon the above referenced methodology, Cigna subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to pre-service medical necessity review (a/k/a prior authorization). Examples of medical/surgical outpatient services subject to pre-service review include outpatient surgery, advanced radiology, chemotherapy, speech therapy, etc.	Based upon the above referenced methodology, Cigna subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to pre-service review (a/k/a prior authorization). MH/SUD outpatient services subject to pre-service review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS).

Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Pre-Service Review Process: PSR_Outpat_process_2018_001	The customer's treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer determines the customer meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer assesses the customer does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider).	The customer's treating provider submits a request for benefit authorization of an outpatient level of care electronically or by phone, fax or mail. The case is referred to a Care Manager (a licensed behavioral health clinician) who collects and reviews the supporting clinical information for medical necessity. If the Care Manager determines the customer meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the Care Manager assesses the customer does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider).

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• Cost of treatment/procedure
• Whether treatment type is a driver of high cost growth
• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region
• Annualized claim volume for treatment type including total paid and denied claims
• Treatment types subject to a higher potential for fraud, waste and/or abuse
• Cost of UM and appeals for treatment type if subject to concurrent care review
• Projected return on investment and/or savings if treatment type is subjected to concurrent care review
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<tr><td>List of Outpatient Benefits Subject to Concurrent Care Review:

CSR_Outpat_list_2018_001</td><td>Based upon the above referenced methodology, Cigna subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical necessity review. Examples of medical/surgical outpatient surgical services subject to concurrent care review include home health care, chemotherapy, speech therapy, physical therapy, occupational therapy, etc.</td><td>Based upon the above referenced methodology, Cigna subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical necessity review. MH/SUD outpatient surgical services subject to concurrent care review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS).</td></tr>
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Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Concurrent Care Review Process: CSR_Outpat_process_2018_001	Concurrent care reviews are typically initiated by a nurse reviewer telephonically a few days before the last covered/authorized visit. The nurse reviewer collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer determines the customer meets criteria for continued outpatient care, he/she authorizes continued care. If the nurse reviewer assesses the customer does not appear to meet medical necessity criteria for continued outpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets criteria for continued outpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider).	Concurrent care reviews are typically initiated by a Care Manager (licensed behavioral health clinician) telephonically a few days before the last covered/authorized visit. The Care Manager collects the updated clinical information and/or reviews it for medical necessity. If the Care Manager determines the customer meets criteria for continued inpatient or outpatient care, he/she authorizes the services at issue. If the Care Manager assesses the customer does not appear to meet medical necessity criteria for continued outpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the customer meets criteria for continued outpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider).

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Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Retrospective Review: Retro_Outpat_Review_2018_001	Medical/surgical outpatient services are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Customers 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 customer 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 in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the customer met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the customer harmless for the services at issue. For denials of out-of-network services, the customer would have the right to pursue the full internal and/or external appeal process.	MH/SUD outpatient services are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Customers 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 Care Manager (licensed behavioral health clinician) for review. If the Care Manager determines the customer met criteria for the services at issue, he/she authorizes the services at issue. If the Care Manager assesses the customer 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 in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the customer met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the customer harmless for the services at issue. For denials of out-of-network services, the customer would have the right to pursue the full internal and/or external appeal process.
Emergency Care		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Emergency Care Prior Authorization: ER_2018_001	Emergency medical/surgical services are not subject to prior authorization.	Emergency MH/SUD services are not subject to prior authorization.

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Network Admission Requirements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Network Admission Requirements: Netw_Admin_2018_001	Cigna's medical network is open; however, when determining whether to admit a provider into its provider network, Cigna takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification. In the event Cigna's medical network had a sufficient supply of a particular type and/or specialty of provider within a geographic region (i.e. zip code), Cigna closes its network to that provider type and/or specialty in that geographic region. Assessing supply and demand of medical/surgical provider types and/or specialties is based upon an array of factors including, but not limited to NCQA and state network adequacy and access standards focused upon distribution of provider type within geographic regions (i.e. zip codes); population density within geographic regions (i.e. zip code); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys.; and member complaint data.	Cigna Behavioral Health, Inc.'s provider network is open; however, when determining whether to admit a provider into its provider network, Cigna Behavioral Health, Inc. takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification. In the event Cigna Behavioral Health, Inc.'s network had a sufficient supply of a particular type and/or specialty of provider within a geographic region (i.e. zip code), Cigna Behavioral Health, Inc. closes its network to that provider type and/or specialty in that geographic region. Assessing supply and demand of MH/SUD provider types and/or sub-specialties is based upon the same array of factors including, but not limited to NCQA and state network adequacy and access standards focused upon distribution of provider types within geographic regions (i.e. zip codes); population density within geographic regions (i.e. zip code); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

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Credentialing and Re-Credentialing Requirements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Credentialing and Re-Credentialing Requirements: Netw_Credtial_2018_001	Credentialing Requirements for facilities: • Signed application • Signed agreement • Unrestricted license/state operating certificate • Accreditation • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of malpractice claim experience • Proof of professional and general liability insurance coverage • Quality Assurance/Quality Improvement Program Credentialing Requirements for independently practicing practitioners: • Signed application • Signed agreement to participate • Unrestricted state license to practice • Valid unrestricted DEA and CDS certificate for practitioners choosing to prescribe controlled substances • In good standing at facility at which he/she has privileges • Verification of education, training, license and board certification • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of sanctions (i.e. restrictions on license and/or scope of practice) • Acceptable history of malpractice claim experience • Proof of adequate professional liability insurance coverage	Credentialing Requirements for facilities: • Signed application • Signed agreement • Unrestricted license/state operating certificate • Accreditation • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of malpractice claim experience • Proof of professional and general liability insurance coverage • Quality Assurance/Quality Improvement Program Credentialing Requirements for independently practicing practitioners: • Signed application • Signed agreement to participate • Unrestricted state license to practice • Valid unrestricted DEA and CDS certificate for practitioners choosing to prescribe controlled substances • In good standing at facility at which he/she has privileges • Verification of education, training, license and board certification • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of sanctions (i.e. restrictions on license and/or scope of practice) • Acceptable history of malpractice claim experience • Proof of adequate professional liability insurance coverage

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Methodology for Determining Provider Reimbursements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Methodology for Determining In-Network Provider Reimbursements: INN_Prov_Reim_2018_001	Medical/surgical in-network facility based services are reimbursed on an assigned diagnosis-related group (DRG) or case rate basis and on a per diem basis. Cigna's in-network provider reimbursement methodology for medical/surgical providers are based upon the same array of factors including, but not limited to: • Geographic market (i.e. market rate and payment type for provider type and/or specialty) • Type of provider (i.e. hospital, clinic and practitioner) and/or specialty • Supply of provider type and/or specialty • Network need and/or demand for provider type and/or specialty • Medicare reimbursement rates • Training, experience and licensure of provider Assessing supply and demand of medical/surgical provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.	MH/SUD in-network facility based services are reimbursed on a per diem basis based upon the competitive rate for the type of service (a/k/a level of care) or procedure with the geographic market. Cigna's in-network provider reimbursement methodology for MH/SUD providers are based upon the same array of factors including, but not limited to: • Geographic market (i.e. market rate and payment type for provider type and/or specialty) • Type of provider (i.e. hospital, clinic and practitioner) and/or specialty • Supply of provider type and/or specialty • Network need and/or demand for provider type and/or specialty • Medicare reimbursement rates • Training, experience and licensure of provider Assessing supply and demand of MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

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Methodology for Determining Provider Reimbursements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Methodology for Determining Out-of-Network Provider Reimbursements: OON_Prov_Reim_2018_001	Out-of-Network medical/surgical providers are reimbursed the Maximum Reimbursable Charge for covered services which is determined based upon the lesser of: • The provider's normal charge for a similar service or supply; or • The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in FAIR Health database.	Out-of-Network MH/SUD providers are reimbursed the Maximum Reimbursable Charge for covered services which is determined based upon the lesser of: • The provider's normal charge for a similar service or supply; or • The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in FAIR Health database.

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