Voluntary mediation

If you have received an appeal decision from us that you are not satisfied with, you may also request voluntary mediation with us before exercising your right to submit a grievance to the DMHC or participate in the IMR process. In order for mediation to take place, we must voluntarily agree to the mediation. We will consider each request for mediation on a case-by-case basis. Each side will share the expenses of the mediation equally. To initiate mediation, please submit a written request to the address listed in this brochure.

Mandatory binding arbitration

To the extent permitted by law, we contractually require the use of binding arbitration when disputes are left unsettled by other means. Arbitration may be initiated by a Demand to Arbitrate served on Cigna HealthCare of California, Inc. Binding arbitration is not mandatory for disputes concerning coverage plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). If your plan is governed by ERISA you have the right to bring civil action under Section 502(a) if you are not satisfied with the outcome of the appeal procedure. In most instances, you may not initiate a legal action until you have completed our internal appeal process.

For more specific information regarding these grievance procedures, please refer to your Group Service Agreement or contact our Customer Service Department.

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YOUR RIGHTS FOR COMPLAINTS AND APPEALS

California

Together, all the way.®

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YOUR RIGHTS FOR COMPLAINTS AND APPEALS

Your rights to file grievances with Cigna HealthCare of California ("Cigna").

We want you to be satisfied with the care you receive. That's why we've established an internal grievance process for addressing your concerns and resolving your problems.

Grievances include both complaints and appeals. Complaints can include concerns about people, quality of service, quality of care, benefit exclusions or eligibility.

Appeals are requests to reverse a prior denial or modified decision about your care.

How to file a grievance

By phone: Call us toll-free at **800.Cigna24 or the number on your ID card**. Hearing impaired or TTY users dial 711 to reach the California relay service and provide the operator with the phone number on your ID card.

By mail: For medical services send written grievances to:

Cigna
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422

Or services for Mental Health/Substance Use Disorders send written grievances to:

Evernorth Behavioral Health
Central Appeals Unit
PO Box 188064
Chattanooga, TN 37422

Or services for Dental send written grievances to:

Cigna Dental Health of California, Inc.
PO Box 188047
Chattanooga, TN 37422-8047

We will provide you with a grievance form upon request, but you are not required to use the form to make a written grievance.

Online: You can download a grievance form or submit an online grievance through our website: **Cigna.com/Cigna-ca** (click on the Member Grievance and Appeals tab).

In person: During normal business hours, we will assist you in submitting your grievance at the following address.

400 N. Brand Boulevard, Suite 400
Glendale, CA 91203

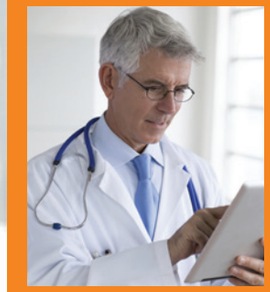
If the member is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative or other legal representative acting on behalf of the member, as appropriate, may submit a grievance to us or the California Department of Managed Health Care (DMHC or "Department"), as the agent of the member. Also, a participating provider, or any other person you identify, may join with or assist you or your agent in submitting a grievance to us or the DMHC.

A. Complaints

If you are concerned about the quality of service or care you have received, benefit exclusion, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you call us to file a complaint, we will attempt to document and/or resolve your complaint over the phone. If we are unable to resolve your complaint the day your call is received, or if we receive your complaint in the mail, we will send you a letter confirming that we received the complaint within five calendar days. This letter will tell you whom to contact if you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within 30 calendar days.

B. Appeals

If you are not satisfied with the outcome of a decision about your care and are requesting that we reverse a previous decision, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may support a reversal of the original decision. Within five calendar days after we receive your appeal, we will confirm with you in writing that we received it. The letter will tell you whom to contact if you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who has authority to take action. We will investigate your appeal and notify you of our decision within 30 calendar days after we receive your appeal. You may request that the appeal process be expedited, if the time frames under this process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum functionality, or if you are experiencing severe pain. A licensed doctor or health care professional, in consultation with your treating doctor, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond verbally and in writing with a decision within 72 hours.



You have additional rights under state law, including voluntary binding independent medical review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800.244.6224** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(888.466.2219)** and a TDD line **(877.688.9891)** for the hearing and speech impaired. The department's internet website **dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.