Cigna Health and Life Insurance Company/
Cigna Healthcare of Indiana, Inc.
Cigna Healthcare of Illinois, Inc. (IN Residents)

Grievance/Appeal Rights

Your Rights and Other Important Information
Your rights:

1. You, your health care professional or your authorized representative can ask for free copies of the documents, guidelines or other information we used to make this decision. Here's how:

   • You or your authorized representative: Call Customer Service at the toll-free number on your ID card or call 1.800.244.6224.
   • Your doctor, hospital or health care professional: Call our Health Services Department at 800.244.6224

2. Your health care professional can call our Health Services Department at 800.244.6224 to discuss this decision with a physician reviewer.

3. If you're still not satisfied, you can ask us to review our decision through the Appeal process.

Request a review:
If you disagree with the coverage decision, you, your authorized representative, or your health care professional on your behalf can start the Grievance process by sending a request within one year of the date of this letter.

Here is how:

1. Write or call us to ask us to review our decision.

2. If you request a review in writing, include the following:

   • A copy of this letter, if possible.
   • Any other information you want us to consider. You may have information we did not have when we made our decision.
   • Mail your request to:

   Cigna Healthcare
   National Appeals Organization
   P.O. Box 188011
   Chattanooga, TN 37422
   Attn: Grievance Coordinator

3. To request a review by phone, call:
   800.244.6224
   OR
   FAX: 877.815.4827

Note: If your health plan is governed by the Employee Retirement Income Security Act (ERISA), you also may have the right to file a lawsuit under section 502(a) of ERISA.

If your coverage is provided under a non-federal governmental plan, instead of contacting EBSA, you may contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

What happens in the Grievance process:

We have a two-level internal grievance process.

Level 1: Resolution of Grievances
• If you file a grievance, a doctor will review your request. This doctor wasn't involved in the first decision.
• We respond to Level 1 appeals as quickly as possible, but usually within 15 calendar days.
• We will respond within 3 business days for step therapy exceptions.
• We'll mail you a letter with the reviewer's decision.

Level 2: Appeals of Grievance Decisions
• If you're still not satisfied with our decision, you may request a Level 2 review.
• An Appeals Committee decides Level 2 reviews. This committee includes a doctor. This doctor:

  o Specializes in the same medical condition, or a similar one, as yours.
  o Was not involved in the earlier decisions.
• We respond to Level 2 appeals as quickly as possible, but usually within 20 business days.
• We will respond within 3 business days for step therapy exceptions.
• We'll mail you a letter with the committee's decision.

Please note: If you're covered under an individual insurance policy, federal law only allows you one internal review.

Expedited grievances

In certain cases we can make a decision more quickly. This is called an expedited grievance. Your grievance may be expedited, if you haven't had the health care service yet and you're in one or both of these situations:

• You believe, or your doctor believes, a delay:

  o Might harm your life, health or ability to regain your full health.
  o Would cause you severe pain that can't be managed without the care or treatment you're requesting.

A doctor will review your request. Our reviewer will work with your doctor to decide if we should expedite your grievance. If so, we'll respond within one (1) business day for step therapy exceptions and otherwise within 48 hours of when we receive all of the information we need for our review. Expedited requests should be faxed to the number above. Write "EXPEDITED" on it. If you call or write us, let us know this is an expedited request.

If you would like the Indiana Department of Insurance to review this matter, you can contact their consumer division at the Public Service Division, Indiana Department of Insurance, 311 West Washington, Suite 300, Indianapolis, Indiana, 46204 or by telephone at (800) 622-4461.

Independent external reviews

If you're not satisfied with our final decision, you may be able to ask for an independent, external organization to review it. This depends on the type of request, your plan and any state or federal requirements. External reviews may also be expedited. In urgent cases, an expedited external review can be done at the same time as our expedited internal review.

Help may also be available from the consumer assistance or ombudsman program(s) at:

Indiana Department of Insurance
311 W. Washington Street, Suite 300
Indianapolis, IN 46204
(800) 622-4461
Email: idoi@idoi.in.gov
http://www.in.gov/idoi/3008.htm

Review your plan to see what it does and doesn't cover.

For more information about your appeal rights:

For questions about your appeal rights or for help requesting an appeal, call the Employee Benefits Security Administration at 1.866.444.EBSA (3272) or visit askebsa.dol.gov.

Additional Information related to the Affordable Care Act

If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to cigna.com, click on the Terms of Use link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs". If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.