KNOW BEFORE YOU GO
Understanding Your Cigna Benefits and the Appeal Process

At Cigna, we're more than just an insurance company. We're your wellness partner. Whether your goal is to stay well, improve your health, learn ways to better manage your health and health spending, or all of these we're here to help. In fact, we're here for you 24 hours a day, seven days a week. Call us anytime at **800.Cigna24** (800.244.6224).

Know Before You Go

Cigna wants you to be satisfied with your health care plan. That's why we have a process to address your concerns and complaints and an appeal process* to request review of coverage decisions. To make the most out of your Cigna benefits, you need to understand how they work. This will prevent any unnecessary surprises.

Below are some steps you can take to help make sure you get the most out of your plan:

1) Confirm that your doctors, hospitals, equipment suppliers, etc., are Cigna in-network (participating) providers. Simply visit myCigna.com or call us. We'll be happy to help. Remember that you'll save money when you stay in-network.

2) Cigna developed a health care professional directory on myCigna.com that combined cost and quality into nearly every basic search. You can view cost estimates for a wide range of procedures and even look at cost breakdowns and how benefits would be applied.

3) Read the exclusions and limitations in your plan materials. This information explains what your benefits cover. It's important to know what your plan covers before receiving treatment.

4) Review the Schedule of Benefits[1] in your plan materials. It has details on your copays, coinsurance[2], deductibles[3], etc.

What Is An Appeal?

Sometimes you may want to question a coverage decision. For example, if we deny payment on a claim you may want to ask us to reconsider the decision. We call this an appeal. There are two types of appeals: first-level appeals and second level appeals. You always start with a first-level appeal. Both are done inside within Cigna.

Asking for an appeal is easy.

To start, put in writing the decision you'd like us to look at. Include all the important information about the decision. This may include a claim number, a date of service and a doctor's name. Explain why you'd like us to think about our decision. Then, call Cigna Customer Service. Let them know you'd like to file an appeal. They'll give you the address to send your appeal to.

Once we get your appeal, we'll review it. The person looking at your appeal will be someone who wasn't involved in the first decision. This means that a new person will look at your request. He/she will make a decision on your appeal using the terms of your Cigna benefit plan. If necessary, a medical doctor will also look at your appeal. This happens if your appeal involves a decision about whether a service is medically necessary.

The specific appeal process that applies to you is determined by the coverage plan your employer selected. It follows state and/or federal rules that apply to that type of plan.

Offered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company.

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* If you are covered under an insurance policy, we will address your concerns, complaints and appeals according to state rules. Those rules may differ from our national process.
1. A summary of the covered services included in your medical plan.
2. The amount you pay before your insurance begins.
3. The amount you pay before the insurance starts to pay.

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What Happens After I File an Appeal

We'll send you a letter with our decision. It takes between 10 and 30 days for us to complete an appeal.

If you don't agree with our decision, you can file another appeal. We call this a second-level appeal. The process is the same as you followed before. Be sure to include any important information you want us to look at.

If your appeal involves a decision about whether a service is medically necessary, a committee will look at your appeal this time. The committee includes at least three people. They are a doctor, a nurse and a non-clinical person (meaning the person is not a doctor or nurse). None of these committee members will have been involved in your first-level appeal. They will be looking at your appeal for the first time.

We'll let you know when the committee will meet. That way, either you or someone on your behalf can take part in the meeting by phone. You can also send an additional letter.

If your appeal doesn't involve a medical necessity review, then it will be reviewed be a new person. This person wasn't involved in the first-level review.

External Review Option

An External Review happens after you've filed both a first-level and second-level appeal. If you're not satisfied with our decision, you may be able to ask for an external review. This means that someone outside of Cigna will look at your request and make a decision. Your ability to file an External Review depends on your plan and any state or federal requirements. If an external review is available to you, your final internal appeal decision letter will include instructions on how to ask for this review.

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