Mental Health Parity and Addiction Equity Act (MHPAEA)

Cigna + Oscar coverage is insured by Cigna Health and Life Insurance Company	**Date:** January 1, 2021
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)	
Funding Arrangement Types(s): Fully Insured and Self-Insured	
This document provides a summary of Cigna + Oscar's methodologies and processes for ensuring financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations administered by Cigna + Oscar 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_rx	

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Mental Health Parity and Addiction Equity Act (MHPAEA)

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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:	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.

<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>

	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Inpatient Classification(s) of Benefits (Continued):	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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<table>
<tr><th>Medical/Surgical Outpatient Services Include:</th></tr>
<tr><td>Office Visits with primary care physicians (PCPs)</td></tr>
<tr><th>Medical/Surgical Outpatient Services (Continued):</th></tr>
<tr><td>Office Visits with Specialists</td></tr>
<tr><td>Lab Services</td></tr>
<tr><td>Radiology Services</td></tr>
<tr><td>Advanced Radiology (MRI/CT/PET)</td></tr>
<tr><td>Outpatient Surgery</td></tr>
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<tr><td>Outpatient Professional Services</td></tr>
<tr><td>Speech Therapy</td></tr>
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<tr><td>Chiropractic Services</td></tr>
<tr><td>Neuropsychological Testing</td></tr>
<tr><td>Home Health Care</td></tr>
<tr><td>Hospice – Outpatient services</td></tr>
<tr><td>Durable Medical Equipment</td></tr>
<tr><td>Breast Feeding Equipment and Supplies</td></tr>
<tr><td>Urgent Care</td></tr>
</table></td><td>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:
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<tr><th>MH/SUD Outpatient Services Include:</th></tr>
<tr><td>Individual Psychotherapy Services</td></tr>
<tr><td>Family Psychotherapy Services</td></tr>
<tr><th>MH/SUD Outpatient Services (Continued):</th></tr>
<tr><td>Group Psychotherapy Services</td></tr>
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<tr><td>Medication Management</td></tr>
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<tr><td>Outpatient Professional Services</td></tr>
<tr><td>Intensive Outpatient Services</td></tr>
<tr><td>Applied Behavior Analysis</td></tr>
<tr><td>Transcranial Magnetic Stimulation</td></tr>
</table></td></tr>
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	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Outpatient Classification(s) of Benefits (Continued):	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:	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 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 (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 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 (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.

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:	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.

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 (prior authorization) requirements; network admission (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.

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:	The Clinical Advisory Subcommittee applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The Committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. The committee reviews FDA approval/clearance status, English language peer reviewed publications as well as relevant documents prepared by specialty societies and evidence-based review centers. The committee uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage polices. The Committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven. 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 the Clinical Advisory Subcommittee 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.	The Clinical Advisory Subcommittee applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The Committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. The committee reviews FDA approval/clearance status, English language peer reviewed publications as well as relevant documents prepared by specialty societies and evidence-based review centers. The committee uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage polices. The Committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven. 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 the Clinical Advisory Subcommittee 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.

Medical Necessity		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Medical Necessity Definition:	When conducting medical necessity reviews of medical/surgical services, Plan Medical Directors and licensed physician reviewers 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, Plan Medical Directors and licensed physician reviewers 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.

	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Development of Medical Necessity Criteria:	The Plan utilizes internally developed Coverage Policies (i.e. 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. The Clinical Advisory Subcommittee 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 Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as 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. The Committee 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.	The Plan utilizes Milliman Care Guidelines (MCG) when conducting medical necessity reviews of MH/SUD services and technologies and "The ASAM Criteria®" when conducting medical necessity reviews of SUD services and technologies. The Clinical Advisory Subcommittee 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 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. The Committee 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.
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Development of Medical Necessity Criteria (Continued):	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, the Clinical Advisory Subcommittee and the impetus of new, emerging and evolving technologies.	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, the Clinical Advisory Subcommittee and the impetus of new, emerging and evolving technologies.

Utilization Management - 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 (Prior Authorization):	When determining which medical/surgical inpatient benefits are subject to pre-service medical necessity review (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 (prior authorization).	When determining MH/SUD inpatient benefits are subject to pre-service medical necessity review (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 (prior authorization).
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 (Prior Authorization):	All non-emergent medical/surgical inpatient services are subject to pre-service medical necessity review (prior authorization).	All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (prior authorization).

Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Pre-Service Review Process:	The customer's treating provider submits a request for benefit authorization of an inpatient level of care. 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 who 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). When required by law, the peer reviewer will conduct a peer-to-peer review with the treating provider prior to issuing a determination. 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. The case is referred to an appropriately licensed and credentialed clinician who collects and reviews the supporting clinical information for medical necessity. If the clinician determines the customer meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the clinician 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 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.

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 Concurrent Care Review:	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.	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 • 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.
Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
List of Inpatient Benefits Subject to Concurrent Care Review:	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.	All non-emergent MH/SUD inpatient services reimbursed on a per diem basis are subject to concurrent care medical necessity review.

Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Concurrent Care Review Process:	When conducting concurrent care reviews, 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 who 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). When required by law, the peer reviewer will conduct a peer-to-peer review with the treating provider prior to issuing a determination. Cigna typically authorizes 1-4 medical/surgical inpatient days upon concurrent care review.	The licensed clinician collects the updated clinical information and/or reviews it for medical necessity. If the clinician determines the customer meets criteria for continued inpatient care, he/she authorizes the services at issue. If the clinician assesses the customer does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer 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.

Inpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Retrospective Review:	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. The request for retrospective review and supporting clinical information is 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 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. The request for retrospective review and supporting clinical information is referred to appropriately licensed and credentialed clinician for review. If the clinician determines the customer met criteria for the services at issue, he/she authorizes the services at issue. If the clinician assesses the customer did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer 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.

Utilization Management - 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 (Prior Authorization):	When determining which medical/surgical outpatient benefits are subject to pre-service medical necessity review (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 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 (prior authorization).	When determining MH/SUD outpatient benefits are subject to pre-service medical necessity review (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 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 (prior authorization).
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 (Prior Authorization):	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 (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 (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:	The customer's treating provider submits a request for benefit authorization of an outpatient service. 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 who 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). When required by law, the peer reviewer will conduct a peer-to-peer review with the treating provider prior to issuing a determination	The customer's treating provider submits a request for benefit authorization of an outpatient level of. The case is referred to an appropriately licensed and credentialed clinician who collects and reviews the supporting clinical information for medical necessity. If the clinician determines the customer meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the clinician 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 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).

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 Concurrent Care Review:	When determining which medical/surgical outpatient 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.	When determining which MH/SUD outpatient 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.
Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
List of Outpatient Benefits Subject to Concurrent Care Review:	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.	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).

Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Concurrent Care Review Process:	When conducting concurrent care reviews, 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 who 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). When required by law, the peer reviewer will conduct a peer-to-peer review with the treating provider prior to issuing a determination	When conducting concurrent care reviews, the licensed clinician collects the updated clinical information and/or reviews it for medical necessity. If the clinician determines the customer meets criteria for continued inpatient or outpatient care, he/she authorizes the services at issue. If the clinician assesses the customer does not appear to meet medical necessity criteria for continued outpatient care, he/she refers the case to a peer reviewer 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).

Outpatient Services (In-Network and Out-of-Network)		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Retrospective Review:	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. 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 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. The request for retrospective review and supporting clinical information is referred to an appropriately licensed and credentialed clinician for review. If the licensed clinician determines the customer met criteria for the services at issue, he/she authorizes the services at issue. If the licensed clinician assesses the customer did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer 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:	Emergency medical/surgical services are not subject to prior authorization.	Emergency MH/SUD services are not subject to prior authorization.

Pharmacy Management	

Prescription Drug Formularies:	Cigna offers a variety of prescription drug formularies comprised of generic, preferred, and non-preferred brand name drugs and specialty drugs. Cigna's Pharmacy and Therapeutics committee (comprised of pharmacists and physicians in medical and behavioral health specialty areas employed by Cigna and from the external medical community) develop Cigna's formularies (prescription drug lists). Cigna's P&T committee makes formulary inclusion and placement determinations of medications on the following drug tiers based upon the same evidentiary standards including review and evaluation of primary medical literature; published data from clinical trials; clinical practice guidelines and FDA product information (Label) without regard as to whether the drug is used to treat a medical condition or a MH/SUD condition:
	• Tier 1 – Generic drugs which have the same active ingredients, safety, dosage, quality, and strength as their brand name counterparts. Tier one is split into 1A and 1B for non-HSA plans only:
	  ○ 1A: $3 drug list
	  ○ 1B: Traditional Tier 1 drug copays not exceeding $30. Copay amount may vary by plan.
	• Tier 2 – Preferred brand-name drugs (with no generic equivalent)
	• Tier 3 – Non-preferred brand-name drugs that have a generic equivalent and/or that have one or more preferred brand options within the same drug class.
	• Tier 4 – Specialty drugs including, but not limited to, self-administered injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, and asthma).

Pharmacy Management	
Pharmacy Step Therapy Program:	Cigna offers a Step Therapy Program designed to encourage cost-effective, clinically appropriate drug utilization at the lowest necessary cost by requiring the use of less expensive therapeutically equivalent medications (typically generics and preferred brands) before moving to more costly alternatives unless prior authorization for coverage is obtained. Criteria for authorization include failure and/or intolerance or contradiction of the prerequisite agents. Step Therapy medications are grouped into three "steps." Though the Step Therapy requirements vary by condition, in general, customers are required to try at least one Step 1 medication before a Step 2 medication is eligible for coverage without prior authorization. Similarly, a customer is required to try a Step 2 medication before a Step 3 medication is eligible for coverage without prior authorization. • Customer tries a Step 1 medication, typically a generic. Prior authorization is not required for Step 1 medications. • If a customer tries a Step 1 medication and it is not successful, then the Step 2 medications (typically Preferred Brands) would be eligible for coverage without the need for prior authorization. • If a customer tries a Step 1 and a Step 2 medication and it is not successful, then the Step 3 medications (typically Non Preferred Brands) would be eligible for coverage without the need for prior authorization. Cigna's Step Therapy Program was developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.

<table>
<tr><th colspan="3">Pharmacy Management</th></tr>
<tr><td>Pharmacy Prior Authorization:</td><td colspan="2">Cigna requires prior authorization for certain prescription drugs to ensure the prescribed drugs are being used safely and effectively to ensure optimal patient outcomes and to minimize waste and error.

Cigna covers drugs and biologics as medically necessary when the following criteria are met:
• One of the following:
o indication for use is approved and listed in the FDA product information (Label) and the dosage, frequency, site of administration, and duration of therapy is not contraindicated or otherwise not recommended in the Label, OR
o indication is an accepted off-label use, according to the American Hospital Formulary Service (AHFS) compendium and is not contraindicated in the Label.
• Dosage, frequency, site of administration, and duration of therapy is reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy as applicable.

Cigna's prior authorization requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.</td></tr>
<tr><td colspan="3">Network Admission Requirements</td></tr>
<tr><td></td><td>Medical/Surgical</td><td>Mental Health and Substance Use Disorder (MH/SUD)</td></tr>
<tr><td>Network Admission Requirements:</td><td>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.</td><td>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</td></tr>
</table>

		emergent, urgent and routine visits; member satisfaction surveys.; and member complaint data.

Credentialing and Re-Credentialing Requirements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Credentialing and Re-Credentialing Requirements:	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 • 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 • 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

Methodology for Determining Provider Reimbursements		
	Medical/Surgical	**Mental Health and Substance Use Disorder (MH/SUD)**
Methodology for Determining In-Network Provider Reimbursements:	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 (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.

	Medical/Surgical	Mental Health and Substance Use Disorder (MH/SUD)
Methodology for Determining Out-of-Network Provider Reimbursements:	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 • A percentile of charges made by providers of such services in the geographic area where the service is received as compiled by FAIR Health database (MRC1); or • A percentage of fee schedule developed by Cigna using a methodology similar to the one used by Medicare to determine an allowable fee for similar services within the geographic market (MRC2).	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 • A percentile of charges made by providers of such services in the geographic area where the service is received as compiled by FAIR Health database (MRC1); or • A percentage of fee schedule developed by Cigna using a methodology similar to the one used by Medicare to determine an allowable fee for similar services within the geographic market (MRC2).