Preferred Provider Organization (PPO) And Open Access Plus (OAP) Shared Administration–Repricing Administrative Manual

Cigna Taft-Hartley & Federal Business Segment

Thank you for Choosing Cigna HealthCare

We sincerely appreciate the opportunity to do business with you.

This Cigna HealthCare Shared Administration Repricing Manual is intended to answer general questions on how our Fund and Administrator partners can implement and administer the Cigna PPO and OAP products. It also gives you the proper Cigna contacts when you have questions.

Again, thank you for choosing Cigna HealthCare.

Contents

Special Administrator Requirements

1. The Administrator will ensure that a benefit differential exists for all benefits between in and out-of-network. For the OAP product, that differential must be a minimum of 20%, and the minimum in-network coinsurance cannot be below 70%.
2. For the OAP product, the Administrator will ensure that members are notified that they have the optional election to choose a Primary Care Physician.
3. The Administrator must allow Cigna to perform an annual onsite operational and claims review which is used to verify scorecard information, service levels and performance within the terms of the agreement.
4. The Administrator must participate in Payer Partnership Meetings with the Cigna Account team once every 3 years.
5. The Administrator may not sublease the Cigna network or medical management services or use them for other groups.
6. The Administrator may not provide access to members to any other network inside the defined network access area, without the express permission of Cigna.
7. The Administrator shall refrain from sharing the Cigna discount, provider or product information with any third party, without the express permission of Cigna.
8. The Administrator must submit monthly scorecards as outlined on page 15-16.
9. The Administrator must honor all terms of any Cigna provider agreement, including but not limited to all contractual reimbursement terms (implant payments, lesser of language, coding definitions), appeals, prompt pay, timely filing and over/underpayment provisions (e.g., some contracts prohibit auto-debiting of overpayments).
10. The Administrator must solely utilize Cigna's claim bundling logic for participating provider claims.
11. The Administrator must work with Cigna in a collaborative manner to resolve contractual disputes with providers.
12. The Administrator must have the flexibility to accommodate non-standard terms/provisions in provider agreements.
13. The Administrator must maintain appropriate service levels as defined by the agreement.
14. The Administrator agrees to work towards the reporting of the percentage of calls closed after initial contact, percentage of denials overturned & the initial denial type and the number of claims denied for eligibility/benefits/additional information needed/failure for additional information to be provided.
15. The Administrator must maintain a business contingency plan.
16. The Administrator must provide paid claims data in a mutually agreed upon format and frequency, no less than weekly. Other data used to process claims, such as eligibility and benefit design, shall also be provided in a mutually agreed format and frequency.

Claims Management

Claim Submission

Claims from providers and members will be sent directly to Cigna. Cigna will provide an electronic file to the Administrator containing original claim information and the repriced data.

Claim Repricing

Cigna reprices claims based on both the provider contract and the allowed/authorized days from medical management review. Cigna will match member access based on eligibility provided by the Administrator. Cigna will then determine if the provider rendering services is in or out-of-network. Cigna's Repricing System can search for duplicate claims, based on customer preference. In-Network Claims are repriced in accordance with the Cigna PPO or OAP contracted discounts. During this process, ClaimsXten (bundling and un-bundling software) is applied to in-network claims only, and will only be reviewed for billing edits. Claims from providers that are not in the Cigna network will also be processed, but returned to the Administrator as non-participating (non-par) with the appropriate "reason not covered" (RNC) standard 'remark' code. An indication of the provider's in-network or out-of-network status will be included in the repriced claim data file to the Administrator.

Cigna will send all original claims information and the repricing information electronically to the Administrator. The electronic repricing data will be sent to the Administrator in an EDI 837 file format. Cigna's standard is to send images to our Administrator Offices. The Administrator Office must have the ability to receive, store and retrieve images.

Administrator Offices may wish to program their systems to enable the repricing data to flow directly into the payment system to facilitate auto-adjudication. This, in combination with the Cigna data entry function, should significantly reduce Administrator Office administrative expenses over time.

Once received, the Administrator Office will apply the discount amount as the allowed amount as communicated by Cigna. Then the Administrator Office will adjudicate the claim in accordance with the Administrator's specific plan design. At no time may the Administrator Office apply other PPO network discounts to Cigna providers, nor may an Administrator Office "cherry pick" discounts from another network while the Cigna network is in place, in the Cigna network area.

All claims pended externally by the Administrator's Office require a notification to the provider of the information needed, including when the request for information is being directed to the member.

The Administrator Office will release the EOB and Payment to the provider. EOB codes should be in accordance with the Cigna EOB notations. These notations will be provided by Cigna upon implementation.

DRG Contracts and Claims Processing Requirement

Description: Diagnosis Related Groups (DRGs) are a methodology to reimburse hospitals for inpatient services according to a fixed case price depending on which DRG the patient falls into. DRG assignment is based on a combination of principle diagnosis, secondary diagnoses, procedures performed, age, co-morbid conditions and complications while in the hospital. Each DRG is intended to represent similar resource consumption for the patients that are so classified.

Reimbursement: Certain Cigna hospitals have contracts for inpatient admissions based on one of a number of DRG methodologies (e.g. Medicare, N.Y.A.P. DRGs etc.). A subset of these facilities does not have lesser of billed charges or contracted rate language in their agreements. As such there are certain scenarios whereby the case rate payment exceeds the billed charge and providers must be paid according to the higher rate per the payer agreement with Cigna.

The fixed price negotiation is based on the average length of stay for each DRG however some patients will stay in the hospital under the average and some patients will stay longer. However, it is viewed by these hospitals as a risk-based methodology, depending on actual resources consumed by the patient. In other words, they expect to gain in those

scenarios. Situations in which the billed charge is less than DRG case rate are rare and only involve patients with a lower severity of illness. Furthermore, a DRG is a case rate and not subject to a per-day allowable. The DRG allowed amount is for the entire confinement/procedure and should not be reduced based on the number of days allowed and/or denied.

If the priced amount of a claim is higher than the billed amount and 'Lesser Of' language applies, the claim will be priced using the billed amount. If 'Lesser Of' language does not apply, the claim will be priced based on the contractual agreement with the provider and include a comment/message that is passed along to the Administrator in the repricing file that states "Contract does not include "Lesser Of" language." The payer is required to pay the contracted rate, even if it is above billed charges.

Payment and Repricing Turnaround Time

Cigna will reprice paper claims within six (6) business days and electronic claims within four (4) business days.

Payers are required to take action (i.e. make a payment or provide written notice of denial or external pend) on one hundred percent (100%) of Participating Provider Claims within eighteen (18) business days after receipt of a re-pricing determination from Cigna or the date that action is required to be taken under applicable federal and state law or regulation, whichever is earlier.

The Administrator shall be solely responsible for any penalties due and owing with respect to late payments of Covered Services and shall maintain systems capable of appropriately administering any such penalty payments.

If you have questions on the status of a specific claim or claim submission, please feel free to contact us at (800) 549-8908, or via email at SARepricing@Cigna.com. Please have the following information available for each claim inquiry:

- Fund (Group) Name
- Document Control Number
- First and Last Name of Patient
- Date(s) of Service
- Total Charges

For escalated issues, please see contact your Cigna Representative. The following hours apply: Business hours are Monday—Friday from 8:00 a.m. to 6:00 p.m. (Eastern)

ClaimsXten Procedure Code Auditing

ClaimsXten® software is a procedure code auditing system, which evaluates submitted claims for adherence to industry-standard coding practices based mainly on Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) guidelines. The software uses rules-based logic to:

- assess provider claims information including Current Procedural Terminology (CPT®) and Health Care Procedure Coding System (HCPCS) procedure codes against a series of edits using a clinically-based software system that evaluates claim information to detect coding irregularities, conflicts or errors;
- recommend CPT®/HCPCS procedure code combinations and request additional claims information, when necessary; and reflect Cigna HealthCare's coding guidelines and reimbursement

The software is updated to stay current with changes in the medical field, and coding in particular. As part of the repricing process, Cigna HealthCare will apply ClaimsXten logic to professional claims from participating providers. Any adjustments will be outlined on the electronic repricing data file to the Administrator Office. Questions on ClaimsXten edits should be directed to the Repricing Customer Service Unit at (800) 549-8908. All ClaimsXten edits MUST be included on the explanation of payment (EOB) to the provider. ClaimsXten EOB notations will be provided during implementation and must be programmed into the Administrator Office's system.

The Administrator will not apply other Procedure Code Auditing software to participating provider claims.

Electronic Claims Provider Matching Process

The following is our current provider matching process. The methodologies used are designed to achieve the highest possible match rate while still retaining the highest possible accuracy.

As incoming electronic claims are processed, each one is sent through the provider matching routine. The incoming claim data (Billing Physician name and address as well as Rendering Physician name & address if available) is run through the Name & Address Standardization Routine removing credentials as well. If the claim contains both an individual and group provider information, the matching process is invoked twice – once for each name.

Provider Name

The incoming name is compared to the name in the corresponding provider record. Each word in the name with the most words is compared letter by letter to each word in the name with the least words. If at least a 90% match rate is found, the word will be considered a match. This is referred to as a "Word by Word Match". If any word in the name with the most words does not find a corresponding word on the name with the least words, the entire name field is compared letter by letter. If at least a 90% match rate is found, the name is considered a match and we proceed to the zip code match. Otherwise, the name is considered a non-match and the provider record is no longer a candidate for acceptance as a participating provider. This is referred to as a "Compressed Match".

Zip Code

If the incoming zip code contains 9 digits, the last 4 digits are NOT '0000', and it matches exactly to a 9 digit zip code on the provider record, we continue to the address matching.
Otherwise, if the first 5 digits of the incoming zip code match the first 5 digits of the zip code on the provider record, we continue to the address matching. If less than the first 5 digits match, the record is considered as a non-match and is no longer a candidate for acceptance as a participating provider.

Address

The criteria for the address fields are the same as the criteria for the name fields with the exception of the compression. In addition to spaces, periods, commas, slashes, and dashes being removed prior to the matching attempt, the pound sign is also removed from the address compression. If the combination does not produce a match, the record is considered a non-match and is not a candidate for acceptance as a participating provider.

Never Events

As part of our ongoing focus on improving health care quality, Cigna HealthCare has taken steps to stop reimbursing hospitals for so-called "never events" which are errors in patient care that can and should be prevented. Cigna's new policy is consistent with the Centers for Medicare and Medicaid Services (CMS) national policy, and both became effective October 1, 2008.

A "never event" is a surgical procedure performed on the wrong side, wrong site, wrong body part or wrong person.

In addition to improving patient safety and promoting quality care for members, Cigna's policy is intended to improve hospital reporting, help reduce the number of errors in patient care, and align our practice more closely with CMS. And by using existing provider contract provisions, the new policy has been designed to avoid plan and member liability for denials for payment to a participating provider, specifically for the hospital and surgeon.

We have recognized the need to extend this policy to our Shared Administration Repricing customers through our Care Management services. While Cigna does not make claim payment determinations for our Shared Administration Repricing customers, we will use information received from our participating providers to make medical necessity determinations for services provided and settings for level of care. Never Events will be denied as not medically necessary and may be identified from notes in ICIS, the Care Management tool made available to our Shared Administration Repricing claims payers.

We do not expect to see a large volume of claims submitted that would result from a "never event", as hospitals and surgeons generally refrain from billing plans and members, and billing plans and patients for these "never events" is not consistent with CMS guidelines or our participating provider contracts.

However, in an effort to capture claims submitted for these events, Cigna will use a process to identify such claims and to provide denial information on the 837 claim file. If and when Cigna receives a claim submitted that has been identified as a Never Event situation, we will deny the claim pricing and forward to you, via the 837 with an RNC Code 224 (language description - Based on review of information received by Cigna, these services are not considered medically necessary. These services are denied and the provider is prohibited from billing the patient for these charges. Any payments by the patient to the provider for these services should be reimbursed by the provider. To appeal the decision contact: Appeal Coordinator 1777 Sentry Park West Dublin Hall, 4th Floor Blue Bell, PA 19422) that should be used in your denial to the provider and member.

Claim Review Process

Cigna performs an additional review on all claims that are billed at $100,000 or greater. This review will be performed by an auditor that specializes in high dollar claims. This review will also occur before the claim is initially released to you for processing.

Claim Issue Resolution Process

Cigna will also review claims at the request of the Administrator if it is felt additional research is needed. This review will include an assessment of the provider contract, rates and in the case of an adjusted claim, the coding of the original submission. The information will be compiled and returned to you on an inquiry document. Due to the thoroughness of this review, it may take up to 10 business days for completion. The Cigna provider contract expectation is that the claim will be adjudicated within the standard claims processing timing of 18 days of the initial receipt.

Administrators may request this service via submission of an inquiry document to their assigned Cigna Client Service Executive.

Overpayment Recovery Process Involving Cigna Participating Providers

Cigna works closely with our Administrator clients to ensure that the repricing of claims results in accurate payments to our participating providers. Every effort is made to see that the providers rendering services receive the correct amount due to them, based on the contractual reimbursement arrangement with Cigna. We regret that there are occasions when a pricing error results in an Administrator making a payment to a provider that is in excess of the appropriate amount due. In those instances Cigna will provide support to our Shared Administration Repricing (SAR) clients/payers to assist in the recovery of any such overpayments made to providers. Cigna will assist with our contracted providers only for amounts over $100.00. We can assist with the request for payments within 1 year of the paid date or specific required time limitations under our provider contracts. We will make every attempt to recover your overpayment however we do not guarantee success. After receiving your electronic version of the overpayment letter including your EOB, we begin to make outreach calls to our provider to discuss the overpayment which will include follow ups for status. We will work the cases for 60 days. If after 60 days we do not have an agreement to return the refund or a confirmed time the overpayment is being released to your office, we will notify your office that we were unsuccessful in the recovery. See details below outlining the process.

The Cigna Overpayment Recovery Process involves the following steps:

1. When it has been identified that an overpayment has been made to a Cigna Participating Provider, the SAR payer should send an overpayment notification letter to the provider in question, requesting reimbursement for the overpaid amount. The SAR payer should indicate the reason(s) for overpayment (e.g. retro termination of member, duplicate payment, COB, etc.), supply all applicable data elements (e.g. patient name, dates of service, member number, etc.) and clearly identify the entity (name and address) to whom the check is to be made payable.

2. The Cigna Participating Provider is then contractually obligated to refund the identified overpayment(s) within 30 days of receiving notice via the overpayment notification letter.
3. The Cigna Participating Health Care Profession (HCP) may initiate claim appeal if there is disagreement as to interpretation of contract or basis for overpayment. Appeals by a Cigna Participating Provider relative to the Cigna/provider contract interpretation should be referred to Cigna for handling, while the SAR payer will handle claim appeals specific to benefit interpretation or eligibility per their current process.
4. The SAR payer should call the provider's Accounts Receivables department within two weeks post release of the overpayment recovery request requesting confirmation of receipt of the refund request and commitment to refund payment.
5. Once positive contact and confirmation of receipt of letter is made, the SAR payer should initiate a follow-up according to the date the provider commits to payment: (See example below)

If there is no response from the provider after 45 days of the overpayment recovery request, the payer should escalate the issue to their Cigna Client Service Executive (CSE) for Cigna's Network Team involvement by completing the overpayment form provided in this manual. (Exhibit IV)

Note: If there is no response after 60 days, a network contact will authorize offsetting of future claim payments to the impacted provider (if the payer has the ability to accommodate offsetting.)
Offsetting of overpayment amounts should only be performed when authorized by Cigna to do so. Certain Cigna provider contractual arrangements may prohibit such activity, therefore, it is important for Cigna to validate the contractual ability to take such action. When authorized by Cigna for a payer to do so, offset recovery effort should be performed on the impacted provider only.

Appeals

Member Claim and Benefit Appeals

The Administrator is responsible for all member appeals, with the exception of Medical Management appeals (see below). The Administrator is also responsible for all appeals and disputes reporting to external entities [e.g. state, federal and client level]. Cigna will work to support the Administrator in gathering all required information from participating providers and Cigna contracted vendors and entities.

Medical Management Appeals (Member and Provider)

Upon receipt of a first level medical necessity appeal, Cigna will respond in writing within 30 calendar days. If additional information is needed in order to complete the appeal review, an extension letter would be sent to all parties, and an additional 15 calendar days would added to complete request.

A second level medical necessity review would be conducted by an external independent review entity. State specific, jurisdictional and Department of Labor mandates related to this process are followed. Cigna will respond in writing to acknowledge receipt of the appeal request within two business days. This response will inform the requestor of the expected completion of the appeal.

Any additional appeal requests would be forwarded to the Administrator.

Provider Claim Appeals

The Administrator is responsible for the administration of all provider-related claim disputes in accordance with the terms of their benefit plan and/or eligibility.

The Administrator is required to forward to Cigna all Participating Provider questions, complaints, disputes and appeals related to the performance or interpretation of a provider's contract within two business days. The Administrator should not respond to a network provider regarding these types of issues on Cigna's behalf.

CignaForEmployers.com – Introduction and Overview

The ability to access eligibility, billing and banking reports (if applicable) is available through cignaforemployers.com.

- Go to www.cignaforemployers.com and click "Register now for cignaforemployers.com."
- Enter your Temporary User ID and Password, then click "Register."
- Further instructions will lead you through the rest of the process. You will be given a Permanent User ID and be prompted to create a new Permanent Password to use every time you log in to cignaforemployers.com.
- When you log in to cignaforemployers.com for the first time, a user agreement will appear. Please read and respond appropriately. Upon responding to the user agreement, you then enter cignaforemployers.com.

Secure Access

Access to the system is through your existing Internet connection and with a secure ID and PIN that will be provided to you. Please commit your ID and PIN to memory and treat them as confidential information.

Repriced Claim Data

Cigna will send all the repricing information electronically to the Administrator. The electronic repricing data will be sent to the Administrator in the EDI 837 format. Unless specifically requested and agreed to during the sales process (including proper pricing adjustments), the hardcopy claim will not be released to the Administrator Office.

Out of Network savings Negotiation Form

Administrator must be able to accept electronic submission of Out of Network Savings Negotiation Information as part of the Pre-certification Report electronic file.

Service Standards

The Administrator's service standards for the post-service payment activities shall, at a minimum, comply with industry standards for such payment activities as determined by Cigna. In addition, the Administrator shall use best efforts to comply with the following service standards:

1. Action shall be taken (i.e., make a payment or provide written notice of denial or external pend) on one-hundred percent (100%) of Participating Provider Claims within eighteen (18) business days after receipt of a re-pricing determination from Cigna or the date that action is required to be taken under applicable federal and state law or regulation, whichever is earlier. Certain Prompt Pay facilities and providers require quicker turnaround times. A complete listing of our Prompt Pay providers will be provided to you regularly, so you can develop a process to manage this requirement. Prompt Pay providers will be identified uniquely on each claim in the outbound 837 file (see Prompt Pay section for more details). Penalty for not meeting the prompt pay guidelines can result in a complete loss of discount.
2. Participating Provider Claims shall be paid with 99% financial accuracy. Financial accuracy shall be measured during routinely conducted audits and calculated in accordance with the following formula: total value of dollars paid correctly divided by total dollars paid.
3. Participating Provider Claims shall be processed with 90% accuracy. Processing accuracy shall be measured during routinely conducted audits and calculated in accordance with the following formula: total number of Participating Provider Claims processed without data errors, divided by the total number of Participating Provider Claims audited.
4. There are to be no pended Participating Provider claims over 90 days old.
5. Appropriate levels of telephone line staffing for the payment and administration activities required to be performed hereunder shall be maintained so as to satisfy the following standards:

    (i) the overall telephone abandonment rate shall be less than 5%;
    (ii) the average speed of answer shall be less than 45 seconds; and
    (iii) these telephone service metrics shall be monitored and communicated to Cigna.

The Administrator shall establish and maintain a process acceptable to Cigna that tracks, reports and audits the performance against the foregoing standards. The Administrator shall report to Cigna the results on a monthly basis in our Scorecard format. Administrator shall promptly correct any deficiencies identified or identify a plan of corrective action satisfactory to Cigna.

Reporting Monthly Performance Metrics

As it our mutual responsibility to provide superior service and responsiveness to members and to maintain stay in compliance with our network providers, we must work together to ensure we are providing the customer service and claims adjudication function in accordance with metrics levels identified in the agreement.

Administrators are required to demonstrate performance against industry metrics. Our intent in managing to these metrics is to ensure the Shared Administration provider and member experience meets or exceeds industry standards. Also, prompt claims processing and response to phone inquiries as to eligibility, benefits and claim status help avoid costly re-work and promotes satisfaction with the Shared Administration product. In accordance with these objectives, the Administrator's monthly performance metrics must be reported to Cigna.
Those metrics should include:

- Time to Pay
- Open Inventory
- Claim Quality Results
- Telephone Responsiveness

Cigna has available a Scorecard document (Exhibit III) whereby these metrics may be recorded and returned. However, we are flexible with the format of communication of this information. If you have another format that you use internally as a standard that captures the above information, we are happy to use that format. It is the content, not the format on which we are focused.

Provider Payments Standards – Requests for Additional Information

The superior Cigna contractual discounts deliver significant savings to our customers and medical volume to our providers. It is in the best interest of all parties to protect these valued relationships and prevent potential loss of access to provider contracts or reduction of discounts.

As a general rule, providers have 180 days to submit claims from the date of service. However, there are situations where providers have negotiated claim submission timelines greater than 180 days.

Many of our provider contracts require claims be processed within 30 calendar days from receipt of a complete claim. As per the Administrator agreement and addressed above, the Administrator will process participating provider claims no later than eighteen (18) business days following receipt of the claim information and re-pricing determination from Cigna. A claim is considered processed when payment is made, a denial letter is issued, or a request for additional information is released externally.

All claims pended externally by the Administrator's Office require a notification to the provider of the information needed, including when the request for information is being directed to the member.

A request for additional information means a request for information necessary to resolve issues related to eligibility, coordination of benefits, subrogation, medical necessity, preexisting conditions, pre-certification, case management, worker's compensation, Medicare eligibility or COBRA. Such requests for participating provider claims must be resolved within 90 days, otherwise a letter of denial should be issued to the provider and member, at which time our participating provider may seek reimbursement of the services provided from the plan member. We recognize that there will be times when additional information is needed to adjudicate or make a determination on the claim. We would expect that these requests be managed within the 90 day period as well. However, if there is difficulty obtaining

the information and the time period might extend beyond the 90 days, please ask for our assistance. We further ask that medical necessity, pre-certification and case management issues be resolved by contacting Cigna for assistance.

Utilization Review Compliance – For In-Patient Services

Cigna's participating providers are required by contract to comply with our Medical Management programs including prior authorization of elective admissions and notice of emergency admissions once the member is identified as accessing the Cigna provider network. Occasionally our providers may fail to notify Cigna/CareAllies either because the member did not present an ID card or administrative processes at the facility break down. When a claim is presented for a service requiring prior authorization and Cigna/CareAllies has no approval on file, the administrator may deny the claim for lack of medical information. It is the responsibility of the participating provider to submit this information to Cigna/CareAllies for a retrospective review. If the provider should contact the Administrator relative to a denial of a claim for medical information, the administrator should direct the provider to contact Cigna/CareAllies for retrospective review. Upon Cigna/CareAllies receipt of the necessary information from the provider, the admission is reviewed and either approved as medically necessary, or denied for either a portion of or the entire length of stay as medically unnecessary. When an admission is approved on retrospective review, we require that the Administrator re-adjudicate the claim, if initially denied, with no administrative penalty. If either a portion of or the entire length of stay is deemed medically unnecessary, the payer may deny those services and the participating provider may not balance bill the member. Providers (and members) have the right to appeal the denial to the Cigna/CareAllies Appeals unit. Relative to payment being made, the Administrator agreement notes that:

(a) Payment will be made to the Participating Provider, as reimbursement for covered services in accordance with our Participating Provider Agreements, less any applicable deductible, coinsurance, co-payments or reductions in benefits due to a Participant's non-compliance with the terms of the Plan.
(b) Cigna's claim coding and bundling methodology in administering payments to participating providers must be applied.

Cigna's repriced claims should not be reduced for reasons other than those listed above.

To further protect access to our network discounts and contracted providers, Cigna requires that all provider disputes not resolved to the satisfaction of all parties be reported immediately to Cigna for intervention. This allows Cigna to interpret the Cigna-provider contract and resolve the dispute in accordance with the executed provider contract. As addressed in the Administrator agreement, inquiries or disputes relative to or arising from the performance or interpretation of participating provider agreements should be handled by Cigna, whereas, Cigna will reach out to our participating provider for discussion or further information as deemed appropriate to the situation and/or our participating provider contracts.

There will be times when the Plan Administrator's claims/payments become part of an overall Cigna HealthCare – provider payment negotiation. As a result of such agreements, the Administrator may be required to resolve provider disputes through the re-adjudication and payment of specific claims, at Cigna's direction and as reasonably necessary.

Utilization Review Compliance – For Out-Patient Services

Cigna's participating providers are required by contract to comply with our Medical Management programs including prior authorization of outpatient services that have been purchased by the client once the member is identified as accessing the Cigna provider network. Occasionally our providers may fail to notify Cigna/CareAllies because the member did not present an ID Card. When a claim is presented for a service requiring prior authorization and Cigna/CareAllies has no approval on file, the administrator should deny the claim for lack of prior authorization. If the provider should contact the Administrator relative to a denial of a claim for prior authorization, the administrator should direct the provider to contact Cigna/CareAllies. Upon review, if the service is found to be provided due to an urgent or emergency situation, we require that the Administrator re-adjudicate the claim, if initially denied, with no administrative penalty. There may be some providers with unique prior authorization situations. In these cases, the administrator should work with Cigna/CareAllies to adjudicate the claim appropriately.

Provider Network

Contracting Methodology

The following will provide basic information on Cigna HealthCare's contracting structure:

Cigna relationships with hospital systems are negotiated and contracted in a variety of manners. The arrangements may include per diem, DRG, case rates, percent off charges, pay-for-performance based arrangements, or Ambulatory Payment Classifications (APC).

Our professional and ancillary contracts are typically based on a fee schedule, pay-for-performance based arrangements, and discount off charges. Ambulatory surgery is reimbursed according to a fee schedule, discount off charges, or Ambulatory Surgery Center (ASC) methodology.

If you want to verify a repriced amount, or you have questions on an amount, please call Cigna at (800) 549-8908. Please have claim information available as noted above in Payment and Repricing Turnaround Time.

Provider Discounts

The repricing model used by Cigna HealthCare does not require us to provide the Administrator Office with fee schedules. If the Administrator wants to re-verify a provider's network status, which will appear on the electronic repricing data file, they may call Cigna at (800) 549-8908 or check the online directory at the web address provided by Cigna.

Cigna PPO and OAP Networks

Fund members will have access to Cigna's national PPO or OAP network.

Online Provider Directory

- www.MyCigna.com (Member access only – member must create a personal account to view; available once the member's plan is effective)
- www.cignasharedadministration.com (Administrator or Member access)

The above websites can be used to inquire about participating providers in the Cigna PPO and OAP networks. The online directory will include the National Cigna contracted PPO and OAP providers for Shared Administration Repricing. The directory is updated on a daily basis. The site will contain the following disclaimers:

Provider Participation

The Cigna HealthCare on-line provider directory is a convenience we're pleased to provide to Web users.

The online directory information is updated six days per week, excluding holidays, Sundays, or interruptions due to system maintenance, upgrades or unplanned outages. This information is subject to change at any time. Providers may delay informing Cigna that they no longer accept new patients so we cannot guarantee that each provider is still accepting new patients. When calling to make your appointment, please confirm that the provider is a Cigna participating provider. Call the toll-free number on the back of your ID card for additional directory assistance including help locating a network provider for services and appointment assistance, confirming provider participation, and assistance generating a provider listing.

The listing of a provider in this directory does not guarantee that the services rendered by that provider are covered under your specific medical plan. Check the materials that describe your particular plan benefits, or call the Administrator for information about the services covered under your plan.

Primary Care Physician (PCP) Requirements (for OAP)

- A core requirement of the SAR OAP product is for Administrators to communicate to members that they have the option to select a Primary Care Physician (PCP).
- Members are not required to choose a PCP, but they need to be given the option.
- Members can choose a PCP by searching the SAR OAP provider directory.
- Members who select a PCP can provide it to the Administrator or to Cigna where it must be stored.
- Cigna can accept PCP elections in two ways:
    - Administrators can pass PCP elections on the initial eligibility feed, or
    - Members can access the MyCigna.com website, select the SAR OAP provider directory, search for a PCP and then click on the link Add/Change your Physician and follow the steps
- Administrators who produce their own ID cards can choose to either:
    - Add the PCP's name and phone number to their ID cards (not required); or
    - Store the PCP election on an enrollment form or spreadsheet; or
    - Direct members who want to select a PCP to the MyCigna.com website

Hospital Based Providers

Cigna's guiding principle is to provide our clients with a deeply discounted national network. We attempt to contract with these providers, i.e. Anesthesiologists, Pathologists, Radiologist, by contracting with their legal entities and with them directly. Although we are often successful, there may be instances where Cigna may not be able to contract directly with a provider because the provider does not meet our credentialing standards or contracting guidelines or will not agree to our financial or contracting terms. In those instances, such provider claims will be passed to you under the Shared Administration agreement as out of network. There may also be rare instances in which Emergency Room Physicians are not contracted and the claim will be passed to you as out of network.

Vision

The SAR PPO and OAP networks contain a robust network of participating ophthalmologists and optometrists. Discounts for these providers are for medically-related eye/vision disorders only. Discounts for these providers do not include routine vision care.

Access to Hawaii Network and U.S. Territories

All plans with active employees in HI must file plan design for approval with the State of Hawaii and the Department of Labor. This is a State requirement and not a network requirement, but the network will not allow access unless approval is obtained. Exceptions are retirees, COBRA participants, plans where 100% of membership is Union members and Government plans. These members/plans require network approval, and the differential [at least 20%] must be in place. No retro approvals are allowed. The approval process must be secured 90 days in advance of when your plan is effective.

Please note, there is currently no Cigna PPO or OAP network in Guam, Puerto Rico or U.S. Virgin Islands.

Cigna Contracted Networks

Cigna has contracted with several external networks to provide network access on our behalf. Access to these entities is included in the network of providers in the Cigna PPO or OAP networks. Please see Exhibit II for a listing of TPV Networks.

Cigna National and Regional Contracted Vendors – Delegation of UM

Please contact your Cigna representative for a listing.

Cigna contracts with several national and regional vendors for certain ancillary services. These contracts provide network access and several include delegation of utilization management to include pre-certification and medical necessity review.

These include, but are not limited to, the following:

American Specialty Health (ASH) – Cigna's vendor for Chiropractic, outpatient Physical Therapy (PT) and Occupational Therapy (OT) services. Acupuncture services are managed by ASH as of 09/01/2021.

Medical Necessity Review is not required for the PPO product, however it standard for the OAP product. If the plan requires review, the participating health care professional will submit a treatment plan to ASH after the designated number of chiropractic, physical therapy, occupational therapy visits, or acupuncture visits per the terms of their contract. ASH will review for medical necessity. Cigna will provide the ASH Tax Identification Numbers to the Payer to assist in identification of claims received for approved services.

Cigna will only forward ASH claims to the Payer that have been approved. As such, we require that these claims be paid as billed with no reduction in payment outside of eligibility and benefit rules. We further require that no retrospective or payer reviews be requested or performed as the review was done prospectively by ASH. Payers should not request rendering provider's prescription, frequency duration, clinical records, etc. as this information is reviewed and included in the medical necessity review completed by ASH prior to the release of the claim to Cigna.

Amplifon – Cigna's exclusive national vendor that supplies digital and digitally programmable analog hearing aids and supplies to customers with the hearing aid benefit.

eviCore healthcare (eviCore) - a Cigna company, provides the following services to Cigna customers:

- eviCore arranges the provider network, including credentialing, contracting and care coordination for HH, DME, and HIT services. Most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are contracted as a rent-to-purchase price, or purchase upon initial delivery; however, some devices are continuous rental only, including but not limited to, items that require frequent servicing or that are considered life sustaining devices (i.e. oxygen delivery systems, ventilators).
- With the Cigna Sleep Program, eviCore performs utilization management. The eviCore provider network is accessed through the Cigna directory.
- Outpatient, nonemergency, high-technology radiology (HTR) and diagnostic cardiology services. eviCore's network of contracted free standing radiology facilities provide expanded access to customers in order to provide adequate, accessible coverage for urban, suburban, and rural customers. This network supplements Cigna's own network of health care professionals and is accessed through the Cigna directory.
- eviCore manages the MSK program which is a specialized utilization management program that includes expanded precertification and clinical appeals for major joint surgery and interventional pain management both on an inpatient and outpatient basis.

**Advanced Radiology claims submitted to Cigna from eviCore are to be paid as billed with no reduction in payment outside of eligibility and benefit rules. We further require that no retrospective or payer reviews be requested or performed as the review was done prospectively by eviCore.*

Accredo, a Cigna company, is leveraged for specialty home infusion therapy in order to help drive affordability of medical benefit drugs, patient health and safety, deliver quality and convenience, improve standardization and provide consistency of nursing.

In most vendor situations, the vendor bills Cigna the contracted rate for the approved services. In turn, Cigna forwards the claim to the SAR payer for payment. The rendering physician's name is not included on the claim file to eliminate any error of payment being issued to the individual health care profession instead of the vendor. The SAR Payer processes claims back to the vendor and then the vendor processes claims to the individual health care profession.

Should a coordination of benefits (COB) claim arise, the vendor claim will include a copy of the primary carrier's Explanation of Benefits (EOB). The primary carrier may not utilize Cigna's national vendors and EOB from the primary carrier will instead show the sub-contracted health care professional as the provider of service. Codes and charges on the primary carrier's EOB may not exactly match the claim submitted to Cigna by the national health care professional. Do not immediately deny a COB claim when the primary EOB does not match. Verify the billing name on the claim to determine whether it is a nationally contracted health care professional.

National Provider Identification

NPI is required on claims when the health care professional or provider are submitting claims for services rendered and they are a direct provider of those services or are providing other health care services such as utilization management. Cigna will not require an NPI from vendors that do not provide health care services.

Balance Billing

Sometimes a contracted Cigna PPO or OAP provider will incorrectly balance bill a patient for an amount in excess of the Cigna HealthCare PPO or OAP allowance, after they have been correctly reimbursed by the Administrator Office. This is not allowed under our provider contracts. If you believe that the provider has incorrectly balance billed your member, please contact the Shared Administration Customer Service Department at (800) 549-8908 and ask us to follow up with the provider. Please have ready the following information:

- Fund (Group) Name
- Document Control Number
- First and Last Name of Patient
- Patient Social Security Number / Alternate Member Identifier
- Date(s) of Service
- Total Charges, Allowed Amount, Paid Amount
- Provider Name and Tax Identification Number

Responding to Provider Disputes

Clearly, our provider relationships are a critical part to maintaining our broad network access and our deep discounts. To protect our provider relationships, Cigna HealthCare requires that all provider disputes not resolved to the satisfaction of all parties be reported immediately to Cigna HealthCare for intervention. These disputes should be reported to the Cigna Client Service Executive. There will be times when the Administrator's claims/payments become part of an overall Cigna HealthCare – provider payment negotiation. As a result of such agreements, the Administrator may be required to resolve provider disputes through the re-adjudication and payment of specific claims, at Cigna's direction and as reasonably necessary. Overall, the aggressiveness of the Cigna contractual discounts will result in superior discounts and savings for our Funds. However, it may in fact be necessary, to protect the long-term interest of all parties, to settle disputes professionally and effectively before they result in the loss of provider contracts, the reduction in long term discounts, or the detriment of an effective provider contact.

Prompt Pay Arrangements

Cigna HealthCare will, at times, enter into a discount arrangement with a Network provider that contains a Prompt Pay clause. This rare contractual arrangement is typically negotiated with "Loss of Discount" language. The arrangement may include language that indicates the claim must be paid within a specified timeframe, otherwise the discount will not be honored, and the claim must be paid at billed charges or a percentage of charges.

- Cigna HealthCare will provide a list of those providers with which we are currently honoring this type of contract arrangement. We will provide updates to this list as changes occur in these contracts or additional contracts are negotiated with this type of arrangement. For payers who currently receive an 837 claim file, prompt pay providers will be identified uniquely on each claim in the outbound 837. The specific indicator will be marked in the K3 segment of each record, with the word 'PROMPT' in the first six characters of the field.

- The days listed in the Prompt Pay list for each facility is the time from which the hospital bills Cigna a complete claim until the date that the Payer issues the check to said facility. The time period does not stop should the Payer pend the claim for additional information. Payers can perform audit functions post - payment and appeal any findings and request a refund or pursue subrogation rights. These practices are in line with the standards by which Cigna processes claims for its own insured and administered accounts.

Please note, we have set controls in place to identify these providers that enable us to turn around the claims repricing timely as to not impact your service level timing for claims payment. We ask that you also implement procedures on your end to ensure these claims are given prompt attention.

Eligibility

Data File

It is the responsibility of the Administrator to maintain current/accurate eligibility records and to send a regular automated eligibility file. The standard frequency is weekly, with a minimum frequency of monthly.

The eligibility file from the Administrator will feed into two systems, the Central Eligibility Database (CED) that is used for pricing, and to the Care Allies system, which houses medical management elections.

The Automated Eligibility Analyst will communicate any file errors to the Administrator and work with them to resolve those errors.

See Exhibit V for more eligibility file processing information.

Who is eligible?

All active participants and their eligible dependents on the plan. Eligibility is determined by the Administrator.

Medicare

As a general rule, the patient's primary plan rules should be followed, which means when a member is Medicare eligible, Medicare's plan design would prevail. The expectation is that the Administrator will not send Medicare eligible members to Cigna. If an active member becomes Medicare eligible, the Administrator will send a termination date for that member on the eligibility file to Cigna.

Survivor and Non-Medicare-Primary Dependents

If non-Medicare eligible dependents of Medicare-primary subscribers are to be covered by the plan, the primary dependent should be elevated to a subscriber-level status, and passed on the eligibility file as a subscriber.

Puerto Rico & Other U.S. Territories

If your plan has membership residing in Puerto Rico and/or other U.S. territories, participation and network options should be discussed with your Cigna Client Manager or New Business Manager.

ID Cards

Cigna can produce cards for new or renewing funds, or the fund has the option of producing their own cards, as long as those cards meet Cigna's product requirements.

Please see Exhibit X for a Cigna ID Card sample and ID card requirements.

When Cards Are Produced by Cigna

Standard Card

For new accounts, cards are produced/issued once eligibility has been loaded into our system. Your Implementation Manager will coordinate the release of cards. For PPO, cards are standardly produced at the subscriber level, meaning all cards will be issued with the subscriber's name. If the member has individual coverage, one card will be received. If the member has one or more dependents, two cards will be issued to the family, each with the name of the subscriber. For OAP, cards are standardly issued at the dependent level, and each card will be issued with the name of the dependent.

Cards are mailed to the address of the primary subscriber.

There are certain scenarios that will trigger new cards. They are outlined in Exhibit X. If there are plan changes that require new cards be issued, your Implementation Manager will coordinate issuing new cards.

Replacement ID Cards

If a member loses or mistakenly destroys their card, they should reach out to the Administrator to request a new card. In turn, the administrator should forward that request to the Client Manager (CM), Eligibility Analyst (EA), or Client Service Executive (CSE). See Exhibit X for additional information and ID card production and ordering scenarios.

Students

If an eligible student dependent needs an ID card, the Administrator should contact their CM, EA, or CSE to request a card. Cards can be mailed directly to the student upon request.

Returned ID Card Process

All ID cards are mailed in an envelope that has a return address. When a card is determined to be "undeliverable" (address is not known), it is returned to Vendor Services Operations and is immediately destroyed. Hence, it is imperative that the customer consistently provide Cigna with updated and accurate eligibility information.

ID Card Reports

There are three types of reports available:

1. ID Card Production Summary – one page summary of cards produced and current outstanding
2. ID Card Production Detail – report which lists all members that had cards mailed within a pre-determined report period
3. ID Card Outstanding Detail – reports which lists all current outstanding cards for members flagged since a given Start Date

You will need to work with your Client Manager to receive these reports.

Standard Medical Management

Required Medical Management Services for SAR Product:

Utilization Management

- Pre-Admission Certification (PAC)/Continued Stay Review (CSR)
- All Inpatient Admissions (includes acute care facilities, acute rehabilitation facilities and skilled nursing facilities)

Case Management Services

- Complex and Catastrophic Case Management
- Neonatal Intensive Care Unit (NICU) Specialty Case Management Program
- High-Risk Maternity
- Oncology
- Transplant Case Management (LifeSource) (access to Transplant Network for an additional access fee)

Other

- 24 Hour Health Information Line (24HR HIL)
- Network Channeling at medical management touch points within Utilization Management/Case Management processes
- Basic Web Tools: mycigna.com (Cigna online health and wellness information and tools designed for consumers).

Optional Medical Management Services for SAR Product

Clients may purchase precertification services for any of the outpatient procedures listed below:

- Diagnostic Radiology (MRI, MRA, CAT, PET scans, nuclear cardiology)
- Durable Medical Equipment
- Ear Devices
- Erectile Dysfunction
- Gastric Bypass
- Home Health Care (Home Nursing Care)
- Home Infusion Therapy - (Intravenous, enteral, parenteral)
- Injectable Medications
- MSK
- Oral Pharynx
- Orthotics and Prosthetics
- Outpatient Procedures
- Potential Experimental/Investigational/Unproven
- Speech Therapy
- Sleep Management Program
- Spinal Procedures
- Therapeutic Radiology
- Transplants
- Unlisted Procedures – Automatic inclusion

General Information for Utilization Review and Case Management Services

Business hours are Monday through Friday from 8:30 a.m. to 5:00 p.m. across all time zones within the contiguous United States. However, a live representative can be reached 24 hours a day for urgent care services.

Multi-lingual capabilities are available via Language Line Services

Industry Recognized Guidelines

For consistent decision making, standardized, approved guidelines are used. Note: It is the responsibility of the payer to apply any and all benefit rules concerning non-approved days or for lack of pre-certification. Administrative denials (decision made based on benefit limits/ requirements) are not part of the review process. Only Medical Directors can render a clinical denial.

Guideline Hierarchy (inclusive of clinical guidelines managed by Cigna's CPU (Coverage Policy Unit):

- Federal mandates
- State mandates
- Account specifics
- Cigna Medical Necessity Guidelines (CAMNGs) (Reformatted Cigna Coverage Positions)
- Milliman
- Other evidence-based resources
- Clinical professional experience

Utilization Review

Standard Product Components

Medical Necessity Review for members admitted to:

- Acute care hospitals
- Acute rehab facilities
- Skilled nursing facilities

This includes pre-admission certification (including procedure necessity reviews) and continued stay reviews. This does not include an assessment or application of member's plan of benefits.

Screening for Referral to Case Management: to identify members who need assistance in coordinating care with providers and the benefit plan.

During implementation, general benefit templates will be created for each plan for Case Management reference. The Administrator will need to review and approve content.

At the time of case management, the Administrator will be contacted in order to confirm the available benefits for the member.

Maternity Education: materials are mailed to expectant mothers when maternity notification calls are received in order to promote a healthy and positive pregnancy experience.

Buy Up Options

Outpatient Review Services Buy-Up Options
(medical necessity review, no benefit coordination):

- *See complete listing in Medical Management section above*

Mental Health Buy Up Options
(If the Behavioral Health network is purchased, all Inpatient UM is performed by Cigna)

- Inpatient medical necessity review – for mental health and substance abuse review (acute care).
- Outpatient medical necessity review - for mental health and substance abuse review (includes Partial Hospitalization and Applied Behavior Analysis (ABA Therapy).
- Case Management – Behavioral Health and Chemical Dependency.

Please note: Outpatient mental-health and substance abuse cases cannot be reviewed unless all nineteen (19) Outpatient Care Management categories are elected.

Transplant Network / Transplant Case Management

Standard Product Components
The Cigna LifeSOURCE Transplant Network® is available and offers members access to quality care for organ and tissue transplantation, as well as a commitment to manage the high costs associated with such complex procedures.

Transplant Case Management is included as part of the standard Case Management offering. Standardly, Cigna provides Case Management for the Cigna LifeSOURCE network.

We offer a national network of over 145 of the leading transplant facilities which must meet Cigna's quality standards before inclusion in the network. In addition to the highest quality of care, we have successfully negotiated significant network discounts for our clients.

The cost associated with accessing the transplant network is an access fee based on a percentage of the savings from our negotiated discounts, with a minimum and maximum access fee per transplant type. The access fee is only charged when the member accesses one of our Cigna LifeSOURCE transplant network facilities.

Benefit Guidelines
The following benefit guidelines must be followed in order to obtain access to the LifeSource transplant network:

- Kidney, kidney/pancreas, pancreas and autologous Bone Marrow/Stem Cell Transplant - $250,000 minimum.
- Liver, heart, lung, heart/lung, intestine, multivisceral, allogeneic related and unrelated Bone Marrow/Stem Cell Transplant - $500,000 minimum.

Note: Transplant benefits will not be subject to any calendar year maximums.

Fees
A network access fee is an incremental fee that will be incurred only when a member accesses one of our transplant network facilities. Note: Your current Network Access fee schedule/rates are in your contract. The appropriate access fee above will be billed after Cigna has received notification from the Cigna LifeSOURCE provider that the transplant procedure has occurred. For any case that incurs claims but does not proceed to transplant for any reason, the access fee will be 25% of savings (billed charges minus contracted rates) up to a maximum of the applicable access fee stated above. For Letters of Agreement (LOA) that are negotiated for specific transplant cases – the minimum fee is $2,500

which will be billed after execution of the Letter of Agreement. The LOA fee is 25% of savings (billed charges minus contracted rates) up to a maximum of the applicable access fee stated above, less the initial payment of $2,500. For a retransplant that occurs within the same admission as the initial transplant, or prior to the end of the zone 4 (follow-up care) time period, the access fee for the re-transplant will be 50% of the applicable fee stated above, in addition to the access fee for the initial transplant.

Billing
Fund will be charged a "flat fee" for transplants. Fee will be assessed once the transplant has occurred (in Zone 3). If the member does not make it to Zone 3, then a percent of savings on a retroactive basis will be billed.

Buy Up Options
N/A

Network Channeling

Standard Product Components

Provider Inquiry (for Pre-authorization)
When the provider calls for pre-authorization, the Case Associate will document the provider responses to five standard network referral questions and provides the following disclaimer:

Channeling Disclaimer
If a non-network provider is used, benefits may be reduced. Prior to seeking care, please verify that the provider is still participating in your network.

Member Inquiry (to determine if a provider is in-network or to request in-network provider listing)
When the member calls with a provider inquiry, the Case Associate reviews the network information for that fund/member to determine if there are any special network instructions. The Case Associate will provide the names of the network providers, document the provider names in the case notes and record the member responses to the five standard network referral questions.

Network referral questions:

- Is this a Network inquiry only?
- What is the Provider type?
- Is the patient utilizing a pre-selected network provider?
- Referred to provider in network?
- Able to impact network usage?

Retrospective Review

Standard Product Components

Retrospective Review:
There is a 48 hour grace period for admission notification (48 hours from date of admission).

- If notification occurs within the 48 hour grace period, the reviews are done, whether the member is still in-patient or discharged.
- If notification occurs after the grace period and the member is still in-patient, then a review is completed back to the date of admission.

- If notification occurs after the grace period and the member is discharged the provider may submit the medical records to Cigna for a retrospective medical record review and approval. There is no additional charge if the request is for a non-par/non-OAP discounted provider.
- A retro review can be requested for services purchased for up to one year from date of service.
- A retro review can be requested by either the Administrator or by the provider.
- Please note: retro reviews can only be requested for dates of service after a member's effective date. They cannot be requested for date of service prior to being effective with Cigna

Physician Consultative Review Services (PCS)

Optional Service Available

Upon request, PCS will provide customers' access to Cigna physician specialists who will review proposed treatments, provide opinions based on current medical literature, standards of care and professional experience, addressing customers' needs for:

- Independent Opinions;
- Internal validation of claims decisions;
- Consistent decision policy and administration; and
- Decisions based upon the most up-to-date research.

Fees for this service will be charged by the hour. Portions of an hour will be billed on a prorated basis (in 15 minute increments).

Web Tools

Standard Product Components

The Care Management web tool package provides information and tools to help participants improve and maintain their health, provides access to health and medical information and offers interactive tools that allow participants to get immediate feedback on their health status. The "mycigna.com" website can be accessed directly by logging onto mycigna.com.

The web tool package includes information on the following:

- 24 Hour Health Information Line (24HR HIL)
- Healthy Rewards
- Your Health Library
- Health Assessment

Apps & Activities

- On-Line behavioral coaching topics: Stress, Nutrition and Physical Activity
- Additional resources (hyperlinks to health related websites)
- Condition Centers (information on over 35 common medical conditions)
- Link to Network Provider Locator

Additional Web Tools

The web tool package includes everything listed under basic above plus the following services. These additional services include access to WebMD web tools:

- Personal Health Manager home page

- Personal Health Record (helps the member keep track of their personal health record – doctor visits, billing and more. It provides an easy way to review your health history at any time.)
- Messaging (simple way to keep the member up-to-date on issues that are important to them and their health).
- Symptom Checker (symptom diagnostic)
- Drug Comparison Tool - (standard tool - no customization)
- Health Record-(secure on-line tool to store personal health information such as medical data).

24 Hour Health Information Line (HIL)

Standard Product Components

All Day, Every Day Telephonic Nurse Access

Members and their dependents have access to a registered nurse for health information and level of care counseling all day, every day of the year.

Level-of-Care Counseling

Clinical assessment and triage by a nurse to the right care, at the right time. The nurse determines the appropriate level of care disposition (the level of care disposition timeframes to be seen are categorized as: immediate (911), within 2, 18 or 72 hours, or Self Care) through utilization of one of more than 350 online symptom based guidelines. The nurse helps the caller decide on the most appropriate setting to seek care. There is 24/7 back up by a Medical Director.

Medical/Health Information

Telephonic information is provided by a nurse using credentialed medical information including online resources, clinical decision tools and national support networks

Reporting

Standard Product Components

Standard Online Utilization Management Reporting Package — for each Product category. Reports are issued quarterly.

Cigna/CareAllies Claims Inquiry System (ICIS)

ICIS is the Cigna/CareAllies Claims Inquiry System which was created for the Administrator to use. It is a Web-based application that gives the Administrator READ ONLY access to the system record which displays comments and additional information on reviews and coordination that Cigna has completed.

The Administrator can see all information about a case with the exception of case management notes. Cases with a diagnosis such as AIDS or MHSA cannot be viewed.

We require that the Administrator identify an employee to be the primary administrator of the account. As the primary administrator this person is responsible for adding and deleting users. If, for some reason, the primary administrator must change (i.e., leaves the company), the Administrator must notify Cigna/CareAllies immediately to delete the old primary administrator and add the new person; as long as an administrator has an account, they have access to the cases.

Pre-Certification Determination

A report containing all pre-certification determination can be provided electronically. The Administrator Office is encouraged to load this into their claims system to facilitate payment of pre-certified claims. Please contact your Cigna representative for the standard file layout.

Buy Up Options

Your Health First[SM] is a comprehensive chronic condition coaching program that identifies multiple conditions for outreach. As such, Your Health First is currently only offered as a bundled solution so our health advocates may maintain a complete and comprehensive view of each participant's health.

Your Health First bundles support for proactive outreach and coaching on the following 16 chronic conditions, eliminating the need for condition-specific purchases:

- heart disease
- coronary artery disease
- angina
- congestive heart failure
- acute myocardial infarction
- peripheral arterial disease
- asthma
- chronic obstructive pulmonary disease (emphysema and chronic bronchitis)
- diabetes type 1
- diabetes type 2
- metabolic syndrome/weight complications
- osteoarthritis
- low back pain
- anxiety
- bipolar disorder
- depression

Supported by evidence-based medical guidelines and the most effective behavioral techniques, health advocates help members manage all aspects of their health. This includes adherence to medications, understanding and managing risk factors, maintaining up-to-date screenings, participating in monitoring tests, treatment decision support, pre- and post-admission outreach, and more. Because each person has a unique situation, our health advocates strive to build a personal relationship with each individual they coach by understanding what contributes to his or her success in maintaining optimal health, which in turn improves active participation in the services.

Many individuals who are identified with 1 of these 16 target conditions also have co morbid conditions that the health advocates address. In addition, individuals presenting with more than one condition or with questions about other conditions will not be turned away from coaching sessions. As a result, our health advocates actually support approximately 35 conditions.

Members are identified for these programs primarily through the Administrator claim data. The Administrators must provide historical paid claim data for the last 24-30 months prior to the effective date and historical eligibility data for the last 12 months prior to the effective date.

A variety of program materials will be shared with the Administrator Office for distribution to their entire disease management-eligible population. We encourage communication to the entire population because new participants are identified each month and individuals may want to self-refer themselves or a family member who is newly diagnosed or a recent plan participant.

Members are identified for programs based on preset guidelines. Welcome calls are made and letters are sent to qualifying members. The chronic population are split into two groups those that are targeted for on-going coaching and those directed towards self-help tools with the option to work with a coach. The member is considered to be

participating in the plan, unless they opt out, although only considered engaged if they work with a coach or enroll in an online coaching program.

Activity and outcome reports are available.

Pay-For-Performance Invoice Billing

While Pay-for-Performance reimbursements are not claims, the Fund's claims data is used for determining the Fund's proportionate reimbursement to the hospital based upon utilization by their members. As such, a claim-level detailed report will be provided to the Administrator based on priced claim data displaying potential Pay for Performance liability.

The purpose of the claim-level detail is to enable the Administrator to confirm that the fund's proportionate reimbursement to the hospital was calculated based upon their member's utilization. As the pay for performance amounts are based on covered services rendered to eligible members, claims on the claim-level impact report for ineligible members or services not covered by the benefit plan will be excluded from the amount due on the fund invoice.

Reconciliation Process

Upon receipt of the claim-level impact report, the Administrator will have 30 days to dispute any items/amounts included in the pay for performance calculation. Disputes identified should be sent to your Cigna Account Manager, along with an explanation for the dispute, i.e. member ineligible – claim denied. This will ensure an adjustment to the amount due is made prior to the invoice being generated.

If the Administrator does not respond within 20 days, the Account Management team will contact them to ensure feedback will be provided timely. If there is not a response by the 30th day, the invoice will be generated without any adjustments.

For funds submitting paid claim data we will base our liability on the data we have received, typically no reconciliation needed.

However, for all funds, there may be instances where we may need additional information from the fund relative to claim payment details.

Billing Method

There will be a line item(s) on the Cigna Shared Administration invoice in the Current Costs Special Charges section for an "Optional Service" charge (this is not "optional," but is our current capability for implementing this reimbursement).

Billing Timing

The current arrangements call for quarterly or annual payments, but future arrangements may have different timing. Please note – this may mean that you will see a line item on each monthly invoice for the various arrangement.

Out-Of-Network Savings Program (Optional Program)

Cigna's Out-of-Network Savings Program (OONSP) is an optional cost containment program that supplements your current SAR PPO product by enabling plan participants and their dependents to receive discounts from many providers not covered by the SAR PPO network. This program is enabled through agreements with vendors who provide network access, discounts and negotiation services to drive improved cost outcomes.

Once received, the Administrator will apply the OONSP discount amount as the allowed amount as communicated by Cigna. Then the Administrator will adjudicate the claim in accordance with the Plan's specific out-of-network plan design. At no time may the Administrator apply other cost containment or out-of-network discounts to claims that received a discount through Cigna's Out-of-Network Savings Program, nor may an Administrator "cherry pick" OONSP discounts. The Administrator will release the EOP/EOB and Payment to the provider. EOP/EOB messages should be in accordance with the Cigna RNC list, which will be provided by Cigna during Implementation.

Administrators are required to process out-of-network claims within eighteen (18) business days after receipt of a re-pricing determination from Cigna or the date that action is required to be taken under applicable federal and state law or regulation, whichever is earlier. Claims paid beyond 30 days of receipt have a risk of forfeiture of savings upon appeal from the provider.

For escalated issues, please contact your assigned Client Service Executive.

Claim Flow

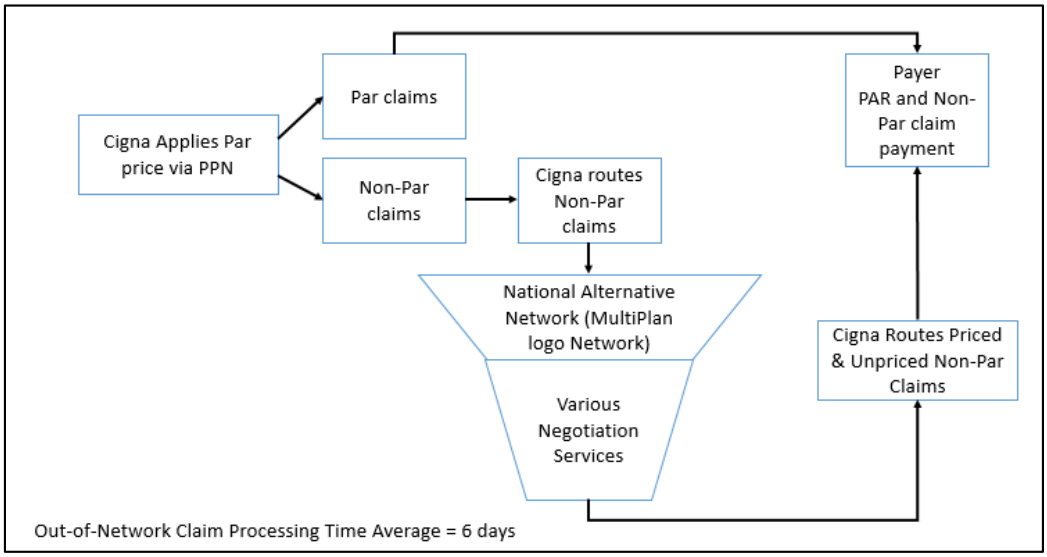
No additional paperwork involved. Individuals present their ID card at the time of service. Claims are submitted for reimbursement as usual. Discounts that may apply are automatically calculated. EOBs show any discount applied and the reduction in the individual's share for the covered service.

- Provider/member/Administrator sends claim to Cigna.
- Cigna reviews claims received as standard under the Shared Administration Repricing, applying participating provider discounts where appropriate, and identifying claims for non-participating providers.
- Claims for participating providers are delivered to the Administrator via the Electronic 837 file.
- Claims for non-participating providers are then further reviewed for secondary network discount consideration. Claims are routed through a hierarchy of supplemental networks (funnel) to determine a provider match.
- As discounts are achieved through a provider match via the funnel, original claims information and repricing information are provided to the payer via the Electronic 837 file.
- If a discount or provider match is unsuccessful through the funnel, Bill Negotiation services are available to drive an improved cost outcome.
- Claims which fail to achieve a discount via the funnel and/or Bill Negotiation are provided to the payer, identified as non-participating provider with RNC code 100, via the Electronic 837 file.

The Payer adjudicates the claim applying the Cigna repriced amounts and plan benefits, and prints and mails the check and EOP/EOB. Each EOP/EOB should include all of the RNC codes that were on 837 for the corresponding claim.

- The Payer responds to claims, benefits and eligibility inquiries.

Claim Flow



EOB/EOP Requirements

As with the Shared Administration Repricing requirement, remark codes and EOBs/EOPs messaging are required for non-participating provider discounts achieved. As a result, additional RNC codes will be provided to the Administrator for programming in their systems.

The specific EOB/EOP remarks, for respective OON vendors will be provided to you during implementation. The appropriate code to be applied to the claim will be identified on the Electronic 837 file.

All of these EOB/EOP remark codes must be programmed in your system and be ready to be displayed on the claim EOB/EOPs as of the effective date of the OONSP.

For examples of Network Codes and Corresponding EOB Messages, see page 38.

Billing Reconciliation Process

As access to the Out of Network Savings Program is funded through a percentage of savings, billing reconciliation is a requirement. Reconciliation is achieved through a match of discounts presented versus discounts utilized.

Paid Claim Data Format

Format will be discussed during implementation.

Invoice Details

Each invoice will include:

- A summary of the claims considered during the reconciliation. The claim volume, the associated charges, the discount returned, and the access fees associated.
- The total information will be broken down into three categories.
    - Open - those claims considered during the reconciliation that have not yet been reported on an 835 file
    - Discount not Utilized – those claims where the returned discounts were not utilized base on the data provided in the paid claims data
    - Paid Claims – those claims reported in the paid claim data where the returned discount was applied.
- The Shared Savings Fee payable for the provided discount which was reported as utilized.

Sample invoice

Reconciliation for Claims through: 03/31/2021

	Reconciliation Totals	Open	Discount not Utilized	Paid Claims
Claim volume	70	1	35	34
Total charges	$52,521.12	$225.00	$30,917.50	$21,378.62
Discounts	$10,265.65	$15.00	$5,339.49	$4,911.16
Billed savings	$2,566.41	$3.75	$1,334.87	$1,227.79
Shared Savings Fee:	25%			

Total Amount due:		$1,227.79

- The Administrator should review the invoice for any discrepancies. Any concerns should be addressed with your Cigna Client Management contact.
- The Administrator's payment should balance to the invoice provided and must be returned within 10 business days from receipt of the invoice.
- Each month following the receipt and processing of the Administrator invoice and payment, Cigna will generate an Accounts Receivable (AR) report. This AR report will identify all claims which have been returned with a discount but which have not been reported on a paid claims report. Any shared savings fee not closed (1) after 60 days from the date the discount was returned will be considered delinquent.

****With the Out-of-Network Savings Program (OONSP) or as a standalone program (without OONSP). ****

Medicare-Based Maximum Reimbursable Charge – Optional Program

Cigna's Medicare-based Maximum Reimbursable Charge (MRC) is an optional cost containment program that supplements your current Shared Administration Repricing (SAR) product by enabling plan participants and their dependents to receive discounts from providers not covered by the SAR network.

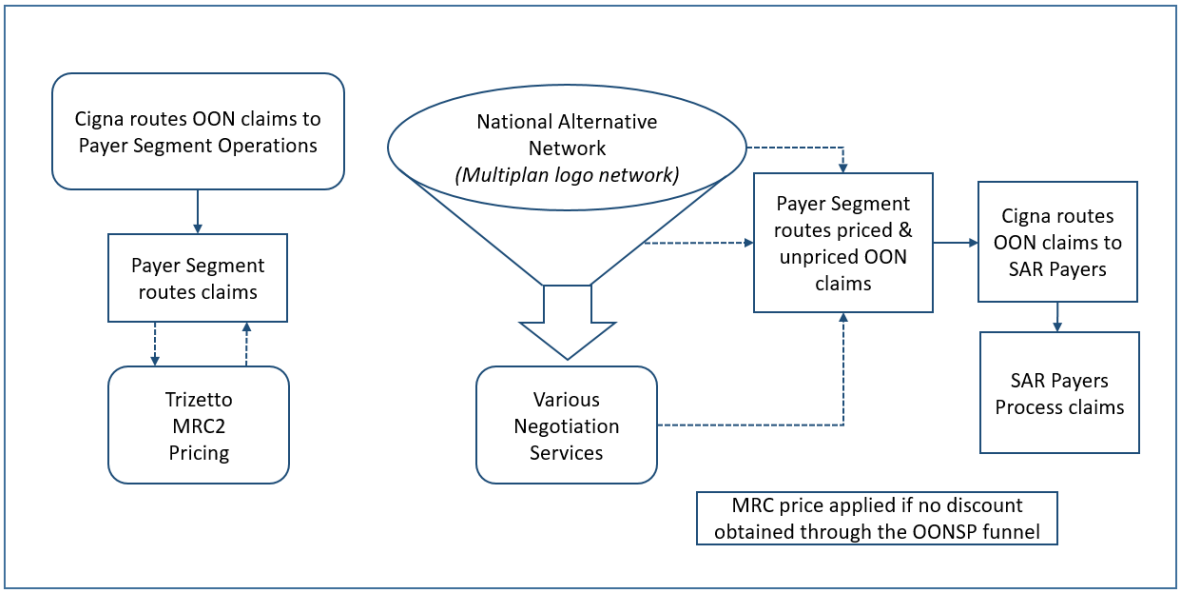
This program prices out-of-network claims using a percentage of a fee schedule which is based on a methodology similar to Medicare to drive improved cost outcomes. The Medicare-based MRC program can be sold in conjunction with the Out of Network Savings Program.

Medicare-Based Maximum Reimbursable Charge - Claim Flow

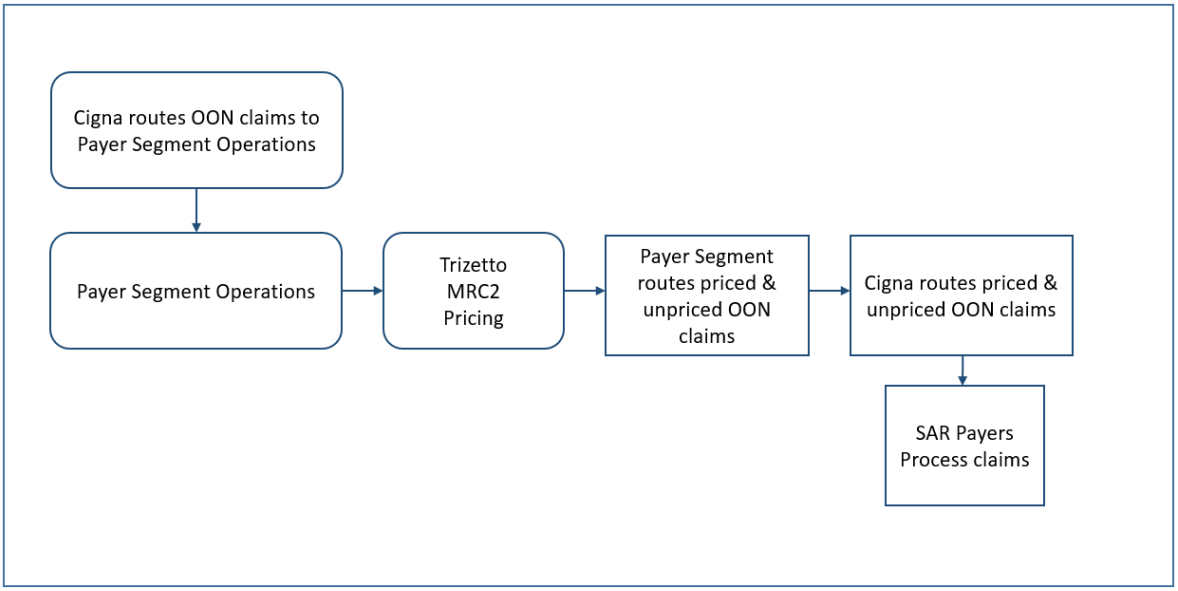
No additional paperwork involved. Individuals present their ID card at the time of service. Claims are submitted for repricing as usual. Discounts that may apply are automatically calculated. EOBs show any discount applied.

- Health Care Professionals send claims to Cigna.
- Cigna processes claims received as standard under the Shared Administration Repricing, applying participating provider discounts where appropriate, and identifying claims for non-participating providers.
- Claims for participating providers are delivered to the Administrator via the Electronic 837 file.
- If the Out of Network Savings Program (OONSP) cost containment program is elected along with the Medicare-based MRC program, claims for non-participating providers are then further reviewed for secondary network discount consideration. Claims are routed through a hierarchy of supplemental networks (funnel) to determine a provider match. If a discount or provider match is unsuccessful through the funnel, Bill Negotiation services are available to drive an improved cost outcome. If a discount is not able to be achieved through secondary networks or Bill Negotiations, then a Medicare-based MRC price may be applied.
- Claims billed in excess of 4 times Medicare for a covered service will not be eligible for pricing through the Out-of-network Savings Program (OONSP) but will be priced according to the SAR Fund's Medicare-based MRC reimbursement election.
- For clients that elected the Medicare-based MRC without the Out of Network Savings Programs, claims for non-participating providers may achieve a discount through MRC pricing.
- As discounts are achieved through Medicare-based MRC pricing, original claims information and repricing information are provided to the payer via the Electronic 837 file.
- Claims which fail to achieve a discount through Medicare-based MRC pricing are provided to the payer, identified as non-participating provider with RNC code 100, via the Electronic 837 file.
- The Payer adjudicates the claim applying the Cigna repriced amounts and plan benefits, and prints and mails the check and EOP/EOB, including the appropriate RNC Code.
- The Payer responds to claims, benefits and eligibility inquiries.

OONSP with MRC



MRC Only



EOB/EOP Requirements:

As with the Shared Administration Repricing requirement, remark codes and EOBs/EOPs messaging are required for non-participating provider MRC rates provided. As a result, an additional RNC code will be provided to the Administrator for programming in their systems.

The EOB/EOP remark code must be programmed in your system and be ready to be displayed on the claim EOB/Ps as of the effective date of Medicare-based MRC.

Examples of Network Codes and corresponding EOB Messages:

Network	Received from MPI	Network Code on CostPro 837	Network Code on ISSI 837	Discounting Network	EOB Text Required
MRC		1231	1231	MRC Discount	Member's benefit plan limits payment to Maximum Reimbursable Charge. The provider may bill the member for the balance.
		0100	0100	Out of Network	

Billing Process

Medicare-based MRC will be billed a Per Employee Per Month (PEPM) fee that will be included as part of your SAR Administration Fee on your monthly invoice.

Reporting

MRC paid claim data is required from Payers on a daily or weekly basis for reporting

Exhibit I: Sample EOB Notations

6	A	Duplicate	D	These expenses are duplicates and have been previously processed.
13	A	Auth	F	THESE BENEFITS WERE REDUCED OR DENIED BECAUSE THE REQUIRED PRE-ADMISSION REVIEW PROCEDURES WERE NOT FOLLOWED. SEND ALL CLINICAL INFORMATION FOR REVIEW ALONG WITH A COPY OF EOB TO: Retro Review 1777 Sentry Park West, Dublin Hall 4th floor Blue Bell, PA
19	A	Auth	F	These benefits were reduced because the PRE-ADMISSION REVIEW procedures outlined in your plan were not followed.
27	A	Eligibility	D	Our records indicate that this dependent is not covered by your plan.
28	A	Eligibility	D	These expenses were incurred prior to your effective date.
29	A	Eligibility	D	Your coverage was terminated at the time this expense was incurred.
32	A	Inappropriate Billing	D	Network savings discount does not apply to routine vision services with Shared Administration.
41	A	Missing Information / Incomp Claim	E	We are denying your claim because information we requested was not received. We are unable to make a coverage decision due to a lack of information.
92	A	Network Savings	F	Thank you for using a PREFERRED PROVIDER. This represents your savings, so you are not required to pay this amount. If you have already paid the full amount, please request reimbursement from your provider.
100	A	Non Par	D	The provider is not a Network participant

Exhibit II: TPV Logo Grid for PPO and OAP

Shared Administration PPO and OAP Third Party Vendor Information for ID Cards
Please utilize for ID cards issued for 1/1/2022 and after
Note: Your Client Engagement Manager (CEM) will send updates as they are available.

Third Party Vendor and Alliance Network Replacement Information for ID Cards effective for ID cards issued 7/1/2022

This chart is a reference guide for clients who have customers in a TPV or Alliance Network. It includes the TPV or Alliance name, a copy of the logo, and the general geographic location (driven by Zip Code) of the TPV or Alliance Network in which the customer resides.

TPV Name PPO Network Code	**TPV Name OAP Network Code**	**Logo**	**General Geographic Location**	**TPV address, if applicable. TPV address is for In-Network claims ONLY**
Center Care **KY704**	Center Care **OAP – KY351**	CENTER CARE Health Benefit Programs	Kentucky	Not Required
CHN* **MT704**	CHN* **OAP - MT353**	CHN Community Health Network	Montana	Cigna MT-CHN PO Box 3018 Missoula, MT 59806 Payer ID 81040
HealthPartners ***Alliance*** **MN703**	**HealthPartners** ***Alliance*** **OAP - MN351**	HealthPartners	Minnesota North Dakota Western Wisconsin	Not Required
~~**Idaho Physicians Network**~~ **ID703** Effective 7/1/2022 transitions to Cigna	~~**Idaho Physicians Network**~~ **OAP – ID352**	ipn	~~Southern Idaho~~	~~Not Required~~
MDX HAWAII HI901	MDX HAWAII OAP - HI350	Administered By MDX Hawai'i	Hawaii General Market Closed Sales must obtain approval before it is sold.	Not Required

Midland's Choice **NE704**	**Midland's Choice** **OAP - NE350**		NE, IA, SD, IL	Not Required
Mississippi Health Partners **MS904**	**Mississippi Health Partners** **OAP - MS353**		Several counties in Mississippi	MHP Systems PO Box 23908 Jackson, MS 39225-3908
MVP Health Care (MVP) ***Alliance*** **NY704**	**MVP Health Care (MVP)** ***Alliance*** **OAP – NY353**		Upstate New York and Bradford County, PA	Not Required
PHCS Choice MD Plan **Network IDs:** KY201 MO205 NY232 NY234 OH203 ~~PA201~~ WV201 **Effective 1/1/2022 no longer utilized in PA201**	**PHCS Choice MD Plan** **Network IDs:** KY350 MO354 NY350 NY352 OH351 ~~PA350~~ WV350 **Effective 1/1/2022 no longer utilized in PA350**		KY, MO, NY, OH, ~~PA,~~ WV	Not Required
Priority Health ***Alliance*** **MI707**	**Priority Health** ***Alliance*** **MI359**		Lower Peninsula of Michigan	Not Required
Sagamore Health Network **IN703**	**Sagamore Health Network** **OAP - IN351**	No Logo	Certain counties in Indiana	Not Required
UP Healthplan **MI701**	**UP Healthplan** **OAP – MI352**		Upper Peninsula of Michigan	Not Required
Valley Preferred **PA702**	**N/A**		Pennsylvania	Not Required

*The Forward Looking Zip Files for MT704 and MT353 will indicate Allegiance which is the parent company of CHN.

Exhibit III: Payer Scorecard Template

Your Cigna Payer Relationship Manager will provide this to you in electronic format.

Claim Payment Administrator:

To be completed by the Claim Payment Administrator

SERVICE METRIC	Standard	Jan	Feb	Mar	First Quarter	Apr	May	Jun	Second Quarter	Jul	Aug	Sep	Third Quarter	Oct	Nov	Dec	Fourth Quarter	YTD
Time to Pay Results																		
Number of Claims Received in Month		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Claims Paid within 18 Business Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent of Claims Paid within 18 Business Days	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Number of Claims Paid > 30 Business Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent of Claims Paid > 30 Business Days		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Open Inventory																		
Total Open Claim Inventory (Month-End)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Age of Open Inventory																		
Number of Claims 0 - 30 Calendar Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Claims 31 - 60 Calendar Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Claims 61 - 90 Calendar Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Claims > 90 Calendar Days		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Claim Quality Results																		
Total Number of Claims Audited		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Claims with Errors		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Dollars Paid on Claims Reviewed		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Dollars Paid in Error		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Financial Accuracy	99.0%	0%	0%	0%		0%	0%	0%		0%	0%	0%		0%	0%	0%		
Payment Accuracy	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Processing Accuracy	90.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Telephone Responsiveness																		
Average Speed of Answer	<45 seconds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Abandonment Rate	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Number of Calls Received		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Open Calls (Month-End)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denial Rate																		
Ineligible Member		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Benefit limitation or Max achieved		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Request for additional information not received		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Comments/Discussion Items:

Exhibit IV: Overpayment Referral Form

In an effort to better assist you in the recovery of your outstanding refund, please complete the information below. Once completed please send to your Cigna CSE along with a copy of your overpayment letters and your EOP/EOB sent to the provider for these services.

Please note: Cigna will assist with our contracted providers only. We can assist with the request for payments within 1 year of the payment date or specific required time limitations under our provider contracts

Date Referral was sent to Cigna: _____

Member ID _____

Patient Name (First/Last) _____

Cigna Claim Number _____

Date of Service _____

Paid to Provider Name _____

Provider Tax ID _____

Total Charge of claim _____

Total Paid _____

Overpayment Amount _____

Please provide a brief explanation of the reason for the overpayment

_____

Date Overpayment identified _____

Date Original Overpayment was sent _____

Date Outreach Call was made to provider to confirm receipt _____

Phone number and who you spoke to _____

Details of the call

_____

Date of Second Request _____

Date of Third Request _____

Have you confirmed the refund has not been received? ☐ Yes ☐ No

Exhibit V: Eligibility Data Exchange

Eligibility Data Transfer Method

The Client is required to provide Cigna with eligibility data in either the 834 HIPAA Compliant File format or a flat file [Cigna proprietary file] format. Details on transmission, including acknowledgement receipt and frequency will be provided during implementation. Cigna will conduct a specifications call with the Administrator to walk through the HIPAA 834 and/or flat file formats and specific data requirements for enrollment.

Eligibility File Submission Frequency

Weekly file submission is Cigna standard. Receiving a file weekly allows for processing time (standard of 98% within two business days) and resolution of fallout issues (see below items).

Error Report Processing

Upon completion of the update process, reports are immediately produced indicating any error (fallout) and/or changes to records in our system. Any records that cannot be enrolled or updated will appear on an error report.

We ask that fallout review be completed within five (5) working days from the file update. The analyst will determine if he/she can correct the error. If not, the analyst must determine the source of the error and what resolution, if any, is needed on your file/system. Your reports will be available at www.cignaforemployers.com or reports will be provided via email within five (5) business days from the date of update. Should you have any questions about a particular error, your assigned eligibility analyst will guide you in determining the cause and resolution of the error.

Default Cancel Policy

There may be instances where, for some reason, you are unable to consistently process member cancellations. Cigna's Default Cancel with Tolerance processing identifies members who are active in our system, but are not included on your automated full feed eligibility file. The members are identified on a Default Cancel Candidates report for your review. After an agreed upon tolerance period, these members are canceled in our system if you do not add them to your input file. This processing is a means of ensuring that the eligibility records we maintain on your behalf are consistent with your own eligibility data. The Default Cancel process ensures prompt termination of members who are no longer eligible and is part of our standard processing.

You may select a 1 to 45 day tolerance period that will allow time to review and respond to member records that are reported as candidates for cancellation. A zero (0) day option is also available; however, this option will result in ***immediate*** cancellation upon update with no opportunity for you to review the records in advance.

Retroactive Eligibility Terminations

Subscriber terminations, changes, and reinstatements are limited to 90 days retroactivity from the date the change is processed.

Exhibit VI: Providing Data Back to Cigna

Most clients choosing the Cigna Shared Administration Repricing model do so to secure the aggressive discounts that the Cigna network can provide. Our ability to continue to negotiate such superior discounts depends on a variety of factors including being able to renegotiate discounts with our provider partners. In order for us to do that effectively, and to properly monitor our Administrator Office partners, Cigna requires that Administrator Offices provide the following data on ALL claims paid (in and out of network), on a weekly to monthly basis.

Claim data should be submitted to Cigna using the information below.

HIPAA National Electronic Data Interchange Transaction Set Health Care Claim Payment/Advice 835 05010A1 Version or 005010X221A1 Version

This file should follow the standard layout and formatting, ensuring balancing of the charges and payments, and using standard reason codes (CAS Codes) as available for an 835 file.

The only exception to the standard file elements are listed below.

Loop 2100
REF01=F8
REF02 = [Cigna Document Control Number]
REF01=CE
REF02 = [Date Claim Processed]

Exhibit VII: Network Savings Report

This report can be produced on a monthly, quarterly or annual basis. This report provides information on the network savings which is calculated as follows:

Total In-Network billed charges - Network Allowed = Network Savings

This report can be generated for a specific range of dates and records by account, by contract. This report summarizes the Claim Types, Charges, Network Allowed, and Network Savings columns and provides Grand Totals for each.

Network Prepricing Statistical Report – Summary

ABC Health & Welfare Fund

ABC HEALTH & WELFARE FUND

01/01/2021 – 03/31/2021

Claim Type	Charges	Network Allowed	Network Savings
Inpatient	$ 104,299.02	$ 47,770.01	$ 56,529.01
Outpatient	$ 22,906.66	$ 15,260.55	$ 7,646.11
Physician	$ 42,235.23	$ 23,259.91	$ 18,975.32
Grand Totals	**$ 169,440.91**	**$ 86,290.47**	**$ 83,150.44**

A detailed report is available upon request. The detailed report lists the Employee SSN, Employee Name, Patient Name, Claim Type (I = Inpatient, O = Out Patient and P = Physician), Beginning DOS (Date Of Service), Charges, Network Allowed, Network Savings and Totals of each.

Exhibit VIII: Billing Invoice and Payment Administration

Monthly Billing Statement

Cigna HealthCare provides a monthly billing statement that discloses the total charges due for the billed month. Each statement reflects enrollment activity submitted to the Employer Service Center in time to be included on the current invoice, as well as other charges that may not be billed based on eligibility. New enrollments and terminations will impact the monthly invoice. Additional changes to the invoice may be due to actions such as adding/changing/discontinuing benefits or an increase or decrease in rates.

Eligibility Based Billing Policy

You will find that eligibility-based billing benefits you in the following ways:

- Cigna produces a single eligibility-based summary invoice for your Shared Administration: Repricing Services
- The Cigna Accounts Receivable and Billing System (CARBS) provides functionality that links your eligibility and billing information.
- Amounts due on the invoice will be calculated based on the eligibility you currently reported.
- Detail back-up to the eligibility rate basis data on the invoice is available.
- The process eliminates disjoints between your eligibility and invoice data.
- Your eligibility and billing will be "in sync" monthly.
- You will be able to choose a snapshot date – to coordinate eligibility feeds with invoice timing. Snapshot timing – 8th through the 15th.
- Invoice timing – Our invoices produce on a Current Month cycle.
- Payments are automatically applied and reflected on your next invoice.
- The process eliminates the need for reactive financial audits and/or reconciliations.

The service model will maintain end-to-end data integrity for you, and allow you to easily review the invoice and Pay-as-Billed.

Premium Wash

Billing census is calculated using the Fifteenth of the Month Wash Method. Therefore, premium is billed on a full month basis rather than pro-rated. The wash method is applied as follows:

New Enrollment

If a member's Coverage Effective Date is on or before the fifteenth day of the Month of Coverage, then premium or other amounts are due for that member for that month. Example: If March 5 is the member's Coverage Effective Date, then premium or other amounts are due for that member for the entire month of March.

If a member's Coverage Effective Date is after the fifteenth day of the Month of Coverage, then **no** premium or other amounts are due for that member for that month. Example: If March 18 is the member's Coverage Effective Date, then premium or other amounts are NOT due for that member until the month of April. Coverage for March 18 to March 30 is free.

Termination

If a member's Deemed Termination Effective Date is on or before the fifteenth day of the Month of Coverage, then no premium or other amounts are due for that member for that month. Example: If March 5 is the member's Deemed Termination Effective Date, then NO premium or other amounts are due for that member for the month of March. (Coverage for March 1 to March 4 is free.)

If a member's Deemed Termination Effective Date is after the fifteenth day of the Month of Coverage, then premium or other amounts are due for that member for that month. Example: If March 18 is the member's Deemed Termination Effective Date, then premium or other amounts are due for that member for the month of March.

Premium Due Date Policy

The Premium Due Date is the first day of the Month of Coverage. The normal Bill Day (that is, the day on which Cigna produces and mails each monthly bill) will be flexible to accommodate your Accounts Payable and Eligibility Maintenance process (you must select the date). A bill can be produced and mailed on the 8th through the 15th day in the current month. For example, a bill for the month of March would be produced and mailed on March 8th. Each invoice is due and payable on the first of the month of service with a grace period extending to the end of the following month. An overdue reminder is mailed for any statements not paid by the middle of the grace period. A cancellation letter is mailed if payment is not received by the end of the grace period.

Remittance should always equal the Total Amount Due on the billing invoice, which means the invoice is "paid-as-billed". In order to continue group coverage on employees and their covered dependents, it is important to remit premium payments on time and for the full amount due.

Each payment should be sent with the Payment Voucher to the Cigna HealthCare Lockbox shown on the voucher. If the voucher is not received or becomes misplaced, payment should be sent to the Lockbox address shown on the Contact Pages at the beginning of this manual.

Terminations

To ensure timely processing of reported terminations, terminations should be sent on your eligibility file at minimal three business days prior to your snapshot date, in order to reflect on your current invoice. Adjustments to eligibility will be reported on your next month's invoice if submitted after this timeframe.

Monthly Billing Statement

The principle features of the invoice are listed below:

- Voucher Page
- Monthly Summary
- Summary of Account Activity
- Summary of Current Costs
- Account Level Summary of Current Costs
- Adjustments – Summary of Eligibility Updates Processed
- Adjustments of Client Reported Lives/Volume Changes
- Adjustments – Summary of Retroactive Billing Line Charges
- Optional Service or Special Charges*

Exhibit IX: Medical Claim Images

The Payer must understand and have a method for accepting and accessing Medical Claim Images from Cigna. Cigna utilizes .TIF files for Images and XML files for indexing these Images. If the Payer does not have the compatibility to accept images in this way, Cigna can recommend 3rd party vendors to handle this process for them.

An image will be transmitted once unless a request is provided to resend or rescan an image.
Images are in .TIF format with a 1762 x 2224 Resolution

See Ecommerce documentation for transmission methods which include 1, 2 and 3 below but may also include other methods.

1. HTTPS File Transfer
2. FTP using PGP
3. Secure File Transfer Protocol

The file transfers are performed at scheduled intervals determined with payer at implementation. Transfer intervals are subject to change, upon mutual agreement.

Information sent with the Images and file:

- Image Info Tag
- Image Type: Required – must be one of the following: Appeal, Correspondence, or Claim
- Date Received: Required – Date the original document is considered received. The format is CCYYMMDD example: 20200821
- DCN: Required – The Document Control Number
- Transmission Type: required – must be one of the following: Send or Resend.
- EDI Claim Key: optional (required for Claim) – This is the EDI Claim Key. The external party will send their key to Cigna. Cigna will send out the Cigna EDI Claim Key. If the value is applicable, it will be provided
- Claim Engine Identifier: optional - required if claim engine key is provided when the claim is out bound from Cigna.
- Member Suffix: optional – Not all external parties use the member suffix in the identification of a member. If it is used by the external party, it must be populated.
- Subscriber SSN: optional – either this value or the Subscriber AMI must be populated for every entry.
- Subscriber AMI: optional – either this value or the Subscriber SSN must be populated for every entry.
- Account Number: Required – The account number is required for the conversion from SSN to AMI or AMI to SSN.

Exhibit X: ID Card

ID Card Preparation, Requirements and Usage: Cards Produced by Cigna

You have the option of having Cigna produce your ID cards for both new and renewing Funds. If you have purchased a Cigna Pharmacy product, the card can include both the medical and the pharmacy data on the ID card.

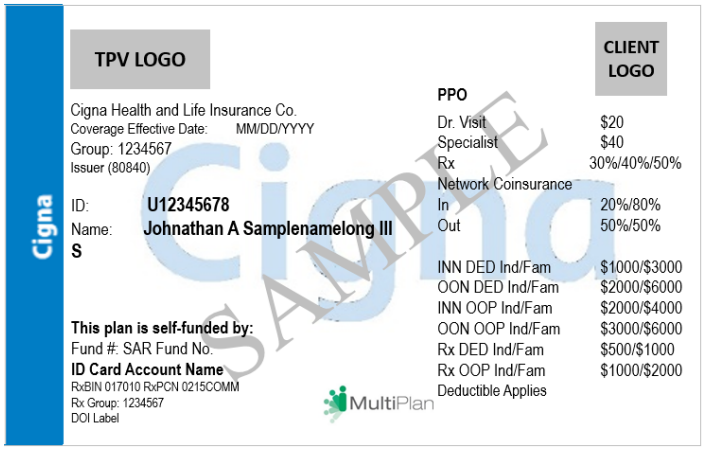
See below for an outline of what Cigna's "standard" medical/pharmacy ID card looks like. If pharmacy is not purchased, then the Issuer, RxBin and RX benefit fields would be removed. Any deviation from this standard will require additional charges.

All SAR Medical ID Card standard card stock includes:

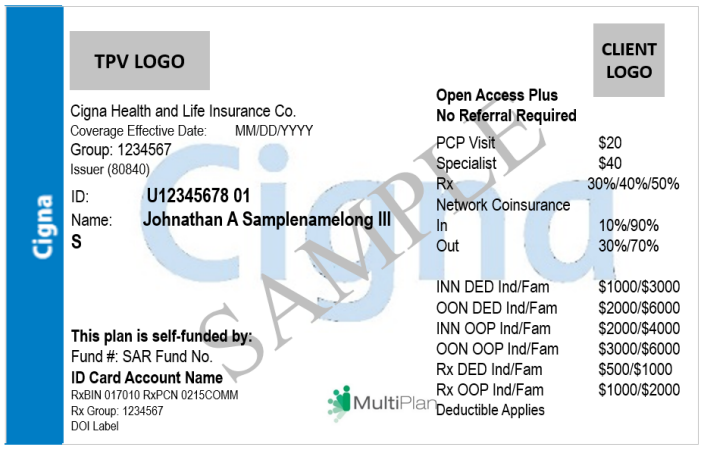
- White background (front of card)
- Blue strip on left hand side of front of card denoting "Cigna"
- Cigna's word mark logo (front of card)
- Union Bug (back of card – bottom right hand corner)

Requirements on Front of PPO and OAP Medical ID Cards:

PPO



OAP



Requirements for both PPO and OAP

- Third Party Vendor logo, when applicable to display
- Cigna's Legal Entity Name
- Cigna Group/Account Number – this is the 7 digit Cigna-assigned group/account number
- Coverage Effective date of the member's benefits e.g. 01/01/2022
- Member ID which can be identified as either:
  - Text which is "Use Participant's SSN"
  - The Cigna AMI (Alternate Member Identifier) – number that Cigna assigns to every member
  - Customer's External AMI (Alternate Member Identifier) – subject to Cigna's review/approval
- "S" – which denotes Shared Administration
- Participant or Dependents' name – total characters for First/Last Name is 21. If necessary to display middle initial on card, need to add to the First Name field on eligibility file
- Name of the Fund – (21 characters)
- Product Branding (this will display as Cigna HealthCare PPO or Open Access Plus)
- CAA benefit information – (see details on layouts above)

- Fund's Company Number – unique account identifier sometimes used by customer – (this is an optional field – if not applicable, no additional charges are incurred)

Additional Requirements for OAP

- "No Referral Required" (verbiage to be placed under Open Access Plus branding)

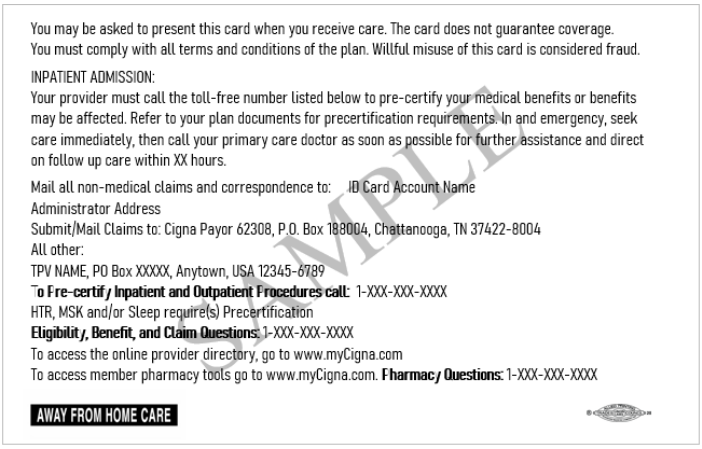
Additional requirements on front of combined medical/pharmacy ID Card

(This is only when Cigna's pharmacy product is purchased.)

- RxBIN number – (International Identification number) – used by Cigna for pharmacy claim payment processing
- RxPCN number (Processor Control number) – numbers assigned and used by Cigna for pharmacy claim payment processing
- Card Issuer number - number used by Cigna for pharmacy
- Copay amounts and descriptions (same as above)
  Additional note for pharmacy – If min/max plan applies or the customer elects to hide the Rx copay/coinsurance, the "Yes" will print in place of the Rx copay/coinsurance amount (s)
- "Deductible Applies" – will display if combined pharmacy/medical deductible

Requirements on Back of PPO and OAP Medical ID Cards:

PPO


You may be asked to present this card when you receive care. The card does not guarantee coverage.
You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud.

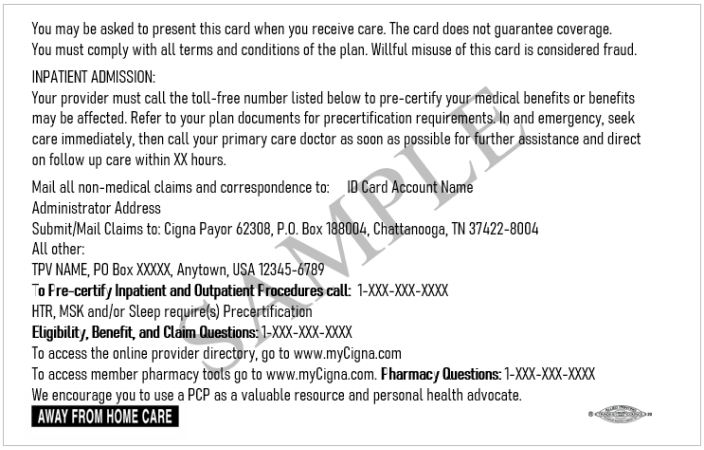
INPATIENT ADMISSION:
Your provider must call the toll-free number listed below to pre-certify your medical benefits or benefits may be affected. Refer to your plan documents for precertification requirements. In and emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and direct on follow up care within XX hours.

Mail all non-medical claims and correspondence to: ID Card Account Name
Administrator Address
Submit/Mail Claims to: Cigna Payor 62308, P.O. Box 188004, Chattanooga, TN 37422-8004
All other:
TPV NAME, PO Box XXXXX, Anytown, USA 12345-6789
To Pre-certify Inpatient and Outpatient Procedures call: 1-XXX-XXX-XXXX
HTR, MSK and/or Sleep require(s) Precertification
Eligibility, Benefit, and Claim Questions: 1-XXX-XXX-XXXX
To access the online provider directory, go to www.myCigna.com
To access member pharmacy tools go to www.myCigna.com. **Pharmacy Questions:** 1-XXX-XXX-XXXX

AWAY FROM HOME CARE

SAMPLE

OAP


You may be asked to present this card when you receive care. The card does not guarantee coverage.
You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud.

INPATIENT ADMISSION:
Your provider must call the toll-free number listed below to pre-certify your medical benefits or benefits may be affected. Refer to your plan documents for precertification requirements. In and emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and direct on follow up care within XX hours.

Mail all non-medical claims and correspondence to: ID Card Account Name
Administrator Address
Submit/Mail Claims to: Cigna Payor 62308, P.O. Box 188004, Chattanooga, TN 37422-8004
All other:
TPV NAME, PO Box XXXXX, Anytown, USA 12345-6789
To Pre-certify Inpatient and Outpatient Procedures call: 1-XXX-XXX-XXXX
HTR, MSK and/or Sleep require(s) Precertification
Eligibility, Benefit, and Claim Questions: 1-XXX-XXX-XXXX
To access the online provider directory, go to www.myCigna.com
To access member pharmacy tools go to www.myCigna.com. **Pharmacy Questions:** 1-XXX-XXX-XXXX
We encourage you to use a PCP as a valuable resource and personal health advocate.

AWAY FROM HOME CARE

SAMPLE

- Eligibility disclaimer (see detail on layout above)
- Inpatient/emergency admission instructions (see detail on layout above)
- Fund Name and address to send "non" medical claims to – currently, there is only space for one address. If multiple addresses are needed (for example, pharmacy carrier address and dental carrier address) please see custom template section below.
- Cigna electronic payor ID and Cigna address – this is for claim mailing/electronic claim submissions
- TPV claim address when applicable
- Pre-certification telephone number – as follows:

  1. If client elected Inpatient precert only add:
     To Pre-certify Inpatient Admissions call: 1-800-768-4695

  2. If client elected inpatient and outpatient precert add:
     To Pre-certify Inpatient and Outpatient Procedures call: 1-800-768-4695

  3. If client requires precertification of HTR, MSK and/or Sleep, include appropriate additional verbiage:

To Pre-certify Inpatient and Outpatient Procedures call: 1-800-768-4695
HTR, MSK and/or Sleep requires Precertification

- Payer's telephone number – number to be used when inquiring about eligibility, benefit or claim questions
- Cigna on-line provider directory website address
- "Away From Home Care" logo

Additional Requirements for OAP

- Primary Care Physician (PCP) steerage language – We encourage you to use a primary care physician as a valuable resource and personal health advocate – placement towards the bottom of the card (this text cannot be altered)

Additional requirements on back of combined medical/pharmacy ID Card:

- Pharmacy telephone number – Cigna's pharmacy member services number
- Pharmacy website address – website address for members to access pharmacy tools

Non-Standard ID Card Charges or "Optional Services":

As mentioned above, additional charges are incurred if a customer wants anything other than what the standard ID card package includes. Pricing is not included here, as they are subject to change. Examples are as follows:

1. Mockups – this is a "mockup" of what an ID card will look like, prior to seeing it in production
2. Black and White or colored logo – customer logo
3. Custom template - this may be required if a customer wants to add or change a data element on either the front or back of the ID card. Any type of change to the standard ID card template requires internal, Cigna approval and will be limited to space available on the card. This approval process involves receiving sign-off from many areas including but not limited to: ID Card Operations, Product, Legal, Marketing and Provider Network (depending on extent of non-standard request).

   Examples of what would require a custom template include, but are not limited to:

   - Rewording of inpatient/emergency admission instructions
   - Fund Administrator Name and address for non-medical claims – if more than one address is required (may have multiple carriers)
   - Change in placement of where a data element is displayed on front or back of ID card

4. Custom card stock – custom card stock typically takes 6-8 weeks to be produced. Prices will vary depending on complexity. Examples of what would require custom card stock are as follows:

   - Removal of Cigna blue stripe on left hand side of card
   - Removal of union bug
   - Change in color of card background

5. Reordering custom card stock

ID Card Standard Distribution

- For OAP, cards are produced at a "Member level" – every family member/dependent will receive an ID card.
- For PPO, cards are typically produced at a "Subscriber level" – one card if a participant has single coverage, two if the participant has one or more dependents on the plan, each with the participant's name. We can, however, produce cards at a member level at the request of the administrator.

TPV logos – What Are They and Why Are They Needed?

Cigna owns the vast majority of our networks. However, in order to maximize network coverage, we do have several Third Party Vendor arrangements in certain markets.

- We screen each third-party vendor (TPV) provider network for quality of care, access for members, stability of the existing network, and fair prices with the potential for savings.
- The TPV conducts network recruiting and administration.
- Cigna network management staff oversees relationships with third party provider networks (TPV).

Cigna prints TPV information on its cards to allow TPV staff to identify that the member that they are servicing can obtain in-network benefits (based on their contractual arrangement with Cigna). Members residing in a TPV service area will need to have the *TPV* logo in their ID cards. The *Away from Home Care* logo allows members to see other participating providers outside of their service area (at the in-network benefit level). The Away from Home Care logo is recognized by the participating providers and they extend their discounts to those traveling members. (Exhibit II is a grid containing a list of TPV names, logos, general geographic location and TPV address, if applicable.)

ID Card Carriers

An ID card is affixed to a piece of paper called a "carrier".

The language that is seen on the back of the ID card carrier when a new member is enrolled is as follows:

Top portion

"Enclosed is your new medical Cigna Healthcare OAP identification card. Please destroy any old cards you have. If you attempted to select a primary care physician, and you see the words "Please Select" or another provider's name, this means we were unable to process your request. You can select a new physician by going to www.cignasharedadministration.com and selecting the SAR OAP provider directory.

*Please note, your members are not required to select a PCP, however Cigna encourages members to use a PCP as a valuable resource and health advocate.

Middle portion

Member's address will be displayed

Bottom portion

"Thank you for choosing Cigna Healthcare. Enclosed you will find your new Cigna Healthcare ID card(s). Please show this ID card any time you receive services.

'Maintenance' ID Cards

A card will be automatically generated when any of the following scenarios occur (this is not a comprehensive list):

- New address as a result of TPV change – when a member moves from a non-TPV service area zip code to a TPV service area zip code or vice versa
- Last Name change
- Any letter of first name
- Primary Care Physician (PCP) change
- Account Number change
- Reinstatement with or without gap in coverage
- Change in copays/benefit information displayed on ID card

Scenarios when a new card would not be generated:

- Moving from one Branch to another
- Member moves from a non-TPV service area zip code to another non-TPV service area zip code

Replacement ID Cards

This process should be used when the Administrator needs to order a "replacement" card on behalf of the member. Examples of when this process should be used are when:

- Card is lost/stolen
- Card is mistakenly destroyed

This process is not meant to be used for ordering maintenance cards or high volumes of replacement cards. Regular "maintenance" cards will be automatically generated once eligibility updates are sent and loaded into our systems.

Returned ID Card Process

All ID cards are mailed in an envelope that has a returned address of Bloomfield, CT. When a card is determined to be "undeliverable" (address is not known), it is returned to Vendor Services Operations on the Bloomfield campus and is immediately destroyed. Hence, it is imperative that the customer consistently provide Cigna with updated and accurate eligibility information.

ID Card Reports

There are three types of reports available:

1. ID Card Production Summary – one page summary of cards produced and current outstanding
2. ID Card Production Detail – report which lists all members that had cards mailed within a pre-determined report period
3. ID Card Outstanding Detail – reports which lists all current outstanding cards for members flagged since a given Start Date

You will need to work with your Client Manager to receive these reports.

Puerto Rico

Cigna can accommodate only U.S. state and the District of Columbia addresses in our eligibility system, therefore, membership in Puerto Rico and other U.S. territories should be discussed with your Cigna Client Manager or New Business Manager.

Students

If an eligible student dependent needs an ID card, the Administrator should contact their CM or CSE to request a card. Cards can be mailed directly to the student upon request.

Cards Produced by Administrator

Should the Administrator decide that they would like to produce the ID cards; the ID card must be in the Cigna format, including the proper Cigna logo, colors, content and format. Our camera-ready logo will be provided electronically during implementation if the Administrator decides to print the cards.

The following data must appear on all ID cards. Any request for deviation must follow the approval process:

- Cigna logo, "Away from Home Care" logo and Third Party Vendor (TPV) logo
- Must indicate network designation - Open Access Plus - on the front near Cigna logo
- No Referral Required – verbiage must appear on the front
- Account number to help facilitate provider claim submission

- Member Identification Number (can be member's SSN, AMI or the verbiage *"Use Union Member's SSN"*)
- Must include the letter "S" near the Administrator Office member ID number – this will assist contracted providers in identifying Shared Administration members.
- Member Name – to support participating provider agreement for established member identification.
- Basic benefit information (e.g. office copayment)
- Coverage Effective Date – effective date of member's benefits. This is required on the initial ID cards, and then on an ongoing basis for all new or rehired member's.
- Administrator Office's customer service telephone number for eligibility, benefits and claim service
- Utilization Management telephone number (as shown in the above section) for pre-certification:
- PCP steerage language – We encourage you to use a primary care physician as a valuable resource and personal health advocate – must appear on the back near the bottom (this text cannot be altered)
- Instructions for pre-certification and pre-certification requirement (i.e. Inpatient, Inpatient & Outpatient pre-certification required, 48 hours maximum). It should be similar to the following message:

  "Your Network provider must call the toll-free number listed below to pre-certify the services. Refer to your plan documents for your pre-certification requirements. Failure to obtain pre-certification may affect benefits. In an emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and direction on follow up care within *48 hours."
  **** The number of hours can be less than 48 hours but it cannot be greater than 48 hours.***

- The Administrator Office 800# must be labeled (e.g., Benefits, eligibility and claim inquiries, call '*Administrator Office Name'*: 800-xxx-xxxx)
- Medical Claim Submission address: Electronic and hardcopy addresses will need to match the approved Claim Flow.

Mailing address for Cigna	Electronic address for Cigna
Cigna HealthCare PO Box 188004 Chattanooga, TN 37422	Cigna Payor 62308.

Optional Fields:

Fund Logo
Employer Name
PCP name and phone number
Union Bug
Fund's Policy Number
Online provider directory web site address ("To access online provider directory, go to cignasharedadministration.com"). Placement can be bottom of back of ID card.

Members are required to present their ID cards at the time of service in order to access the Cigna OAP discount. The OAP provider is not obligated to honor the OAP discount unless the ID card is presented as outlined above.

Exhibit XI: Transparency in Coverage & Consolidated Appropriations Act, 2021

For Cigna Shared Administration-Repricing (SAR) Clients, Consultants, and Plan Administrators

(All information in the section is as of March 2022, and is subject to Change.)

Cigna's Position

At Cigna, we are committed to complying with all applicable laws, rules, and regulations. We are actively preparing for the upcoming requirements as part of the Transparency in Coverage rule and Consolidated Appropriations Act. We understand the implications and have established a rigorous compliance implementation program in connection with these requirements. The rulemaking process is likely to produce additional requirements prior to the scheduled effective dates and/or enforcement dates. We will be evaluating the anticipated rulemaking and will work to address the final requirements as they are issued.

In addition, Cigna understands the impact of the Transparency in Coverage rule and Consolidated Appropriations Act to our clients, and we are providing programs and tools to support you where appropriate.

To keep clients, consultants, and plan administrators informed and up to date on these requirements, this document summarizes information regarding provision requirements, Cigna's actions for SAR clients, client next steps and key dates.

Please contact your Cigna representative with any questions.

No new charges will apply for standard Transparency in Coverage on effective dates through the end of 2022, including delivery/hosting of machine readable files. Charges for 2023 effective dates will be evaluated at a later date.

Detailed Updates by Provision

Machine-Readable File Requirements (MRF)

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans or issuers to publish three separate machine-readable files (1) negotiated rates for all covered items and services between the plan or issuer and in-network providers; (2) historical payments to, and billed charges from, out-of-network providers; and (3) in-network negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level. Per the 8/20 announcement from the Tri-Agencies, the Departments will defer enforcement of the machine-readable files requirements until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file.	Cigna will host the IN Medical file that we provide on the client's behalf and at no cost on cigna.com. If a client does not have their own public website, we will build a website with a link to the cigna.com MRF subpage at no cost to the client. Clients who choose to opt out of our standard offering can download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website. Cigna will not be providing a service to intake MRFs provided by non-Cigna carriers. Cigna will not provide a hosting service for a clients' OON Medical MRF.	As required by Transparency in Coverage, clients who agree to our standard MRF delivery will need to post a link on their public website to where we are hosting their files. Clients who opt out of our standard delivery will need to download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website. We will provide additional information closer to the July 1, 2022 enforcement date.	Enforcement deferred until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file. Cigna will make the files available to download through cignaforemployers.com for SAR clients who opt out of hosting services by June 30, 2022. Hosted files will be posted by June 30, 2022. Cigna will provide system requirements for those clients wishing to host their own files in March 2022.

Cost-Share Liability Estimator Tool Requirements

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans or issuers to have an internet-based, self-service tool and paper(if required) that provides real-time, personalized, out-of-pocket cost information, based on the member's plan for covered items and services furnished by a particular provider	Cigna has allocated significant resources to expand our existing cost estimator tools/paper process and is actively working toward compliance with the self-service tool requirements, effective 2023 and 2024.	No action needed at this time.	For plan years beginning on or after 1/1/2023, plan/issuer must disclose cost-share information for 500 shoppable items and services identified within the rule. For plan years beginning on or after 1/1/2024, all covered items and services must be included in the cost-share tool.

Sections 102 and 105: Medical Billing & Air Ambulance

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans or issuers to cover emergency services without prior authorization at the in-network benefit level, regardless of whether emergency services were rendered in-network or out-of-network. Individuals cannot be required to pay out-of-network cost sharing for certain services provided by an out-of-network provider at an in-network facility, unless the nonparticipating provider gives notice to the individual and the	***Cigna will provide assistance to our clients for compliance with the CAA No Surprises – Surprise Billing requirements by identifying potential NSA claims and providing the plan administrator with the Qualifying Payment Amount (QPA) via the 837 file. The plan administrator will be responsible for validation of NSA eligibility, as well as benefit adjudication as directed in the interim final rules released on 7/1/2021.***	Additional operational detail is included as a separate attachment within this communication.	**Effective upon renewal for plan years on or after 1/1/2022.**

individual consents to out-of-network care.* When determining a member's cost share liability, insurers are required to apply the member's in-network benefits to a Median Contracted Rate meant to represent the typical in-network rate a provider would receive for that service.			

Section 103: Independent Dispute Resolution (IDR)

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to implement an independent dispute resolution process which applies to emergency services rendered out-of-network or non-emergency services rendered by an out-of-network provider at an in-network facility, in a state that does not have an applicable specified state law that provides a method for determining the total amount payable for out-of-network services. After a 30 day negotiation period, if the Insurer and the Provider can't come to an agreement, then either can initiate the IDR process.	***Cigna will provide these services thru MultiPlan to our Out-of-Network Savings Program clients as a standard part of the program.*** ***Cigna will provide these services thru MultiPlan to our NON Out-of-Network Savings Program clients at a fee per claim.***	Clients should plan for identifying key employees who will be able to answer question during negotiation and/or IDR. Non OONSP Clients will have to intake the dispute and enter into system. Will also need designated contacts to answer questions during negotiation and/or IDR..	**Effective upon renewal for plan years on or after 1/1/2022.**

Section 106: Air Ambulance Reporting

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Reporting required for 2022 and 2023 plan years (to be submitted by March 31, 2023 and March 30, 2024, respectively).

Section 107: ID Cards

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to include the following on their plan or insurance IDs issued to enrollees: • Amount of the in-network and out-of-network deductibles Out-of-pocket maximum limitations	Cigna is making enhancements to ID cards to include in-network and out of network deductibles and out-of-pocket maximums for those clients for which ***Cigna performs ID card production services.*** **New Business** - Effective Dates 1/1/22 & After: ID cards will be mailed to members with this new information. **Renewing Business** - Renewal Dates 1/1/22 & After: Updated cards will be printed and mailed on renewal only for a change of benefit, of election, a qualifying life event, or at an individual member's request. Fees will be consistent with the current client agreement. No new fees for standard ID card support are being instituted in conjunction with the CAA. When an ID card is requested to be mailed for a 1/1/22 effective date or later, the ID card will be updated to reflect the additional information.	Contact your account team with any questions regarding your members' ID cards.	**Effective for plan years on or after 1/1/2022.** Pending future rulemaking in 2022, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law. Plans and issuers may design various, but reasonable, methods to comply with the law.

Cigna is also making other changes to its ID card processes, not related to the CAA. PCP information will no longer print or generate a reissued medical ID card. ID cards will not be mass reissued for this change. A myCigna.com activation sticker will be applied to medical ID cards based on the registration status of the customer. If the customer has not registered on myCigna.com, the sticker will be adhered to the card. These went into effect at the October 2021.

Section 110: External Review of Surprise Medical Bills

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Allows for existing external review process to apply to determining whether surprise billing protections are applicable when there is an adverse determination by a health plan.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	**Effective 1/1/2022.**

Section 111: Advanced Explanation of Benefits (AEOB)

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires group health plans or issuers offering individual or group coverage to automatically provide an AEOB upon receiving notification from a provider or facility that a participant or enrollee is scheduled to receive an item or service from a specific provider*.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.

*No later than 1 business day after the plan receives notification from a provider or if the item or service is scheduled at least 10 days in advance, no later than 3 business days after the plan receives the notification (or request).

Section 112: Good Faith Estimate

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health care providers and facilities to verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of Good Faith Estimate whether or not patient has coverage.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.

Section 113: Continuity of Care (COC)

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to provide continued coverage at an in-network cost for patients with complex care needs for up to a 90-day period if a provider changes network status due to: (1) the provider's contractual relationship is terminated; (2) benefits are no longer provided because of a change in the terms of network participation; or (3) a contract between a group health plan and a health insurance issuer is terminated, resulting in a loss of benefits provided under the plan with respect to such provider. The plan or issuer must notify continuing care patients on a timely basis of the termination and their right to elect continued transitional care from the provider. Individuals must also have an opportunity to notify the plan or issuer of their need for transitional care.	To assist our clients with the continuity of care requirements, Cigna will send a provider termination file to the plan administrator on a weekly basis. The provider term file will include the necessary information for provider terminations identified the previous week. Cigna expects that plans will identify their members that meet the CAA COC criteria, notify those members of the provider termination, as well as notification of the member's right to elect continued transitional care from the provider. Cigna expects that the plan will complete the Continuity of Care review and approval. Cigna also expects that the plan will notify Cigna when they receive a claim that is approved for CAA COC, is priced as non-par, and requires a pricing adjustment to the providers previously contracted rate.	Additional operational detail is included as a separate attachment within this communication.	**Effective for plan years on or after 1/1/2022.** The Departments do not intend to issue regulations addressing continuity of care requirements prior to the effective date. Any rulemaking will include a prospective applicability date that provides a reasonable amount of time to comply with new requirements, and plans and issuers are expected to use a good faith, reasonable interpretation of the statute.

Section 114: Cost Comparison Tool

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to offer a price comparison tool for consumers and make information available by phone. The tool (to the extent practicable) must allow an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.	Cigna has allocated significant resources and is actively working toward compliance with the similar Transparency in Coverage cost-estimator tool requirements, effective 2023 and 2024.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022. Enforcement date is expected to be aligned with the 1/1/23 cost-estimator tool requirements outlined in the Transparency in Coverage rule.

Section 116: Provider Directory Information

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. Plans must verify key data elements (name, address, telephone, specialty and digital contact information) every 90 days and have a process to suppress providers from the directory that do not respond. Data element updates must be displayed in the directory within 2 business days of validation. Requires plans to make publicly available and post on website and include on each EOB, information on prohibitions on balance billing,	Provider digital contact fields (email and/or website) will be added to the directory and continue to be populated through the validation/suppression processes beginning in 2022. Surprise billing disclosure will be added to directory. We are assessing the 2 day turnaround requirement to understand impacts to our current processes.	No action needed at this time.	**Effective for plan years on or after 1/1/2022.** Pending future rulemaking in 2022 for some parts of this provision, plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the law.

information related to the applicable state law, the requirements applied and information on contacting applicable State and Federal agencies. Requires health plans to respond to an individual who requests information on a provider's network status through a telephone call within 1 business day, in writing electronically or in print, per individual's request. If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. Health plans must retain communication records related to network status inquiries for two years.			

Section 201: Removing Gag Clauses

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Bans gag clauses in contracts between providers and health plans (includes network or association of providers, third-party administrator, or other service provider offering access to a network of providers) that prevent enrollees, plan sponsors, or referring providers from seeing provider-specific cost and quality data.	Cigna does not standardly enter into any contracts that would prohibit the disclosure of information contemplated by Section 201 of the Consolidated Appropriations Act, 2021 ("CAA"). In fact, Cigna's template contracts include compliance provisions that would render ineffective any language that would be non-compliant with the CAA. Cigna continues to review its nonstandard contracts. Such language, if any is identified, will be removed from the contract as soon as practicable.	No action needed.	Effective 12/27/2020.

Section 202: Broker Compensation Reporting

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires group health brokers and consultants to disclose to plan sponsors all direct and indirect compensation received from insurers and associated with selection of insurance products, benefits administration, wellness services, or other defined broker and consultant services.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	**Effective 12/27/2021.**

Section 203: Parity NQTL

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires that plans perform, and provide to a regulator or participant on request, a comparative analysis for any non-quantitative treatment limitation (NQTL) applied to mental health/substance use disorder (MH/SUD) benefits.	Cigna will be prepared to provide necessary information to SAR clients that is consistent with the information it develops for use in evidencing non-quantitative treatment limitations (NQTLs) compliance as an insurer. Cigna is not in a position to perform client-specific testing for NQTL compliance. The comparative analyses that Cigna shares with clients are those Cigna develops by assessing its group-client book of business and not any specific client.	Clients should plan accordingly. Future inquiries should be sent through your Cigna sales representative.	Effective 2/10/2021.

Section 204: Medical Cost and Drug Spend Reporting

Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, and the Treasury.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Enforcement of compliance expected by 12/27/2022 (for plan years 2020 & 2021) and by 6/1 annually thereafter. Rulemaking expected in 2022