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MEDICAL INSURANCE

Provided by

cigna healthcare

Changes in the VUMC Postdoc Plans

VUMC desires to maintain benefits packages that mirror or exceed the plans offered to faculty and staff while keeping benefit program costs in check.

This year, our historical health insurance carrier, Aetna, implemented a new set of health insurance plans and discontinued the plans that VUMC had offered in the past. The new Aetna plans included significant plan “downgrades” while being much more expensive. Thus, the campus made the decision to transition the postdocs to a new health insurance carrier, Cigna, effective October 1, 2026.

The Cigna plans are almost identical to the plans that the VUMC postdocs had in years past, at a lower monthly premium.

VUMC will continue to cover 100% of the “Base” medical plan and your choice of the dental HMO or PPO plans for postdocs and their dependents.

For those who wish to enroll in the “Buy-Up” medical plan, you will be responsible to pay for the difference between the Buy-Up and the Base plans.

The vision plan is voluntary and postdocs who enroll will be billed monthly.

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Postdoctoral Trainee Benefits Program

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CIGNA Medical Plans	Total Monthly Cost	VUMC Contribution	Postdoc Contribution
Cigna Base PPO Medical Plan			
Postdoc	$1,012.66	$1,012.66	$0
Postdoc + Spouse	$2,349.34	$2,349.34	$0
Postdoc + Child(ren)	$2,075.93	$2,075.93	$0
Postdoc + Family	$3,361.98	$3,361.98	$0
Cigna Buy-Up PPO Medical Plan			*Difference between the two plan costs - Billed directly to postdoc via "FreshBooks"*
Postdoc	$1,037.77	$1,012.66	**$25.11**
Postdoc + Spouse	$2,407.62	$2,349.34	**$58.28**
Postdoc + Child(ren)	$2,127.41	$2,075.93	**$51.48**
Postdoc + Family	$3,445.38	$3,361.98	**$83.40**

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What is a PPO Plan?

- The PPO plan offers more flexibility and choice than the HMO plan due to the In-Network and Out-of-Network selection you make at the time you seek services
- The In-Network benefits (copays/coinsurance) will be covered at a higher level than the Out-of-Network benefits
- At the time of service, you have the ability to seek care from a Specialist, without having to obtain a referral from a Primary Care Physician (PCP)
- The contractual agreement between the PPO Plan and the In-Network Provider is on a “discounted fee for service” basis
- You will pay more out-of-pocket when you seek services Out-of-Network because those physicians are not providing the same contracted discounts as the In-Network physicians

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Cigna Base PPO Plan

- The Cigna Base PPO plan offers you comprehensive benefit coverage with an In-Network and Out-of-Network benefit as well as prescription drug benefits
- This plan is the base plan, or 'default plan' that the University offers *at no cost to the postdoc*
- Before enrolling your eligible dependents, please check with your Department Administrator to assure that your dependents are eligible for the plan

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Cigna Buy-Up PPO Plan

- The Cigna Buy-Up PPO Plan offers you comprehensive benefits coverage with an In-Network and Out-of-Network benefit as well as prescription drug benefits
- If you wish to be enrolled in this plan, you will be responsible for a monthly contribution based on your enrollment tier
- Before enrolling your eligible dependents, please check with your Department Administrator to assure that your dependents are eligible for the plan

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Cigna Deductible Carry-Over & Transition of Care

- The current Aetna Plans offered by VUMC have accumulated the deductible and out-of-pocket maximums on an annual basis (January through December each year).
- Gallagher will be working with Aetna to provide Cigna with the information needed to apply the credits for amounts paid towards deductibles and out-of-pocket maximums to the new Cigna plan.
- For those who are currently undergoing medical treatment and need assistance with transition of care, a detailed summary of the Cigna process can be found at the end of this presentation.

VUMC Postdoctoral Trainee Benefits Program:

Aetna vs Cigna Base Medical Plans

VUMC pays 100% of the monthly charges for postdocs enrolled in this plan.

Core Benefits (what member pays)	NO LONGER OFFERED Aetna Open Choice - 500 80/60 PPO			Cigna Open Access Plus Base (40176417) (80/60 Replacement)		
	In-Network		Out-of-Network	In-Network		Out-of-Network
Maximum Out of Pocket:	$3,000 Individual / $6,000 Family		$7,500 Individual / $15,000 Family	$3,000 Individual /$6,000 Family		$7,500 Individual /$15,000 Family
Deductible:						
Individual -	$500		$1,000	$500		$1,000
Family	$1,000		$2,000	$1,000		$2,000
Preventive Care/Screening/Immunization	No Copay		40% coinsurance after deductible	No Copay*		Not Covered
Office Visit	$25 Copay*		40% coinsurance after deductible	$25 Copay*		40% Coinsurance after deductible
Specialist Office Visit	$40 Copay*		40% coinsurance after deductible	$40 Copay*		40% Coinsurance after deductible
Diagnostic Tests (xray, bloodwork)	20% coinsurance after deductible		40% coinsurance after deductible	20% Coinsurance after deductible		40% Coinsurance after deductible
Major Diagnostic & Imaging	20% coinsurance after deductible		40% coinsurance after deductible	20% Coinsurance after deductible		40% Coinsurance after deductible
Hospitalization:						
Inpatient - Facility fee & Physician Fees billed separately	20% Facility after $150 copay and 20% Physician Fees after deductible		40% Facility and 40% Physician Fees after deductible	$150 Copay +20% after deductible		40% Coinsurance after deductible
Outpatient - Facility fee & Physician Fees billed separately	20% Facility and 20% Physician Fees after deductible		40% Facility and 40% Physician Fees after deductible	20% coinsurance after deductible		40% Coinsurance after deductible
Childbirth/Delivery	20% Facility after $150 copay and 20% Physician Fees after deductible		40% Facility and 40% Physician Fees after deductible	$150 Copay +20% after deductible		40% Coinsurance after deductible
Prescription Drugs:						
	In-Network Retail (30 days)	In-Network Mail Order (90 days)	Out-of-Network Retail (30 days)	In-Network Retail (30 days)	In-Network Mail Order (90 days)	Out-of-Network Retail
Generic	$10 Copay*	$20 Copay*	50% coinsurance after copay/prescripton*	$10 Copay*	$20 Copay*	Retail: 50%; No Home Delivery*
Brand Name	$20 Copay*	$40 Copay*	50% coinsurance after copay/prescripton*	$20 Copay*	$40 Copay*	Retail: 50%; No Home Delivery*
Non Formulary	$35 Copay*	$70 Copay*	50% coinsurance after copay/prescripton*	$35 Copay*	$70 Copay*	Retail: 50%; No Home Delivery*
Specialty	20% Copay/prescription*		50% coinsurance after copay/prescripton*	20% up to $250 for 30 day supply		Retail: 50%; No Home Delivery*
Urgent Care Visits	$35 Copay per Visit*			$35 Copay*		$70 Copay*
Emergency Room Visits	20% coinsurance after $150 copay per visit* (copay waived if admitted)			20% coinsurance after $150 copay per visit* (copay waived if admitted)		
Telehealth (primary care/specialist)**	No Charge (Teledoc)			MDLIVE: No copay Regular copays apply to virtual visits with PCP & Specialists		MDLIVE: Not covered 40% Coinsurance after deductible apply to virtual visits with PCP & Specialists
Mental Health:						
Outpatient Office Visits -	$40 Copay per Visit*		40% coinsurance after deductible	Physician's Office or MDLIVE: $40 Copay* All other outpatient: 20% Copay after deductible		40% Coinsurance after deductible
Inpatient -	20% coinsurance after $150 copay per visit*		40% coinsurance after deductible	20% coinsurance after $150 copay per visit*		40% Coinsurance after deductible

*Deductible does not apply

**Infertility covered if treating underlying condition as any other illness

Note: This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

VUMC Postdoctoral Trainee Benefits Program:

Aetna vs Cigna Buy-Up Medical Plans

Postdocs must pay the difference between the Buy-Up and the Base Medical Plans.

Core Benefits (what member pays)	NO LONGER OFFERED Aetna Open Choice - 500 90/70 PPO			Cigna Open Access Plus Buyup (40178418) (90/70 Replacement)		
	In-Network		Out-of-Network	In-Network		Out-of-Network
Maximum Out of Pocket:	$2,000 Individual / $4,000 Family		$4,000 Individual / $8,000 Family	$2,000 Individual /$4,000 Family		$4,000 Individual /$8,000 Family
Deductible:						
Individual -	$500		$1,000	$500		$1,000
Family	$1,000		$2,000	$1,000		$2,000
Preventive Care/Screening/Immunization	No Copay		30% coinsurance after deductible	No Copay*		Not Covered
Office Visit	$20 Copay*		30% coinsurance after deductible	$20 Copay*		30% Coinsurance after deductible
Specialist Office Visit	$40 Copay*		30% coinsurance after deductible	$40 Copay*		30% Coinsurance after deductible
Diagnostic Tests (xray, bloodwork)	10% coinsurance after deductible		30% coinsurance after deductible	10% Coinsurance after deductible		30% Coinsurance after deductible
Major Diagnostic & Imaging	10% coinsurance after deductible		30% coinsurance after deductible	10% Coinsurance after deductible		30% Coinsurance after deductible
Hospitalization:						
Inpatient - Facility fee & Physician Fees billed separately	10% Facility after $150 copay and 10% Physician Fees after deductible		30% Facility and 30% Physician Fees after deductible	$150 Copay +10% after deductible		30% Coinsurance after deductible
Outpatient - Facility fee & Physician Fees billed separately	10% Facility and 10% Physician Fees after deductible		30% Facility and 30% Physician Fees after deductible	10% coinsurance after deductible		30% Coinsurance after deductible
Childbirth/Delivery	10% Facility after $150 copay and 10% Physician Fees after deductible		30% Facility and 30% Physician Fees after deductible	$150 Copay +10% after deductible		30% Coinsurance after deductible
Prescription Drugs:						
	In-Network Retail (30 days)	In-Network Mail Order (90 days)	Out-of-Network Retail (30 days)	In-Network Retail (30 days)	In-Network Mail Order (90 days)	Out-of-Network Retail
Generic	$15 Copay*	$30 Copay*	30% coinsurance after copay/prescripton*	$15 Copay*	$30 Copay*	Retail: 50%; No Home Delivery*
Brand Name	$35 Copay*	$70 Copay*	30% coinsurance after copay/prescripton*	$35 Copay*	$70 Copay*	Retail: 50%; No Home Delivery*
Non Formulary	$50 Copay*	$100 Copay*	30% coinsurance after copay/prescripton*	$50 Copay*	$100 Copay*	Retail: 50%; No Home Delivery*
Specialty	20% Copay/prescription*		30% Copay/prescription*	20% up to $250 for 30 day supply		Retail: 50%; No Home Delivery*
Urgent Care Visits	10% coinsurance after $50 Copay per visit*		30% coinsurance after deductible	$50 Copay*		30% Coinsurance after deductible
Emergency Room Visits	10% coinsurance after $150 copay per visit* (copay waived if admitted)			10% coinsurance after $150 copay per visit* (copay waived if admitted)		
Telehealth (primary care/specialist)**	No Charge (Teledoc)			MDLIVE: No copay Regular copays apply to virtual visits with PCP & Specialists		MDLIVE: Not covered 30% Coinsurance after deductible apply to virtual visits with PCP & Specialists
Mental Health:						
Outpatient Office Visits -	$40 Copay per Visit*		30% coinsurance after deductible	Physician's Office or MDLIVE: $40 Copay* All other outpatient: 10% Copay after deductible		30% Coinsurance after deductible
Inpatient -	10% coinsurance after $150 copay per visit*		30% coinsurance after deductible	10% coinsurance after $150 copay per visit*		30% Coinsurance after deductible

*Deductible does not apply

**Infertility covered if treating underlying condition as any other illness

Note: This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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When and Where to Access Care

Type of Provider	Scenario	Type of Illness or Injury
Primary Care Physician (PCP)	Annual wellness exams, or moderate pain that needs to be diagnosed	General checkup, moderate pain of unknown origin, etc.
Specialist	Experiencing pain specific to a particular region of the body (ie: muscular, gastrointestinal, ocular, bone/joint, skin, ears/nose/throat, etc.)	Ulcers, rash, digestive problems, vision problems, elevated test levels, etc.
24-Hour Nurse Line	Talk with a registered nurse - available 24 hours a day/ 7 days a week	Non-emergency medical scenarios in which you are trying to decide if you need to go to the doctor or not
Virtual Care	Virtual doctor's appointments available 24/7 for general medical, mental health and dermatology issues	Non-emergency medical scenarios conditions like flu, sinus infections, sore throats, eczema, acne, rashes; Access to mental health therapists 7 days a week 7am-9pm
Walk-In Clinic	Treatment of unscheduled, non-emergency illnesses/injuries and certain immunizations	Vaccination, mild cold/flu, minor cuts/abrasions, etc.
Urgent Care (Alternative to ER)	Treatment of most non-life-threatening emergencies	Broken bones (not multiple fractures), minor wounds (not bleeding profusely), mild fever, flu, acute sinusitis, etc.
Emergency Room (ER)	Treatment of all life/limb-threatening emergencies	Severe head trauma, multiple/compound fractures, heavy bleeding, elevated fever, severe burns, seizures, poison, etc.
Hospital	Having an inpatient or outpatient procedure performed, in a critical state	Delivering a baby, major/minor surgery, recovery, monitoring, etc.

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Seeking Same-Day Care

Difference in Copay is substantial as shown on the table below:

Cost Analysis: Same-Day Care			
Medical Plan	**MDLIVE (Virtual Visit)**	**Urgent Care**	**Emergency Room****
Cigna Base PPO Plan	$0	$35 Copay (In-Network)	$150 Copay + 20%
Cigna Buy-Up PPO Plan	$0	$50 Copay (In-Network)	$150 Copay + 10%

*See lists of In-Network sites on the VUMC Postdoc Benefits Portal: https://clients.garnett-powers.com/pd/vumc/
**Please do not hesitate to go to the ER if you are experiencing a life/limb-threatening emergency

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Summaries of Benefits and Coverage

- The Patient Protection and Affordable Care Act (PPACA) requires that you be notified that the Summaries of Benefits and Coverage for your medical plans are currently available on our website

- The Summaries of Benefits and Coverage follow the recommended guidelines of PPACA in a standardized format to make them easier to read and comprehend to better serve you in making your plan selections

- You may request a paper copy at no charge by calling the toll-free number on your new ID card

- You may also print a copy directly from the Gallagher website

TRANSITION OF CARE

CONTINUITY OF CARE

See how they work

What is Transition of Care?

With Transition of Care, you may be able to continue to receive services for specified medical conditions with health care providers who are not in the Cigna network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage.

What is Continuity of Care?

With Continuity of Care, you can receive services at in-network coverage levels for specified medical conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that he or she is leaving your plan's network.

How they both work

- You must already be under treatment for the condition identified on the Transition of Care/ Continuity of Care request form.
- If the request is approved for medical conditions:
  - You will receive the in-network level of coverage for treatment of the specific condition by the health care providers for a defined period of time, as determined by Cigna.
  - If your plan includes out-of-network coverage and you choose to continue care out-of-network beyond the time frame approved by Cigna, you must follow your plan's out-of-network provisions. This includes any precertification requirements.
  - Transition of Care/Continuity of Care applies only to the treatment of the medical condition specified and the health care provider identified on the request form. All other conditions must be cared for by an in-network health care provider for you to receive in-network coverage.
- The availability of Transition of Care/Continuity of Care:
  - Does not guarantee that a treatment is medically necessary.
  - Does not constitute precertification of medical services to be provided.
- Depending on the actual request, a medical necessity determination and formal precertification may still be required for a service to be covered.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy in the second or third trimester at the time of the plan **effective date** of coverage or of the health care provider termination.
- Pregnancy is considered *high risk* if mother's age is 35 years or older, or patient has/had:
  - Early delivery (three weeks) in previous pregnancy.
  - Gestational diabetes.
  - Pregnancy induced hypertension.
  - Multiple inpatient admissions during this pregnancy.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period, that is generally six to eight weeks.
- Acute conditions in **active treatment** such as heart attacks, strokes or unstable chronic conditions.
  - "**Active treatment**" is defined as a provider visit or hospital stay with documented changes in a therapeutic regimen. This is within 21 days prior to your plan effective date or your health care provider's termination date.
- Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).

Examples of conditions that do not qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Routine exams, vaccinations and health assessments.
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma.
- Acute minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries such as removal of lesions, bunionectomy, hernia repair and hysterectomy.

What time frame is allowed for transitioning to a new in-network health care provider?

If Cigna determines that transitioning to an in-network health care provider is inappropriate or unsafe for the conditions that qualify, services by the approved out-of-network health care provider will be authorized for a specified period of time (usually 90 days). Or, services will be approved until care has been completed or transitioned to an in-network health care provider, whichever comes first.

If I am approved for Transition of Care/Continuity of Care for one illness, can I receive in-network coverage for a non-related condition?

In-network coverage levels provided as part of Transition of Care/Continuity of Care are for the specific illness or condition only and cannot be applied to another illness or condition. You need to complete a Transition of Care/Continuity of Care request form for each unrelated illness or condition. You need to complete this form no later than 30 days after your plan becomes effective or your health care provider leaves your plan's network.

Can I apply for Transition of Care/Continuity of Care if I am not currently in treatment or seeing a health care provider?

You must already be in treatment for the condition that is noted on the Transition of Care/Continuity of Care request form.

How do I apply for Transition of Care/Continuity of Care coverage?

Requests must be submitted in writing, using the Transition of Care/Continuity of Care request form. This form must be submitted at the time of enrollment, change in medical plan, or when your health care provider leaves the Cigna network. It cannot be submitted more than 30 days after the effective date of your plan or your health care provider's termination. After receiving your request, Cigna will review and evaluate the information provided. Then, we will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

▼Detach Transition of Care/Continuity of Care request form here.▶

Transition of Care/Continuity of Care request form

See instructions for completing this form on the reverse side.

❑ New Cigna enrollee (Transition of Care applicant)

❑ Existing Cigna customer whose health care provider terminated (Continuity of Care applicant)

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employer	Policy #	Employee Date of Enrollment in Plan (mm/dd/yyyy)
Employee Name	Employee Member ID	Work Phone
Home Address Street City State ZIP		Home Phone/Mobile
Patient's Name	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee ❑ Spouse ❑ Dependent ❑ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date _____(mm/dd/yyyy) ❑ Yes ❑ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ❑ Yes ❑ No
3. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Cigna? ❑ Yes ❑ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
6. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ❑ No
7. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
8. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
9. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

_____

10. Please complete the health care provider information requested below.

Group Practice Name		
Health Care Provider Name		Health Care Provider Phone #
Health Care Provider Specialty		
Health Care Provider Address		
Hospital Where Health Care Provider Practices		Hospital Phone #
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when coverage through Cigna begins or during the next 90 days? ❑ Yes ❑ No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care, you need to complete a separate Transition of Care/Continuity of Care request form.

_____

I hereby authorize the above health care provider to give Cigna Health and Life Insurance Company or its affiliates and contracted parties any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive, Pittsburgh, PA 15275
Fax 866.729.0432

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt. For new Cigna customers, review will occur within 10 days of participant's effective date. Review for organ transplant requests may take longer than 10 days.

Instructions for completing the Transition of Care/Continuity of Care request form

Note: Do not use this form if you are enrolled in a Cigna HealthCare of California, Inc. plan and are seeking a Transition of Care. Contact Cigna for a Cigna HealthCare of California, Inc. Transition of Care brochure.

A separate Transition of Care/Continuity of Care request form must be completed for each condition for which you and/or your covered dependents are seeking Transition of Care/Continuity of Care. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Transition of Care/Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.

To help ensure a timely review of your request, please return the form as soon as possible. You must apply for Transition of Care/Continuity of Care within 30 days of the effective date of your plan, or within 30 days of your provider's termination date.

The first few sections of the form apply to the employee. When the form asks for the patient's name, enter the name of the person who is receiving care and is requesting Transition of Care/Continuity of Care.

If you answered yes to questions #1, #2, #3, #4, #5, #6, #7 or #8, please submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive
Pittsburgh, PA 15275
Fax: 866.729.0432

In #9, include information about the current or proposed treatment plan and the length of time treatment is expected to continue. If surgery has been planned, state the type and the proposed date of the surgery.

In #12, briefly state the health condition, when it began, what health care provider is currently involved, and how often you see this health care provider. Please be as specific as possible.

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt. For new Cigna customers, review will occur within 10 days of participant's effective date. Review for organ transplant requests may take longer than 10 days.