CIGNA RESPONSES TO EXHIBIT B: HPC QUESTIONS FOR WRITTEN TESTIMONY FOR 2014

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

SUMMARY: *See responses below.*

a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

As provided in Cigna's 2013 testimony response, Cigna is committed to achieving the "triple aim of improving health care outcomes, reducing health care costs, and improving patient satisfaction." To achieve this goal, we have made a commitment to moving health care reimbursement away from rewarding doctors and hospitals for volume of services provided to rewarding doctors and hospitals for value in terms of improving health. Part of that commitment is demonstrated by our activities in the accountable care organization area, which we refer to as Collaborative Accountable Care (CAC).

On July 1, 2013, Cigna established its first CAC in western Massachusetts by partnering with Baycare. The partnership will serve more than 17,000 individuals covered by a Cigna health plan who receive care from Baycare's 413 primary care physicians. Cigna will compensate Baycare Health Partners for the medical and care coordination services it provides. Additionally, the medical group may be rewarded through a "pay for value" structure if it meets targets for improving quality and lowering medical costs.

Nationally we continue to move from a volume to value payment/reward strategy with our providers. This includes: small independent practitioners, larger organized primary care and specialty groups, specialists, and hospitals. We have one such arrangement in MA and are actively pursuing more.

b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet its benchmark?

Our roll out strategy will include 2015. As these systems develop and mature we anticipate being able to further define the most cost effective highest quality networks and work to enhance their participation with more patients.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high quality, efficient care delivery.

Summary

As provided in Cigna's 2013 testimony response, fee-for-service remains the primary means of physician reimbursement in the Commonwealth, the reimbursement model referenced in our responses to Question 1 is one of the ways that Cigna is steering the industry away from straight fee-for-service in Massachusetts.

See below response.

a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

As outlined in 1a, and b, we are actively moving to a model that rewards Health Care Providers for high quality more cost effective care. This model covers the entire spectrum of clinicians, primary care, specialty, large and small.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

See above response.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.

SUMMARY: *N/A—Cigna does not have risk contracts in MA.*

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

SUMMARY: *N/A—Cigna does not have risk contracts in MA.*

a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.

SUMMARY: *N/A—Cigna does not have risk contracts in MA.*

a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY: *See attached response in Appendix1*

a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)

ii. units used in counting services (e.g., number of claims, share of allowed expenditures)

iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)

iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and

v. whether patients are attributed retrospectively or prospectively.

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.

SUMMARY:

Cigna's advanced approach to integrated health coverage links people, information, plans, services, and incentives to create a more powerfully connected system of total health support. Our early efforts at connecting members with high-quality, cost-efficient doctors and hospitals that receive rewards for improving outcomes have provided promising results, but we are committed to doing more and achieving better results. Cigna is leveraging the value of health ownership by connecting our network solutions with personal coaching, plan coverage design, and member health participation.

ANSWER:

Our goal is to have the majority of members with high-cost conditions and complex medical needs receiving care from health care professionals who have an incentive relationship with Cigna. Our innovative solutions span the delivery system—from small to large doctor groups, hospital systems, specialist groups, and everything in between. CCC initiatives help health care professionals transition from volume-based reimbursement to value-based reimbursement. As we collaborate, we meet health care professionals wherever they are in the transition, and take them where they need to be to help improve quality, cost, and satisfaction. Our collaborative care reimbursement model is effective in lowering costs, and improving quality and member satisfaction. The highest performing doctor groups have demonstrated a 4-5 percent lower total medical cost trend compared to their market peers.

We have collaborative care arrangements with 105 large doctor groups in 27 states. These initiatives provide care to over 1,100,000 Cigna members, and over 41,000 physicians (over 20,000 primary care physicians and over 20,000 specialists). We have incentive arrangements with over 80 hospitals that promote quality, safety, and efficiency performance, and we continue to expand the number of hospitals with incentive arrangements nationally.

Our high-performance network strategy, Cigna Care Designation, guides members to select doctors in 21 specialties, including primary care, who meet quality and medical cost-efficiency standards. With the Cigna Care Network tiered benefit strategy, health care professionals who achieved Cigna Care Designation are on a less expensive tier for member out-of-pocket costs. Cigna Care designated doctors are more compliant with evidence-based measures of quality, and have shown episode treatment costs on an average of 10 percent less than non-Cigna Care designated doctors. The collaborative care doctor groups that have matured and achieved the necessary standards of high quality and cost-efficiency receive Cigna Care Designation. Collaborative care doctor groups that have the best performance for cost and quality are included in the Cigna Care Network.

Cigna Care Designation is available in 71 markets across the U.S. Cigna Care Network tiered plans are projected to reduce total medical claims by 1-3 percent. (Tiered plans are not currently available in MA.)

LocalPlus is a local network solution designed to guide members to a select network of high-performing health care professionals and facilities in their area, to drive more savings for employers with

employees located in certain geographies. In areas where collaborative care arrangements are available, LocalPlus includes health care professional groups and facilities that participate in collaborative care. The design of LocalPlus means our members have a financial incentive to seek care from doctors and facilities that receive an incentive to deliver better outcomes and are better motivated to improve health. On average, LocalPlus networks lowers costs by 4-15 percent.

Our innovative Centers of Excellence hospital program helps members make more informed health care decisions, providing them with hospital quality data that includes both outcome and cost comparisons for specific procedures via our online directory. In addition, Cigna provides a cost estimator tool for the 200 most common inpatient procedures, which allows members to see their projected costs based on the health care facility they choose.

8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY:

Cigna provides real time pricing for >200 procedures including labs, immunizations, office visits, radiology, outpatient and inpatient procedures with additional procedures to be added. Inpatient procedure costs are calculated based on severity adjusted average length of stay data for the procedure as well as the hospital-specific average cost per day for the procedure. Real time side-by-side medication pricing is available online from 57,000 pharmacies. Our web link allows customers to see cost sharing benefit requirements, including deductibles, OOP expenses and account balances of HSAs, HRAs or FSAs to calculating individual cost-sharing expenses. Cigna has a Provider Cost of Care Estimator online tool that allows contracted providers to create an estimate of a customer's payment responsibility specific to a planned treatment, specific to the customer's medical benefit plan.

Cigna offers cost transparency to our customers via web and mobile app. Additionally, we make a similar tool available to doctors and hospitals in our network, allowing them to run a cost estimate on behalf of their patients to inform them of their likely out of pocket costs prior to rendering service.

Cigna has made substantial investment in transparency tools over the past several years. In 2012. we integrated cost estimates directly into the health care directory on our secure customer website, myCigna. In 2013, we rolled out cost estimates in the myCigna mobile app. In 2015, we will roll out a new version of the directory to our customers. Not only will the new directory provide numerous search and navigation improvements, but it will offer a substantial increase in the number of cost estimates from 200 procedures to over 500.

Cost estimates are based on fee schedule information and an analysis of our own claims data, and are personalized to account for the specific member's plan and benefit information. These estimates are backed by five years of testing and research, with an accuracy rate of within 10 percent of the patient's

cost 90 percent of the time.

As noted in the chart below, Cigna systems track over 3 million member inquiries for all of our interactive offerings: member website, mobile app, provider portal and multipayor sites.

Some of the data requested is not tracked in the collection time, inquiry method and average response time noted in your question.

Health Care Services Price Inquiries			
Year 2014	# of Inquiries via website	# of Inquiries via Telephone/ In-Person	Average Response Time to Inquiries
Q1	*	*	*
Q2	*	*	*
Q3	*	*	*
Total	**3,201,228***	*	*

Note:

*total is for all types of inquiries, not just those received via the website.

*Information is not currently differentiated between website vs. telephone/In-person

*Average response time is not currently tracked

*Total is based on Cigna's book of business for the period Q1-Q3 2014, not just on MA inquiries

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.

SUMMARY:

ANSWER:

The findings of the 2013 Health Care Cost Trends Report are generally consistent with Cigna's experience. Specifically, we agree that growing concentration in provider markets raises concerns. Experience in the marketplace demonstrates that consolidation strengthens provider negotiating power,

which can limit competition and result in higher prices for services without improvement in the quality of care delivered.

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY:

Cigna Behavioral Health (CBH), a subsidiary of Cigna Healthcare, promotes and coordinates integration efforts across our business. Behavioral health integration happens through internal and external interactions on behalf of our customers and the triple aim goals of better health, affordability, and satisfaction. Internally we have joint workflows to better coordinate care for customers with comorbid behavioral health and chronic medical conditions. his include co-case management between medical and behavioral staff with screening in medical case management for depression, anxiety, and substance use disorders as screening in behavioral health case management for any medical conditions that require referral to medical case management. We also include behavioral externally we work with health care professionals to integrate behavioral health services in and through medical settings.

a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.

Cigna Behavioral Health and Cigna Healthcare have a number of internal processes in place to address the needs customers with comorbid conditions. We conduct joint multidiciplinary rounds in which we identify the specific needs of any one patient and find solutions to address both the behavioral and medical illnesses. These rounds occur in a number of specialty areas including transplant and oncology. We also have specific joint rounds for our Medicare and Private Exchange populations and workflows like Medical Integration and Mixed Service Protocol that focus on patients in a medical bed who also have behavioral health needs or require transfer to an inpatient behavioral bed. As part of this workflows we identify behavioral health resources and assist with referrals while the patient is still hospitalized.

Cigna Healthcare also collaborates with health care professionals externally to integrate behavioral health in the primary care setting. A prime example is work with Collaborative Accountable Care (private ACO model) partners. Cigna is actively developing new offerings to improve integration of behavioral health services with input obtained from health care professionals, through a survey and discussion, about their specific needs. Specifically we are developing a catalog of clinical and network services to customize the way we support health care professionals icluding colocation of behavioral health providers, embedded EAP provider, telehealth, dedicated case management support, virtual consultation, and enhancement of the behavioral health network. We belive that integration needs of our healthcare providers is unique and we make an effort to individualize the way we support our network partners.

b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.

N/A

11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.

SUMMARY:

Cigna does not provide financial support or incentives for providers to achieve recognition or accreditation from a national organization as a patient centered medical home (PCMH), or improve performance as a PCMH

ANSWER:

The CAC which is an outcome based payment model similar to the ACO model sits on top of a conceptual PCMH chassis. This means that we expect our CACs to have the same foundational patient centered actions as a PCMH, which are process based actions such as having a patient registry for 3 top diagnoses. We enhance the work a stand-alone practice can do by collaborating with our CAC partners,

***Information**: sharing patient actionable information so the Embedded Care Coordinators (ECC) know:*

- *who is inpatient and can reach out to a customer to facilitate transition of care from inpatient and ER visits,*
- *identify those patients who may benefit from case management so they can review their medical history, contact the patient and assess need*
- *identify high risk patients for outreach and care guidance and management,*
- *Identify patients with care gaps and contact them to meet care needs*
- *And more!!*

***Integration**-*

- *Cigna integrates care via aligned case managers who coordinate patient care with the ECCs and develop plans to optimize outcomes results*
- *the CACs receive a modest care coordination fee and outcomes based payment*

12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY:

The findings of the 2013 Health Care Cost Trends Report are generally consistent with Cigna's experience. Specifically, we agree that growing concentration in provider markets raises concerns. Experience in the marketplace demonstrates that consolidation strengthens provider negotiating power, which can limit competition and result in higher prices for services without improvement in the quality of care delivered.

CIGNA RESPONSES TO EXHIBIT C AGO QUESTIONS FOR WRITTEN TESTIMONY FOR 2014

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

Completed in Attachment AGO Payer Exhibit C-1

2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:

a. **Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)**
b. **Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)**
c. **Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).**
d. **Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)**
e. **Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)**
f. **Membership in a high cost sharing plan by market segment (Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)**

See attached response, in Attachment AGO Payer Exhibit C-2

3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

In our 2013 response, we only reported on information for Cigna Health and Life Insurance Company (CHLIC). In the 2014 response, we are reporting combined data for both CHLIC and Connecticut General Life Insurance Company (CGLIC).

The strategy on migrating our business from Connecticut General Life Insurance Company (CGLIC) to its subsidiary company Cigna Health and Life Insurance Company (CHLIC), was to establish Cigna Health and Life Insurance Company, a company bearing the "CIGNA" brand, as Cigna's flagship company for domestic health care business. Our customers already think of us as Cigna," and now they will see the "Cigna" name on their ID cards, benefit books, etc. This required moving client agreements (i.e., insurance policies and ASO agreements) from CGLIC to CHLIC. As a result of this transition, we have seen an increase/shift in managed care membership from CGLIC to CHLIC between 2011 and 2013. As of 2010, we also exited the HMO market in MA, under Cigna HealthCare of Massachusetts (CHC MA). As agreed upon in discussions with the Department, we are not including any CHC MA data in our responses.

4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

See attached response, in Attachment AGO Payer Exhibit C-4

APPENDIX 1: Additional Response to Exhibit B, Question 6

The following data explains Cigna's attribution methodology.

Alignment:

- Uses 24 months of retrospective medical claim data.
- Is run nationally (customer/patient is only aligned to 1 health care professional)
- Uses 29 Evaluation & Management (E & M) procedure codes:
  Office Visit E&M New & Established (99201 – 99205; 99211 – 99215)

  Office Visit Preventive New & Established (99381 – 99387; 99391 – 99397)

  Office Consult (99241 – 99245)

Step 1 - Alignment to Primary Care Physician
Uses Servicing Provider Specialty for Primary Care (See Table 1)

- **Current 12 months**
  - For the most recent 12 months of claims, select services for the 29 E & M codes and sum by customer and PCP (sort by customer ID, # of visits).
  - Customer is assigned to the PCP with the most visits.
  - If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most visits and the most recent visit.
  -
- **Prior 12 months**
  - For customers NOT aligned for the most recent 12 months (no PCP visit), select services for the 29 E & M codes for the prior 12 months (sort by service date).
  - Customer is assigned to the PCP with the most recent visit.

Step 2 – Alignment to a Nurse Practitioner, Physician Assistant or Ob/Gyn Health Care Professional (if customer is not aligned to a PCP in Step 1)

Uses Servicing Provider Specialty for Nurse Practitioners, Physician Assistants and Ob/Gyns. Nurse Practitioners and Physician Assistants must have a Cigna role code of Primary Care in order to have customers aligned (See Table 2)

- **Current 12 months**
  - For the most recent 12 months of claims, select services for the 29 E & M codes and sum by customer and health care professional with a Nurse Practitioner, Physician Assistant or Ob/Gyn specialty (sort by customer ID, # of visits).
  - Customer is assigned to the health care professional with the most visits.
  - If there is a tie for the number of visits (to multiple health care professionals), assignment is to the one with the most visits and the most recent visit.
  -
- **Prior 12 months**
  - For customers NOT aligned for the most recent 12 months (no Nurse Practitioner, Physician or Ob/Gyn visit), select services for the 29 E & M codes for the prior 12 months (sort by service date).

- Customer is assigned to the health care professional with the most recent visit.

Additional checks:

Distance radius check to compare customer zip code to aligned health care professional zip code
If alignment is to a health care professional with a distance greater than100 miles, customer is aligned using the 'next best' alignment from Step 1 and 2 above. If there is no other service to a health care professional with an appropriate specialty within 100 miles, customer is not aligned.

Customer eligibility in the most recent 12 months

If customer was not active in the most recent 12 months (e.g., customer did not have at least 1 month of eligibility), exclude from alignment.

Changes affecting market/peer group alignment:

Collaborative Accountable Care (CAC) aligned patients/customers and associated utilization and costs will be excluded from market peer group. For historical reports, the CAC aligned patients, utilization and costs are included in the market peer group.

Table 1: Cigna PCP Specialty Codes

Provider Category	Cigna CPF Specialty Code	Specialty
PCP	FP	Family Practice
PCP	XI	Family Practice Staff
PCP	GP	General Practice
PCP	IM	Internal Medicine
PCP	XM	Internal Medicine Staff
PCP	GE	Geriatric Medicine
PCP	GM	Geriatric Medicine Staff
PCP	PD	Pediatrics
PCP	XU	Pediatrics Staff
PCP	AM	Adolescent Medicine

Table 2: Cigna Specialty and Role Codes

Provider Category	Cigna CPF Specialty Code	Specialty	Role Code
Nurse Practitioner	NF	Family Nurse Practitioner	
Nurse Practitioner	NG	Family Nurse Practitioner Primary Care	
Nurse Practitioner	NH	Adult Nurse Practitioner Primary Care	
Nurse Practitioner	NK	Gerontological Nurse Practitioner	
Nurse Practitioner	NS	Nurse Practitioner	P
Nurse Practitioner	NI	Pediatric Nurse Practitioner Primary Care	
Nurse Practitioner	NL	Pediatric Nurse Practitioner	P
Nurse Practitioner	NO	Women's Health Nurse Practitioner	
Physician Assistant	FA	Physician Assistant	P
Ob/Gyn	GY	Gynecology (no OB)	
Ob/Gyn	OB	Obstetrics	
Ob/Gyn	OG	Obstetrics/Gynecology	
Ob/Gyn	XO	Obstetrics/Gynecology Staff	
Ob/Gyn	MI	Midwifery	
Ob/Gyn	MW	Midwifery	

AGO PAYER EXHIBIT C

Exhibit C-1

Exhibit C-2

Copy of
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* Note: C-2 b, d and e are N/A

Exhibit C-4

Copy of
final-ago-payer-ex C-

* Note: CE is Cigna East, which includes plans underwritten on Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company, on the same administration platform. CW is Cigna West, which includes plans underwritten on Cigna Health and Life Insurance Company on a separate administration platform. CBH is Cigna Behavioral Health, our behavioral health administrator.