Glossary

Amount billed: The amount charged by the health care professional or facility (physician, hospital, etc.) for services provided to you or your covered dependents.
Amount not covered: The portion of the amount billed that was not covered or eligible for payment under your plan. Examples include charges for services or products that are not covered by your plan, duplicate claims that are not your responsibility and any charges submitted that are above the maximum amount your plan pays for out-of-network care.
Deductible: The portion of submitted charges applied towards your deductible. Your deductible is the amount you need to pay each year before your plan starts paying benefits. You meet your deductible by using the money in your health care account, then your own money.
Copay: A flat fee you pay for certain covered services such as doctor visits or prescriptions. You can use the money in your reimbursement account to pay this fee.
Discount: The amount you save by using a health care professional or facility (doctor, hospital, etc) that belongs to a Cigna network. Cigna negotiates lower rates with its in-network doctors, hospitals and other facilities to help you save money.
In-network: A group of health care professionals and facilities (doctors, hospitals, labs, etc) that offer discounts on services based on their relationship with CIGNA. Using in-network services gives you significant discounts, which help you stretch your health care account money further.
Out-of-network: Health care professionals and facilities (doctors, hospitals, labs, etc) that do not belong to the CIGNA network. Depending on your plan, you can use out-of-network services, but you may pay more for the same services, and you might have to file a separate claim for reimbursement.
What CIGNA plan paid: The portion of the billed amount that was paid by your health care plan.
What I owe: The portion of the billed amount that is your responsibility. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time is permitted by your plan). Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.