Commitment to quality

Convenient, supportive, responsive and satisfying health services

Commitment to quality[1]

Focusing on quality to improve health

We believe quality is vital to protecting and improving your health and well-being. That's why we're committed to:

- Giving you convenient access to quality health care providers.
- Supporting you and your provider to help you stay healthy.
- Supporting your return to health if you become **physically** or **emotionally** ill.
- Making sure you're satisfied with our services.
- Giving responsive customer service.

With the help of **quality management committees**, we maintain standards for service and quality medical and behavioral care from network providers. The committees involve providers in our network. They meet to talk about how health care trends affect network provider services. They then recommend ways we can improve those services.

Here are some systems we have in place to help you get quality services.

Access to quality providers

We check the quality of independent providers in our network. We review each candidate's credentials and history before we decide whether to add that provider to our network. We reevaluate providers' credentials every three years to be sure **they still qualify for participation**.

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cigna healthcare

Finding health care solutions

At Cigna Healthcare®, we want to help you be your healthiest—both body and mind. We offer programs and services to help make that simpler. With **myCigna.com®** and the my**Cigna® App**, you get provider directories and tools to help you get the most from your health plan.

Our directories have information on in-network medical and behavioral providers. Find names, addresses, phone numbers, professional qualifications and specialties. Know which providers are in your network and how to reach medical or behavioral services before you need them.

Log in to **myCigna**[2] to view your benefits and coverage, including copays, or to manage, track and check the status of your claims. You can estimate medical costs and compare hospitals and doctors. You can review your pharmacy coverage and expenses, compare prescription medication costs, and sign up for refills. You can also do this over the phone.

Need emergency care right away? Go straight to any emergency facility or call 911. Emergencies exist when you or your provider feels medical or behavioral treatment is needed to stop serious harm to yourself or others. They may involve major accidents or illnesses, uncontrolled bleeding, seizure, loss of consciousness, or chest pain or shortness of breath, among other things.

Need after-hours care and not sure what to do? Call your provider or an on-call provider for advice or urgent treatment. You can also call our 24-hour Health Information Line (HIL). Or call the number on your ID card to speak with a clinician or behavioral health coach.

Need urgent care or prompt attention? Call your personal provider. Ask to be seen within 24 to 48 hours. Or visit an urgent care center or convenience care clinic for symptomatic illnesses and infections.

Need symptomatic regular and routine care? Plan a visit so you're seen within 7 to 14 days. Or plan a visit within the time frame your treating provider names.

Need preventive screenings and a physical? Plan a visit so you're seen within 30 days.

Need help with a specific condition? Join a health management program to get help taking care of your condition from a case manager. You can also learn how to reach your health goals with online coaching.

Need a virtual appointment? With medical and behavioral virtual care, you and your eligible family members can connect with providers. These may be board-certified doctors, pediatricians, nurse practitioners, and licensed therapists or psychiatrists. Connect without leaving your home, work or wherever you may be. Based on your plan and location, eligible Cigna Healthcare customers can connect 24/7/365 using a phone, tablet or computer.

Helping you stay healthy

We pay attention to how well providers in our network meet your preventive care needs. We collect data from network providers to find out if customers are taking advantage of covered preventive care. We regularly give you information about our wellness screenings and preventive care programs.

For those who need behavioral care, we provide coordinated services with continuity between providers and settings.

Making sure you're satisfied

One way we offer quality customer service is to make sure you can share feedback. Here are two ways we ask for your views.

- Several times a year we randomly survey customers and providers to ask how we're doing. We use this information to help us improve our services.
- Our customer service representatives are on hand to answer your questions. They can also address your concerns, complaints or suggestions. Just call the number on your ID card.

Responsive customer service

We need to hear from you. But you also need to hear from us. Here are just a few ways we give information about how your health plan works.

- Our websites have resources and tools, such as provider directories, to help you get the most from your plan.
- We offer an interactive voice response system 24/7/365. For more-complex issues, call center staff are on hand to help.
- We can send your call to a clinician on the HIL for medical assistance. Or we can send your call to a behavioral health advocate for behavioral health support.
- You can ask customer service for help getting or giving written or spoken information in your preferred language. Cigna Healthcare also uses TDD/TTY-type services to communicate with customers with hearing loss.

Patient safety resources

Cigna Healthcare encourages practices to help ensure your safety as a patient. We offer tools and services to help you make smart, safe health choices.

- Our Well Informed program alerts you and your provider to possible dangerous gaps in care. These may be missed preventive care screenings or delays in filling your prescriptions.
- You can find quality information and cost-efficiency ratings on hospital care using our online provider directory. You can also find in-network providers. In addition, myCigna compares network provider quality information and cost-efficiency ratings. It shows which hospitals are deemed "Centers of Excellence."
- As we improve and align with new technology, your options related to the online health assessment are growing. The health assessment shows top risk factors that could hurt your health. It can direct you to resources and support to help you reduce these risks. We have online options in English or Spanish.
- Our behavioral website offers an assessment to help you know when you may need behavioral care.

We encourage you to follow these **"SPEAK UP"** steps. The Joint Commission offers these reminders to help you be an active participant in your health care.

S Speak up if you have questions or concerns; don't wait to talk with your provider.

P Pay attention to the care you're getting.

E Educate yourself about your diagnosis, tests and care plan.

A Ask a family member or friend to be your health care advocate.

K Know the medications you take and why you take them.

U Use a health care organization that has undergone a rigorous onsite evaluation by an independent accrediting agency.

P Participate in all decisions about your treatment.

Quality outcomes measurement

Cigna Healthcare measures the effectiveness of our programs in many ways.

- External approval of our medical and behavioral quality programs through ongoing accreditation by the **National Committee for Quality Assurance®** (NCQA®). This not-for-profit measures the quality of America's health care. NCQA accreditation includes these programs and services:
  - Chronic condition management
  - Medical and behavioral screening
  - Care coordination
- Accreditation by **Utilization Review Accreditation Commission** (URAC®). This independent not-for-profit works to ensure consistent quality of care for our medical case management, utilization management and pharmacy benefit management programs.
- Utilization of the NCQA **Healthcare Effectiveness Data and Information Set** (HEDIS®).[3] More than 90% of U.S. health plans measure care and service performance using this tool. It compares health outcomes with industry standards the NCQA established. The tool also helps find opportunities for quality improvement.
- Engagement in the Centers for Medicare & Medicaid Services (CMS) Quality Rating System (QRS) process for our Exchange customers. We measure this through QRS clinical measure data and a Qualified Health Plan enrollee survey. *(See more information on the next page.)*

- Measurement of our medical customers' satisfaction. We do this yearly using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] survey. CAHPS, a public/private initiative, builds standardized surveys to measure customers' experiences with outpatient and facility-level care.
- Implementation of actions to help improve the customer experience.
- Evaluation of customer experience with behavioral care and services. A yearly survey helps us find opportunities for improvement.

HEDIS/QRS – measurements of clinical success

Cigna Healthcare uses HEDIS/QRS clinical metrics to measure clinical interventions results. Each year, we measure and report clinical effectiveness for our medical plans. We send the results to NCQA/CMS to include in national benchmark data. Our results show our success in supporting quality care for our customers.

With your help, we've seen a rise in preventive care screenings and provider follow-ups in recent years.

Quality program staff pursue clinical and health equity initiatives. They do this to improve customers' health, well-being and sense of security. Health equity initiatives promote interventions for food, housing and transportation. Other clinical and health equity initiatives include but aren't limited to:

- Diabetes
- Asthma and hypertension management
- Breast, cervical and colon cancer screenings
- Adult, adolescent, childhood and prenatal immunizations
- Depression
- Alcohol and other drug use

We promote preventive care through phone and email outreach, web and social media campaigns, and mailings. We reach out to people who may not have had recommended screenings, vaccines or follow-ups. We also partner with providers, community groups and select employers to offer education.

CAHPS – medical customer satisfaction measurements of success

Cigna Healthcare is committed to quality service. We participate in the Member Satisfaction Survey to get your feedback on how we're doing. This yearly survey measures performance in key care and service delivery areas.

Cigna Healthcare works to keep up and improve results each year by acting on feedback. We've made information on **myCigna** simpler to get, understand and use. The enhanced website is more modular: It breaks down information into smaller parts. This gives users a more holistic view of their coverage, as well as products and services. Each module provides a quick summary of the most vital facts about that coverage or product.

Cigna Healthcare offers annual wellness screenings as part of our virtual care choices through MDLIVE by Evernorth®.[5] During virtual visits, you can talk about your health concerns. You can review family history and lab results and create an action plan for medical and behavioral care. MDLIVE E-Treatment is a convenient option for common, everyday conditions when you don't want or have time to talk live with a doctor or don't feel well enough to jump on a call or video chat. We also offer Cigna One Guide®, a personalized digital and phone service. It helps you reach your health goals. It also helps you save money and stay healthy by removing barriers. You can gain confidence through active education and guidance.

You told us you want greater access to care and service. Our call centers are now open 24 hours a day, seven days a week. Additionally, you can get answers right away in both English and Spanish, customized to your health plan benefits, on **myCigna.com** and the **myCigna App**. And we are working to build our network of qualified providers and convenience care clinics so you can get care quickly.

Rating questions

Rating of personal doctor (QI8)

Rating of specialist seen most often (Q22)

Rating of all health care (Q8)

Rating of health plan (Q3I)

Composite measures

Getting needed care

Getting care quickly

How well doctors communicate

Customer service

Claims processing

Care coordination

To learn more about our Quality Management Program or request a report on progress toward goals, call customer service at the number on your ID card.

Health management programs

Our health management programs offer useful, confidential support for you and your covered family members. These programs include medical and behavioral case management as well as chronic condition support and lifestyle management. The programs can help you manage specific medical, behavioral or wellness conditions. Educational materials help you learn about your condition. This helps you make educated decisions about treatment options and ways to reach your goals. We share information with your provider when appropriate.

How it works

Our health management programs have services to help you understand and manage your condition. We work with you to create a plan that helps you reach your health goals. We do this through one-on-one coaching and online self-guided support tools. You choose a path that's right for you.

Personal interventions and coaching

You have access to the Personal Health Team. This team specializes in your condition to help you:

- Recognize worsening symptoms and when to see your provider.
- Establish questions to ask your provider.
- Know why you should follow your provider's orders.
- Build healthy habits for alcohol, nutrition, sleep, exercise, weight, tobacco and stress, as well as preventive and emotional health.
- Make educated decisions about treatment and follow your provider's directions and treatment plan.

You can take charge of your health using online tools. Self-service tools help you understand your condition, make more-informed treatment decisions and work toward personal goals. To learn more about these online tools, visit **myCigna** and select the Wellness tab.

Fast and accurate identification

To see if you're eligible for health management programs, Cigna Healthcare uses a range of information, such as medical and pharmacy claims and health assessment results. We review the information regularly in case your health status changes. If we find you have a health condition, we will share program information by phone call, letter or flyer. We may invite you to use a personalized online program or connect with a coach or case manager one-on-one. You may call us to self-enroll. Your authorized representative or provider may also send you to the program. Or we may get a referral from one of our medical management

programs or your discharge planner. Of course, you can choose not to take our help. If you don't want any more phone calls from Cigna Healthcare, ask the caller to remove you from the list. Or you may call customer service using the number on your ID card.

To make sure you have the confidential support you need, **we offer toll-free access to clinical coaches** Monday through Friday. They're available at least 12 hours a day to speak with you one-on-one. Please note that operating hours may differ based on your individual program. For more on programs and resources, visit **myCigna** and select the Wellness tab.

If you need **help after hours**, we offer the HIL support program. You can get clinician support 24 hours a day, seven days a week.

For emergency care, immediately call 911.

For a nonemergency, call the number on your ID card. For additional or self-service resources, go to your personalized customer website.

How your provider gets paid

The Cigna Healthcare provider network includes physicians/ practitioners, hospitals and ancillary service providers, such as ambulatory surgical centers or urgent care centers. Cigna Healthcare compensates our network of providers in ways intended to motivate them to:

- Practice preventive care.
- Promote quality care.
- Provide medically necessary care.
- Ensure appropriate and cost-effective use of covered medical services and supplies.

Compensation may also include additional payments to providers based on their performance in these same areas. We may also promote use of certain network providers based on their quality of care and cost-effective measures.

Cigna Healthcare does not offer incentives to encourage providers to limit the use of health care services, nor do we reward our medical directors for issuing denials of coverage for care. We weigh providers' quality of care, quality of service and appropriate use of medical services before giving bonuses or incentives.

We reinforce this philosophy through decisions made by our medical directors and clinical staff. These decisions encourage the appropriate use of covered health care services.

Here we name the ways providers in our network agree to be paid. How they're paid varies based on the provider type (physician/practitioner, hospital or ancillary service provider). The amount and type of compensation may also differ based on the type of coverage plan (HMO, PPO and so on).

- **Discounted fee-for-service:** This payment method applies to all provider types:
  - Physicians/practitioners
  - Hospitals
  - Ancillary service providers (e.g., ambulatory surgical centers, physical therapy, urgent care centers)

Payment is based on a discounted fee schedule compared with the usual amount the provider bills for services.

- **Capitation:** This payment method generally applies to physicians or various types of practitioner groups. Physicians or practitioner groups are paid a fixed amount (capitation) at regular intervals for each Cigna Healthcare customer who selects them as their primary care provider. These fixed payments generally cover all services by that provider, with no additional payments made. Capitation offers predictable income. It encourages health care practitioners to keep people well through preventive care. It also removes the financial incentive to provide services that will not benefit the patient.

  Providers paid on a capitation basis may take part in a risk-sharing arrangement with Cigna Healthcare. That means they agree on a target amount for the cost of certain services. Then, they may get a bonus or penalty if actual costs are under or over the target. We track all capitated services using measures that may include the following:
  - Patient access to care
  - Quality of care
  - Satisfaction
  - Appropriate and cost-effective use of medical services and supplies

We also work with separate, third-party administrative entities to administer payments to providers in our networks. Under these arrangements, we may pay the third party a fixed monthly amount per customer for these services. The third party then pays providers for services from that fixed amount.

- **Salary:** This payment method applies to "employed" providers of all types.

In some limited areas, Cigna Healthcare–owned medical groups or affiliates employ providers who are paid a salary for their services. These providers may be eligible for year-end bonuses. These bonuses are based on performance in areas such as quality of care, quality of service, and appropriate and cost-effective use of medical services and supplies.

- **Per diem:** This payment method applies to hospitals and similar facilities.

A specific amount is paid to the hospital each day ("per diem") for all health care received on that day. The per diem payment varies based on several factors. These may include type of service or length of stay. The resulting payment, in some cases, could be greater than the hospital's actual billed charges. Our contracts typically contain a clause that limits the amount paid to the lesser of the billed charges or the contract rate.

- **Case rate:** This payment applies to hospitals and certain ancillary services (e.g., ambulatory surgical centers). It applies to the lesser of the billed charges.

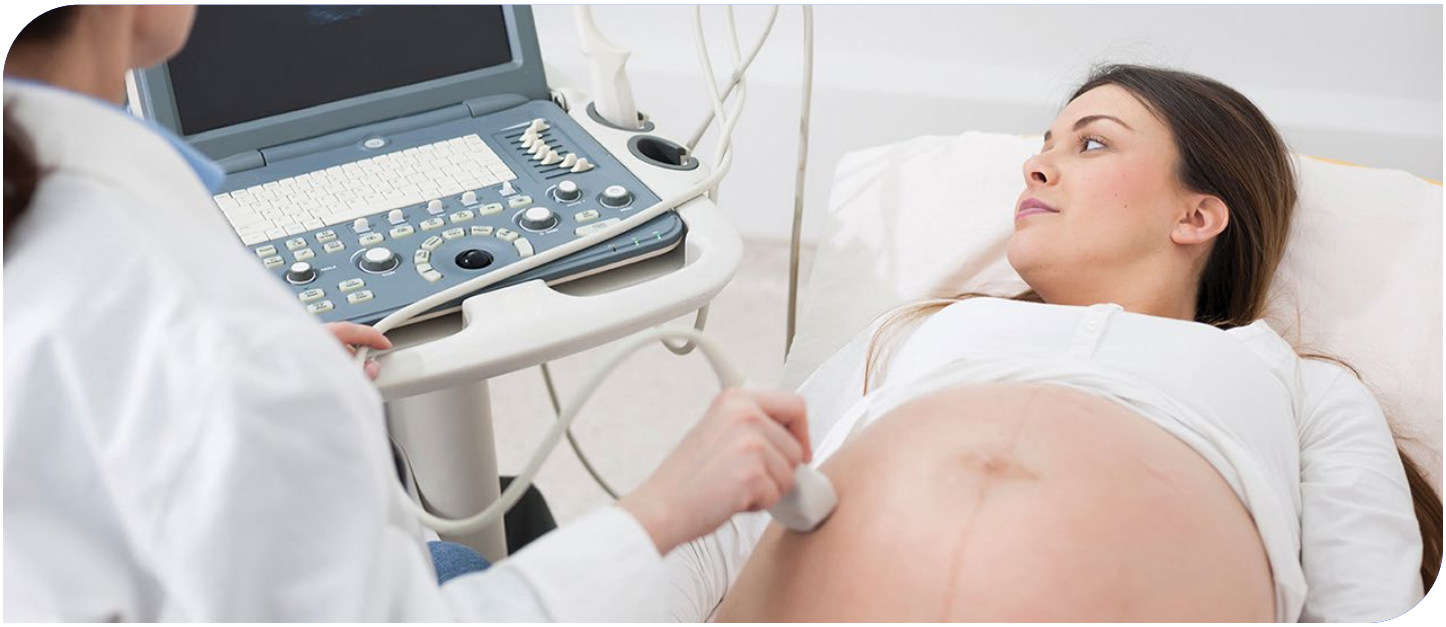
A specific amount is paid for all health care received based on a given period (length of stay) or the procedure/service provided (e.g., an appendectomy or maternity delivery).

- **Bonuses and incentives:** This method can apply to all provider types:
  - Physicians/practitioners
  - Hospitals
  - Ancillary services (e.g., ambulatory surgical centers, physical therapy, urgent care centers)

Some providers may get additional payments based on their performance in certain areas. These may include practicing preventive care, promoting quality care, providing medically necessary care, and ensuring appropriate and cost-effective use of covered medical services and supplies. Providers may also get financial and/or nonfinancial incentives to promote their use of referrals to other high-quality, cost-effective providers in our network, such as certain hospitals, labs, specialists and vendors.

This is an overview of the most common forms of provider compensation. It's not meant to be all-inclusive. As health care evolves, compensation methods may be changed to drive further improvement in quality, affordability and patient satisfaction.

You may have questions about which compensation method applies to services you get from a practitioner, a hospital or an ancillary provider. Please ask the provider or the provider's staff. Cigna Healthcare cannot discuss specific provider contract details. If you have questions about your coverage, including your copays and/or coinsurance obligations, call customer service at the number on your ID card.



Utilization management – How Cigna Healthcare makes coverage decisions

Utilization management (UM) includes the evaluation of coverage of health care services based on the following:

- Terms of your benefit plan
- Medical appropriateness of health care services
- Procedures and the places where you get care

This evaluation uses established evidence-based criteria and/or standard guidelines.

Cigna Healthcare requires prior authorization (prior approval) for a limited number of health care services, medications or procedures before they're delivered. Services that need a provider to ask for prior authorization of coverage include:

- Nonemergency hospital and other facility admissions.
- Services for which coverage is limited or may be excluded by your benefit plan. This is done to make sure you know your potential out-of-pocket costs (costs that your plan doesn't cover and that you're responsible for) in advance.
- A limited number of outpatient services and medications.

Services that need prior authorization may differ, based on your benefit plan. Check your coverage materials for your plan's prior authorization requirements. Or ask your provider or call Cigna Healthcare customer service.

Your provider can ask for prior authorization of coverage by phone, fax or online submission. When we get the request, we may ask for more information about your condition and the treatment planned. This is to determine if your health plan covers the services or to identify coverage your treating provider may not be aware of. Check with your treating provider before getting services to see if prior authorization is required and, if so, if an authorization is in place.

When making a coverage decision, our medical and/or behavioral clinicians will weigh not only evidence-based guidelines and the terms of your benefit plan but also your unique clinical circumstances. They will use our publicly posted medical, behavioral and pharmacy coverage policies. They will also use resources such as independent UM guidelines.

Your health plan may not cover some services, based on your specific benefit plan requirements and exclusions. If you get non-covered services, you may be billed directly for the full cost. Check your coverage materials for more information.

UM decisions are based on the existence of an available benefit and then, if it is available, on the medical necessity for that service. Cigna Healthcare uses a physician—or a behavioral health care practitioner or pharmacist, as appropriate—to make coverage decisions that require medical judgment. We do not reward the medical directors or other individuals involved in coverage determinations for denials of coverage. There are no financial incentives for UM decision-makers for any determination.

If you have questions, call customer service at the number on your ID card.

Cigna Healthcare Customers' Rights and Responsibilities Statement

Rights

You have the right to:

- **Get coverage for the benefits and treatments** available under your health benefit plan when you need it, in a way that respects your privacy and dignity.
- **Get information** about how to access websites or customer service via toll free telephone and fax numbers.
- **Get language interpretation** and TTY services upon request.
- **Get clear, understandable information you need** about your health benefit plan. This includes which services are covered and not covered and any costs that you'll be responsible for paying.
- **Get clear, understandable information** about Cigna Healthcare programs and services. This includes qualifications of staff that support wellness and similar programs and any contractual relationships linked to programs.
- **Have access to current information** on in-network providers, places you can get care, and providers' education, training, and practice.
- **Select a primary care provider** for yourself and each covered family member. Be able to change your primary care provider for any reason. Please note, many benefit plans do not require that you select a primary care provider.
- **Have your personal identifiable data and medical information kept confidential** by Cigna Healthcare and your provider. Know who has access to your information. Know the procedures used to ensure security, privacy and confidentiality. Cigna Healthcare honors the confidentiality of our customers' information. We adhere to all federal and state regulations about confidentiality and the release of personal health information.
- **Participate** with your provider in health decisions. Have your provider inform you about your condition and treatment options, regardless of coverage or cost. You have the right to get this information in terms and language you understand.
- **Learn** about any care you get. You should be asked for your consent for all care, unless there's an emergency and your life and health are in danger.
- **Refuse medical or behavioral care.** If you refuse care, your provider should tell you what might happen. We urge you to talk about your care concerns with your provider. Your provider will give you advice, but you will have the final decision.
- **Be advised** who can assist you with any special Cigna Healthcare programs or services. Also know who can help you change or disenroll from programs or services.
- **Be heard.** Our process for handling complaints is designed to hear and act on your complaint or concern. It may be about Cigna Healthcare and/or the quality of care from providers and the places you get care in our network. We intend to give you courteous, prompt answers. We also want to guide you through our grievance process if you do not agree with our decision. We strive to resolve your complaint on first contact, in a way that's consistent with your applicable benefit plan. Language interpretation and TTY services are available for complaint and appeal processes.
- **Be treated with respect** and with recognition of your dignity and right to privacy.
- **Know and make recommendations** about our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call customer service at the number on your ID card.
- **Ask for and get information** about how to appeal a UM decision.
- **Get UM determinations** from quality professionals who do not get financial incentives based on these decisions.

Responsibilities

You have the responsibility to:

- **Review and understand** the information you get about your health benefit plan. Please call customer service when you have questions or concerns.
- **Understand** how to get services and supplies covered under your plan using the number on your ID card or Cigna Healthcare online resources. These services and supplies include any emergency services needed outside of normal business hours or when you're away from your usual place of residence or work.
- **Show** your ID card before you get care.
- **Schedule** a new patient appointment with any in-network provider. Build a relationship with your provider. Ask questions about things you don't understand. Follow your provider's advice.

  You should understand your health condition may not improve and may even get worse if you don't follow your provider's advice.
- **Understand** your health condition and work with your provider to develop treatment goals you both agree on. Follow the treatment plan and instructions.
- **Provide** honest, complete information to us and the providers caring for you.
- **Take part in** programs offered to you.
- **Know** what medicine you take. Know why and how to take it.
- **Pay** all copays, deductibles and coinsurance for which you're responsible at the time service is rendered or when they're due.
- **Keep** scheduled appointments. Or notify the provider's office ahead of time if you're going to be late or miss an appointment.
- **Pay** all charges for missed appointments and for services not covered by your plan.
- **Voice** your opinions, concerns or complaints to Cigna Healthcare customer service and/or your provider.
- **Tell** your plan administrator and treating provider as soon as possible about any changes in family size, address, phone number or status with your health benefit plan or if you decide to disenroll from Cigna Healthcare programs and services.

Know how to voice your concerns or complaints

Cigna Healthcare wants you to be satisfied with your health benefit plan and the services and programs we provide. That's why we have a process[6] to address your concerns and complaints.

- You can submit your complaint by letter or fax, or you can call the number on your ID card.
- Your complaint will be acknowledged and handled on first contact or investigated based on the type of issue reported.
- In most situations involving quality-of-care concerns, we will be unable to disclose the final resolution because of confidentiality issues.

Customer service help with complaints or appeals

If you have questions or concerns about coverage or claim payments, call customer service at the number on your ID card. If customer service cannot solve your concern, ask for more information about how to have your concerns dealt with. Take these steps to help ensure you get the most coverage under your plan and possibly avoid the need to appeal:

- **Make sure** your providers are in-network. Do this by visiting your personalized website or calling customer service. If your plan covers out-of-network services, know your costs will likely be higher than if you choose in-network services.
- **Read the exclusions and limitations** in your plan materials to make sure services are covered before getting treatment.
- **Review the Schedule of Coverage** in your plan materials for details such as copays, coinsurance or deductibles.

How to ask for an appeal of a coverage decision

The specific appeal process that applies to you is determined by the health plan you or your employer has chosen. Your appeal process will follow state and/or federal rules that apply to that type of plan. To learn more about the appeal process available to you, refer to your coverage materials or call customer service.

To start the appeal process, send your request to the address shown in the notice of adverse determination, included in your coverage materials or provided by customer service. State why you believe the decision should be reviewed again and include any supporting documentation.

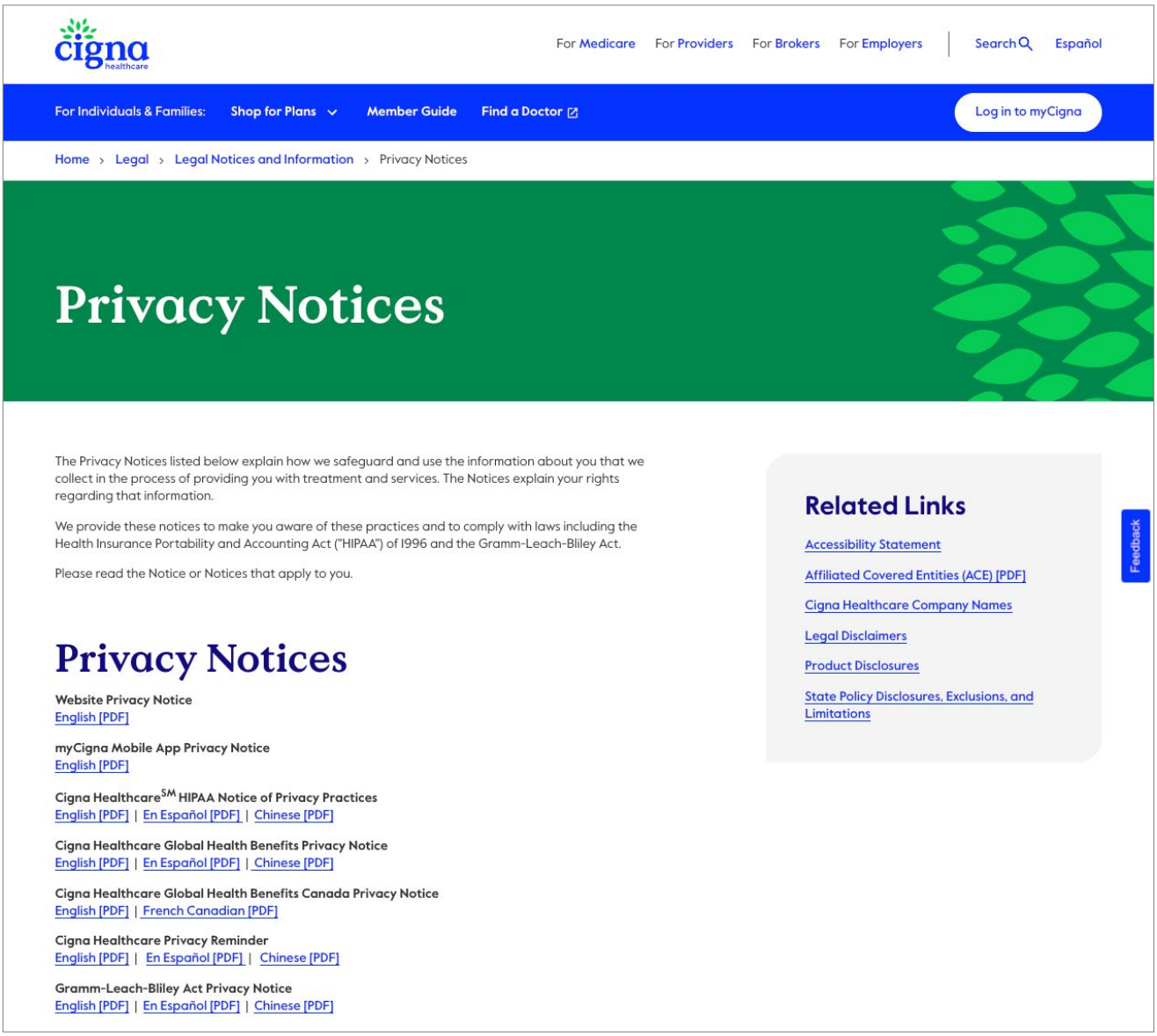
Your request will be reviewed by someone who was not involved in the initial decision. This person will be able to take corrective action based on the terms of your plan. A psychiatrist reviews behavioral appeals. A medical director reviews medical and pharmacy appeals. If your situation calls for urgent care, we will expedite the review and response.

We will tell you in writing of the appeal decision. If you're not satisfied with the decision, depending on the type of plan you or your employer has chosen and the state and/or federal rules that apply, you may have the right to ask for another internal appeal review. The appeal reviewer will not have been involved in any prior decision about your appeal. Nor will this person be a subordinate of a prior decision maker.

Availability of an independent external review

You'll be notified in writing of the final internal appeal decision. If you're not satisfied with the decision, other options may be available. These options will depend on the type of plan you or your employer has chosen and the state and/or federal rules that apply. If the appeal involves a coverage decision concerning medical judgment, you may be able to ask for external review by an independent review organization after your final internal appeal. If external review is available, your final appeal decision letter will have instructions on how to ask for this review.

Your privacy is our priority



We know how important it is to keep your protected health information (PHI) safe. In the normal course of business, we may create, obtain and/or maintain PHI about you. Federal law says that we must tell you how we may use and disclose your PHI and how you can find this information. We do this as part of our HIPAA Notice of Privacy Practices.

You can find the HIPAA Notice of Privacy Practices online at **cigna.com/legal/compliance/privacy-notices**. You can read it in English, Spanish and Chinese. If you want a paper copy, you can print one online. Or call the number on your ID card. We'll be happy to mail you one. We can send the notice in other languages if requested.

The notice is available in English, Spanish and Chinese. You can get a copy of our notice or ask to get the information in other languages by calling customer service at the number on your ID card.

How we assess medical technology

Cigna Healthcare has a specific process to review new and emerging medical products, procedures, devices, therapies and behavioral health procedures. The Cigna Healthcare Medical Assessment Committee is made up of physicians and nurses of various types, including medical, surgical and behavioral health specialties. The committee reviews literature, policies, technology assessments and evidence-based medicine summaries from external experts in the field. It does this to ensure new products and procedures recommended for coverage are proven to be safe and effective for our customers. Cigna Healthcare also talks to internal professional subject matter experts as part of the review. The committee will not consider a new technology for coverage until U.S. Food and Drug Administration (FDA) regulatory approval is obtained, if indicated.

In making recommendations, the committee looks to authoritative sources. These sources include published peer-reviewed medical articles and clinical studies; approval from governmental bodies, such as the FDA; and support by medical professional specialty society positions and independent reviews from experts in the field.

After a new technology gets final approval from the appropriate governmental regulatory body (if needed), the committee reviews the technology. It asks questions such as:

- Is the technology safe and effective?
- Are the studies, if any, well carried out with sound study methodology?
- Are health outcomes positive and/or do they have a beneficial effect?
- Do positive outcomes outweigh any harmful results?
- Is the technology available outside of the investigational/research setting?

Coverage of a product or procedure also depends on terms of your health plan.

Prescription coverage

This information is for customers who have Cigna Healthcare–administered pharmacy benefits. Please check your plan materials to learn more.

The Cigna Healthcare Prescription Drug List is a list of generic and brand-name medications your plan covers. Covered medications are divided into tiers or cost-share levels. Most often, the higher the tier, the higher the price you'll pay to fill the prescription.

How can I see which medications are covered on my plan's drug list?

You can log in to **myCigna.com** or the **myCigna App**[7] and use the Price a Medication tool. It will show if your plan covers your medication and how much it may cost you at the pharmacies in your plan's network. You can see lower-cost alternatives (where available).[8]

Who decides which medications are covered?

The Cigna Healthcare Prescription Drug List is developed with help from the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee. This is a group of practicing doctors and pharmacists. Most of them work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals. This information covers the safety and effectiveness of medications newly approved by the FDA as well as those already on the market. The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review. It also considers the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Does my provider know which medications are covered on my plan's drug list?

Yes. Providers have resources to help them find out which medications are covered on Cigna Healthcare drug lists.

What if I need to take a medication that isn't covered on my plan's drug list?

To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives. That's because these lower-cost options work the same as, or similar to, the non-covered medication. If you're taking a medication that isn't covered and your doctor feels a different medication isn't right for you, your doctor can ask Cigna Healthcare to consider approving your medication through the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with our decision and next steps. It can take up to five business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. You can also log in to **myCigna** to see where your medication is in the review process. Click on Prescriptions, then choose My Medications from the drop-down menu. On the left side of the page under Prior Authorization, click the View List button.[9]

- If you meet coverage requirements, we'll approve your medication to be covered by your plan. Medications are typically approved for one year of coverage.
- If you don't meet coverage requirements and we don't approve your medication, your doctor's office can send us more information to review. The office should use the same process as before. We're happy to review the request again. Based on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal by sending us a request, in writing, telling why the medication should be covered. If you don't get approval and still fill your medication, you'll pay its full cost out of pocket directly to the pharmacy. Also, the cost can't be applied to your annual deductible or out-of-pocket maximum.
- There are also certain medications and products your plan won't cover for any reason because they're considered a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask us to cover it through our review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the FDA. In this case, you should talk with your doctor about your options. You may be able to use another prescription medication. Or you can use an over-the-counter (OTC) product available at your pharmacy without a prescription.[10]

Can I fill a prescription for any medication on my plan's drug list?

No. Some medications may need approval from Cigna Healthcare before your plan will cover them. If your medication needs pre-approval, ask your doctor to contact us to start the coverage review. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with our decision and next steps. It can take up to five business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. You can also log in to **myCigna** to see where your medication is in the review process. Click on Prescriptions, then choose My Medications from the drop-down menu. On the left side of the page under Prior Authorization, click the View List button.[9] If you don't get approval and continue to fill your medication, you'll pay its full cost out of pocket directly to the pharmacy. Also, the cost won't be applied to your annual deductible or out-of-pocket maximum.

Preventive health coverage

Your Cigna Healthcare plan covers designated preventive care services to help keep you well. This is in addition to services to treat an illness or injury. Your plan includes coverage for wellness services for women, men and children.

During a wellness exam, you and your provider determine what tests and screenings are right for you. This determination is based on your age, gender, personal health history and current health.* Cigna Healthcare preventive care coverage complies with the Affordable Care Act (ACA). Services designated as preventive care include periodic well visits, routine immunizations, and certain designated medical or behavioral screenings for symptom-free or disease-free individuals. They also include designated services for individuals at increased risk for a certain disease. Cigna Healthcare has a reference guide for services considered preventive care under your plan. To learn more about preventive services, visit **myCigna** and select Coverage then select Medical. The *Preventive Care Reference Guide* is posted on this page under Preventive Care. Click on View All Preventive Services. You may also call the toll-free number on your ID card to ask for a copy.

Behavioral case management and screenings

Cigna Healthcare offers behavioral case management programs. These programs help you make the most of your treatment and prescribed medicines. We can give you information and ideas to help you better understand your treatment and medicines. A case manager can help you create a personal plan for you or your family. Included in several programs are behavioral screenings to assess depression, alcohol use and substance use. To learn more about behavioral case management, call the number on your ID card.

Health assessment – 15 minutes can change your health

Your health is your most vital asset. There's a tool on your personalized website that can help you take care of it. Your health assessment is a quick, confidential survey. It examines your health status so you can get answers to pressing health questions. Want to know which preventive screenings to consider? Need to lower your cholesterol, stop smoking or manage your emotional health? Interested in losing weight, limiting your alcohol use, or improving your physical activity and healthy eating habits? Here's how your survey results can help.

- Answer questions about your lifestyle, stress levels, habits, alcohol consumption, health history, weight, cholesterol and blood pressure. You'll get customized feedback that explains your risks for certain health conditions. You'll also learn how to maintain or improve your health.
- Based on your answers, you may be able to take part in an online health coaching program. This program shows you how to make lifestyle changes over the course of a few weeks. You may also be referred to other online tools to help you manage health concerns.
- You can review your health benefit plan to see if you're eligible for personalized health coaching to help you manage any health risks.
- You can talk about your risks with your provider and create steps for lowering them.

*Includes eligible in-network preventive care services. Some preventive care services may not be covered, including most immunizations for travel. Reference plan documents for a list of covered and non-covered preventive care service.

1. "Commitment to quality" addresses Cigna Healthcare–administered medical plan customers who have behavioral health benefits through Evernorth Behavioral Health (EBH). Medical plan customers who have behavioral health benefits from other companies should disregard the behavioral references outlined in this document.
2. App/online store terms and mobile phone carrier/data charges apply.
3. HEDIS® is a registered trademark of NCQA.
4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
5. Cigna Healthcare provides access to virtual care through a national telehealth provider, MDLive located on myCigna, as part of your health plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. Virtual care does not guarantee that a prescription will be written. Refer to plan documents for complete description of virtual care services and costs, including other telehealth/telemedicine benefits. For IL customers a primary care provider referral may be required for specialist virtual visits.
6. If you are covered under an insurance policy or by an HMO, we address your concerns, complaints and appeals according to applicable state and federal rules. Those rules may vary from our national process described here. Please check your coverage materials for more information.
7. App/Online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
8. Prices shown on myCigna are not guaranteed, and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
9. When you click the View Details button, we'll connect you to our Prior Authorization Portal on the Express Scripts website. Cigna Healthcare, Evernorth Health Services and Express Scripts are all part of The Cigna Group. Cigna Healthcare uses the Express Scripts website for certain programs and services. There, you can select the patient's name from the dropdown to see where the medication is in the review process or to read more about the decision we made.
10. Most plans don't cover OTCs. That means if you buy an OTC product, you'll pay its retail cash price directly to the pharmacy. The cost can't be applied to your annual deductible or out-of-pocket maximum. Log in to myCigna.com or the myCigna App or check your plan materials to learn more about how your plan covers OTCs. Quality designations, cost-efficiency and other ratings reflect a partial assessment of quality and cost-efficiency. They should not be the sole basis for decision-making. They are not a guarantee of the quality of care that will be provided to individual patients. You're encouraged to consider all relevant factors and consult with your physician when selecting a provider. Providers are independent contractors solely responsible for care delivered. They are not agents of Cigna Healthcare.

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