January 1 - December 31, 2024

# EVIDENCE OF COVERAGE

## Your Medicare Health Benefits and Services and Prescription Drug Coverage Services as a Member of Cigna True Choice Medicare (PPO)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

**For questions about this document, please contact Customer Service at 1-800-668-3813 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. This call is free.**

This plan, Cigna True Choice Medicare (PPO), is offered by Cigna Healthcare[SM]. (When this *Evidence of Coverage* says "we," "us," or "our," it means Cigna Healthcare. When it says "plan" or "our plan," it means Cigna True Choice Medicare (PPO).)

This document is available for free in Spanish.

To get information from us in a way that works for you, please call Customer Service. We can give you information in braille, in large print, or other alternate formats if you need it.

Benefits, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefit;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and
- Other protections required by Medicare law.

H7849_24_961812_C

OMB Approval 0938-1051 (Expires: February 29, 2024)

24_E_H7849_002

# 2024 Evidence of Coverage
# Table of Contents

# CHAPTER 1:

*Getting started as a member*

## SECTION 1 Introduction

### Section 1.1 You are enrolled in Cigna True Choice Medicare (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Cigna True Choice Medicare (PPO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Cigna True Choice Medicare (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

**Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/affordable-care-act/individuals-and-families for more information.

### Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. This document explains your rights and responsibilities, what is covered, and what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered services refer to the medical care and services and the prescription drugs available to you as a member of Cigna True Choice Medicare (PPO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Service.

### Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary),* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in our plan between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

## SECTION 2 What makes you eligible to be a plan member?

### Section 2.1 Your eligibility requirements

*You are eligible for membership in our plan as long as:*

- You have both Medicare Part A and Medicare Part B
- — *and* — you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- — *and* — you are a United States citizen or are lawfully present in the United States.

### Section 2.2 Here is the plan service area for our plan

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Illinois: Cook, DeKalb, DuPage, Kane, Kankakee, Lake, McHenry, Will

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

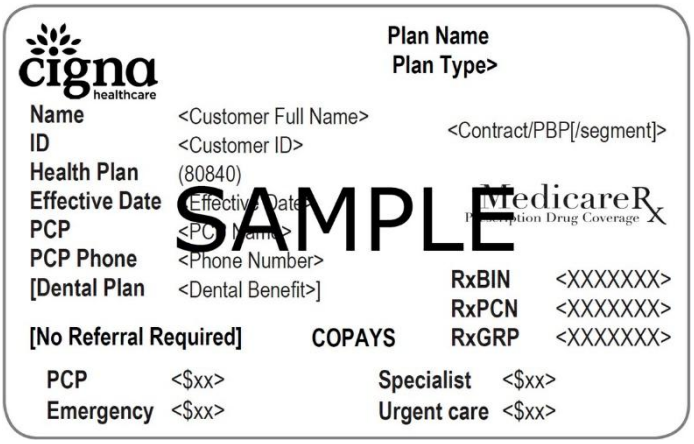
### Section 2.3 U.S. Citizen or Lawful Presence

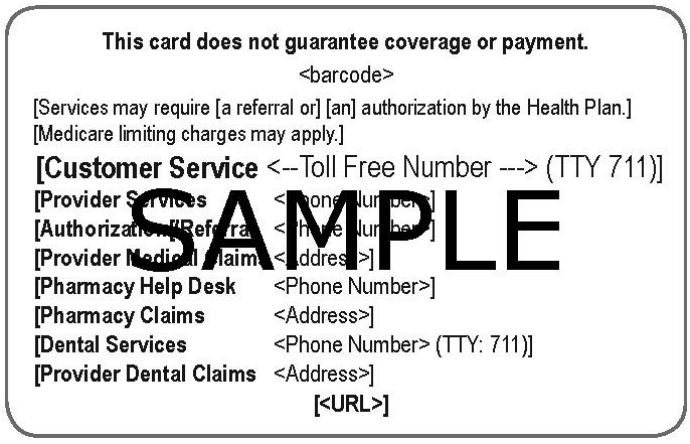
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna Healthcare if you are not eligible to remain a member on this basis. Cigna Healthcare must disenroll you if you do not meet this requirement.

## SECTION 3 Important membership material you will receive

### Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:




Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Cigna True Choice Medicare (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

### Section 3.2 The *Provider and Pharmacy Directory*: Your guide to providers in the plan's network

The *Provider and Pharmacy Directory* lists our current network providers and durable medical equipment suppliers.

**Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 *(Using the plan's coverage for your medical services)* for more specific information.

If you don't have your copy of the *Provider and Pharmacy Directory,* you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.

### Section 3.3 The *Provider and Pharmacy Directory*: Your guide to pharmacies in the plan's network

The *Provider and Pharmacy Directory* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The *Provider and Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have the *Provider and Pharmacy Directory*, you can get a copy from Customer Service. You can also find this information on our website at www.cignamedicare.com, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network pharmacies.

### Section 3.4 The plan's List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan "Drug List."

The "Drug List" also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the "Drug List." The "Drug List" we provide to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.cignamedicare.com) or call Customer Service.

## SECTION 4 Your monthly costs for our plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

### Section 4.1 Plan premium

You do not pay a separate monthly plan premium for your plan.

### Section 4.2 Monthly Medicare Part B Premium

**Many members are required to pay other Medicare premiums**

**You must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

### Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty.** The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in our plan, we let you know the amount of the penalty.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.

- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

**Medicare determines the amount of the penalty.** Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.70, which equals $4.85. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

**If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review.** Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

### Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

## SECTION 5 More information about your monthly premium

### Section 5.1 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

There are three ways you can pay the penalty. Please select your late enrollment penalty payment option when you complete your enrollment form. You can also call Customer Service to let us know which option you choose or if you want to make a change.

**Option 1: Paying by check**

Your Part D late enrollment penalty is due monthly, but you can pay quarterly or yearly if you choose. You may decide to pay your Part D late enrollment penalty directly to our plan. You must submit to us your check or money order made payable to Cigna Healthcare by the last day of the month. Please include your member ID number on the check. Do not make your check payable to the Centers for Medicare and Medicaid Services (CMS) or to the Department of Health and Human Services (HHS). Payment should be sent to Cigna, P.O. Box 742642, Atlanta, GA 30374-2642. Payments mailed to a different Cigna Healthcare address will delay the processing of the payment.

**Option 2: You can make payments online**

You can pay your Part D late enrollment penalty by using Cigna Healthcare's secure online payment system, which allows you to set up automatic payments or make a one-time payment at your convenience. Our secure online payment system is available 24 hours a day, 7 days a week, and can be found online at www.cignamedicare.com/paymybill. If you have questions about this payment option, please contact Customer Service at the phone number listed on the back of this document.

**Option 3: Having your Part D late enrollment penalty taken out of your monthly Social Security check**

**Changing the way you pay your Part D late enrollment penalty**. If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time. To change your payment method, contact Customer Service.

**What to do if you are having trouble paying your late enrollment penalty**

If you are required to pay a Part D late enrollment penalty, that penalty is due in our office by the last day of the month.

If you are having trouble paying your Part D late enrollment penalty on time, please contact Customer Service to see if we can direct you to programs that will help with your costs.

### Section 5.2 Can we change your monthly plan premium during the year?

**No.** We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

## SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider/Medical Group/IPA. A Medical Group is an association of primary care providers (PCPs), specialists and/or ancillary providers, such as therapists and radiologists. An Independent Physician Association, or IPA, is a group of primary care and specialty care physicians who work together in coordinating your medical needs.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

**Let us know about these changes:**

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

## SECTION 7 How other insurance works with our plan

### Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage and/or drug insurance coverage that you may have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits

- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans and/or Medigap have paid.

# CHAPTER 2:

## *Important phone numbers and resources*

## SECTION 1 Plan contacts

(how to contact us, including how to reach Customer Service at the plan)

### How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to our plan's Customer Service. We will be happy to help you.

| Method | Customer Service – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.<br>Customer Service also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Member Services, P.O. Box 2888, Houston, TX 77252 |
| **WEBSITE** | www.cignamedicare.com |

### How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Method | Coverage Decisions for Medical Care – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time; Saturday 8:00 a.m. – 5:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time Saturday 8:00 a.m. – 5:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Precertification Department, P.O. Box 20002, Nashville, TN 37202 |

| Method | Coverage Decisions for Part D Prescription Drugs – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Coverage Determination & Exceptions, 8455 University Place #HQ2L-04, St. Louis, MO 63121 |
| **WEBSITE** | www.cignamedicare.com |

| Method | Appeals for Medical Care – Contact Information |
|---|---|
| **CALL** | 1-800-511-6943<br>Calls to this number are free. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Part C Appeals, P.O. Box 188081, Chattanooga, TN 37422 |

| Method | Appeals for Part D Prescription Drugs – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Medicare Clinical Appeals, P.O. Box 66588, St. Louis, MO 63166-6588 |
| **WEBSITE** | www.cignamedicare.com |

**How to contact us when you are making a complaint about your medical care or Part D prescription drugs**

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Method | Complaints about Medical Care – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Medicare Grievance Dept., P.O. Box 188080, Chattanooga, TN 37422 |
| **MEDICARE WEBSITE** | You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx. |

| Method | Complaints about Part D prescription drugs – Contact Information |
|---|---|
| **CALL** | 1-800-668-3813<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. |
| **WRITE** | Cigna Healthcare, Attn: Medicare Grievance Dept., P.O. Box 188080, Chattanooga, TN 37422 |
| **MEDICARE WEBSITE** | You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx. |

**Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received**

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)*.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

| Method | Payment Requests – Contact Information | |
|---|---|---|
| **WRITE** | **Part C (Medical Services)**<br>Cigna Healthcare<br>Attn: Direct Member Reimbursement,<br>Medical Claims<br>P.O. Box 20002<br>Nashville, TN 37202 | **Part D (Prescription Drugs)**<br>Cigna Healthcare<br>Attn: Medicare Part D<br>P.O. Box 14718<br>Lexington, KY 40512-4718 |
| **WEBSITE** | www.cignamedicare.com | |

## SECTION 2 Medicare

(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

| Method | Medicare – Contact Information |
|---|---|
| **CALL** | 1-800-MEDICARE, or 1-800-633-4227<br>Calls to this number are free.<br>24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. |
| **WEBSITE** | www.Medicare.gov<br>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer.<br>You can also find Medicare contacts in your state.<br>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:<br>□ **Medicare Eligibility Tool:** Provides Medicare eligibility status information.<br>□ **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.<br>You can also use the website to tell Medicare about any complaints you have about our plan<br>□ **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) |

## SECTION 3 State Health Insurance Assistance Program

(free help, information, and answer to your question about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Illinois, the SHIP is called Senior Health Insurance Program (SHIP).

Senior Health Insurance Program (SHIP) is an independent (not connected with any insurance company or health plan) a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior Health Insurance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior Health Insurance Program (SHIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

| Method | Senior Health Insurance Program (SHIP) – State SHIP Contact Information |
|---|---|
| **CALL** | 1-800-252-8966 |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | Senior Health Insurance Program (SHIP), Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702 |
| **WEBSITE** | https://ilaging.illinois.gov/ship.html |

## SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Illinois, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

| Method | Livanta (Illinois's Quality Improvement Organization) – Contact Information |
|---|---|
| **CALL** | 1-888-524-9900<br>Hours are Mon. - Fri. 9:00 a.m. - 5:00 p.m., 24 hour voicemail service is available |
| **TTY** | 1-888-985-8775<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | Livanta, BFCC-QIO Program, 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701 |
| **WEBSITE** | www.livantaqio.com |

## SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

| Method | Social Security– Contact Information |
|---|---|
| **CALL** | 1-800-772-1213<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday.<br>You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | 1-800-325-0778<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br>Available 8:00 am to 7:00 pm, Monday through Friday. |
| **WEBSITE** | www.ssa.gov |

## SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Illinois Department of Healthcare and Family Services.

| Method | Illinois Department of Healthcare and Family Services – State Medicaid Contact Information |
|---|---|
| **CALL** | 1-877-456-1233<br>Hours are Mon. - Fri. 8:00 a.m. - 4:45 p.m. |
| **TTY** | 1-800-447-6404<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | Illinois Department of Healthcare and Family Services, 401 South Clinton, Chicago, IL 60607 |
| **WEBSITE** | https://www2.illinois.gov/hfs/MedicalClients/Pages/medicalprograms.aspx |

## SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

**Medicare's "Extra Help" Program**

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mails you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this Chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please contact Customer Service to request assistance or to provide one of the documents listed below to establish your correct copay level. Please note that any document listed below must show that you were eligible for Medicaid during a month after June of the previous year:
  1. A copy of your Medicaid card which includes your name, eligibility date and status level;
  2. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status;
  3. A copy of a state document that confirms active Medicaid status;
  4. A printout from the State electronic enrollment file showing Medicaid status;
  5. A screen print from the State's Medicaid systems showing Medicaid status;
  6. Other documentation provided by the State showing Medicaid status;
  7. A Supplemental Security Income (SSI) Notice of Award with an effective date; or
  8. An Important Information letter from the Social Security Administration (SSA) confirming that you are "...automatically eligible for Extra Help..."
- If you are a member that is institutionalized, please provide one or more of the following:
  1. A remittance from a long-term care facility showing Medicaid payment for a full calendar month;
  2. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on your behalf;

3. A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month's stay for Medicaid payment purposes.
4. For Individuals receiving home and community based services (HCBS), you may submit a copy of:
   a) A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
   b) A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
   c) A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
   d) Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,
   e) A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

**What if you have coverage from an AIDS Drug Assistance Program (ADAP)?**

**What is the AIDS Drug Assistance Program (ADAP)?**

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also in the ADAP formulary qualify for prescription cost sharing assistance through the Illinois AIDS Drug Assistance Program.

**Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call

| Method | Illinois AIDS Drug Assistance Program – State ADAP Contact Information |
|---|---|
| **CALL** | 1-217-782-4977 or 1-800-825-3518<br>Hours are Mon. - Fri. 8:30 a.m. - 5:00 p.m. |
| **TTY** | 1-800-547-0466<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | Illinois AIDS Drug Assistance Program, Illinois Department of Public Health, Illinois ADAP Office, 525 West Jefferson Street, Springfield, IL 62761 |
| **WEBSITE** | https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services |

## SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

| Method | Railroad Retirement Board – Contact Information |
|---|---|
| **CALL** | 1-877-772-5772<br>Calls to this number are free.<br>If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.<br>If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays. |
| **TTY** | 1-312-751-4701<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are *not* free. |
| **WEBSITE** | rrb.gov/ |

## SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

# CHAPTER 3:

*Using the plan for your medical services*

## SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

### Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

### Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more information about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider and Pharmacy Directory.*
  - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
  - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

## SECTION 2 Using network and out-of-network providers to get your medical care

### Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

**What is a PCP and what does the PCP do for you?**

As a member of our plan, we encourage you to choose a network Primary Care Physician (PCP) and let us know who you choose. Your PCP can help you stay healthy, treat illnesses and coordinate your care with other health care providers. Depending on where you live, the following types of providers may act as your PCP:

- General Practitioner
- Family medicine
- Internal medicine

- Geriatrics

Your PCP will provide most of your care, and they will coordinate your care with other providers when you need more specialized services. They will help you find a specialist and will help arrange the covered services you get as a member of our plan. Some of the services that the PCP will coordinate include:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions

"Coordinating" your services includes consulting with other plan providers about your care and how it's progressing. Since your PCP will provide and coordinate most of your medical care, we recommend that you have your past medical records sent to your PCP's office.

In some cases, your PCP or other provider may need to get approval in advance from our plan's Medical Management Department for certain types of services or tests (this is called getting "prior authorization"). Services and items requiring prior authorization are listed in the Medical Benefits Chart in Chapter 4, Section 2.1. Prior authorization is not required for covered services received out-of-network; however, you or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Customer Service (phone numbers are on the back cover of this document).

**How do you choose your PCP?**

You select a Primary Care Physician (PCP) by choosing from those listed in our plan's *Provider and Pharmacy Directory;* the most updated list can be found on our website at www.cignamedicare.com. If you need help, you can call Customer Service for assistance. You can also change your PCP (as explained later in this section) by contacting Customer Service.

**Changing your PCP**

You may change your PCP for any reason at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

To change your PCP, call Customer Service at the number printed on the back of this document **before** you set up an appointment with a new PCP. When you call, be sure to tell Customer Service if you are seeing specialists or currently getting other covered services that were coordinated by your PCP (such as home health services and durable medical equipment). They will check to see if the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, let you know the effective date of your change request, and answer your questions about the change.

## Section 2.2 What kinds of medical care can you get without getting a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

## Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If you choose to select a PCP, your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. Your PCP may refer you to a specialist, but you can go to any of our specialists in our plan's network without a referral. Selection of a PCP does not limit you to specific specialists or hospitals to which that PCP refers. Please refer to our website at www.cignamedicare.com for a complete listing of PCPs and other participating providers in your area. You can also contact Customer Service at the phone number listed on the back cover of this document.

In some cases, your PCP or other provider may need to get approval in advance from our Medical Management Department for certain types of services or tests that you receive in-network (this is called getting "prior authorization"). Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in the Medical Benefits Chart in Chapter 4, Section 2.1. Prior authorization is not required for covered services received out-of-network; however, if we later determine that the services you received were not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. You or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Customer Service.

**What if a specialist or another network provider leaves our plan?**

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization may be required.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

## Section 2.4 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you**

**use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost sharing amount. See Section 3 for more information about these situations.

## SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

### Section 3.1 Getting care if you have a medical emergency

**What is a medical emergency and what should you do if you have one?**

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life, (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the toll-free number on the back of your membership card. Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. TTY users should call 711. Additionally, you should call your PCP. Your PCP's phone number is listed on the front of your membership card.

**What is covered if you have a medical emergency?**

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

**What if it wasn't a medical emergency?**

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care — thinking that your health is in serious danger — and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

### Section 3.2 Getting care when you have urgent need for services

**What are urgently needed services?**

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

For a list of urgent care centers in our network, please refer to our *Provider and Pharmacy Directory*. You can call Customer Service for information on how to access urgent care centers.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances described in the Emergency Care and Urgently Needed Services benefits listed in the Medical Benefits Chart in Chapter 4 of this document.

### Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.cigna.com/medicare/disaster-policy for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

## SECTION 4 What if you are billed directly for the full cost of your services?

### Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

### Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, you may have to pay the full cost of any skilled nursing facility care you get after our plan's payment reaches the benefit limit. Once you have used up your benefit limit, additional payments you make for the service do not count toward your annual out-of-pocket maximum.

## SECTION 5 How are your medical services covered when you are in a clinical research study?

## Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

## Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

*Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan, such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

**Do you want to know more?**

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies.* (The publication is available at: www.medicaregov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## SECTION 6 Rules for getting care in a religious non-medical health care institution

### Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

### Section 6.2 Receiving care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is **non-excepted.**

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care;
  - — *and* — you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in Chapter 4).

## SECTION 7 Rules for ownership of durable medical equipment

### Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service for more information.

**What happens to payments you made for durable medical equipment if you switch to Original Medicare?**

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the DME item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

## Section 7.2 Rules for oxygen equipment, supplies, and maintenance

**What oxygen benefits are you entitled to?**

If you qualify for Medicare oxygen equipment coverage, our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

**What happens if you leave your plan and return to Original Medicare?**

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

# CHAPTER 4:

## *Medical Benefits Chart (what is covered and what you pay)*

## SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

### Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

### Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $3,200. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for Part D prescription drugs and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are italicized in the Medical Benefits Chart.) If you have paid $3,200 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $5,150. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are italicized in the Medical Benefits Chart.) If you have paid $5,150 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

### Section 1.3 Our plan does not allow providers to balance bill you

As a member of our plan, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Customer Service.

## SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay

### Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from our plan.
  - Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart. **Note: Additional cost share may apply when**

**other services are performed at the same time.**

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
|  **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | In-Network<br>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.<br>Out-of-Network<br>$15 copayment for Medicare-covered screening. |
| **Acupuncture for chronic low back pain**<br>Covered services include:<br>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:<br>For the purpose of this benefit, chronic low back pain is defined as:<br>□Lasting 12 weeks or longer<br>□Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.);<br>□Not associated with surgery; and<br>□Not associated with pregnancy<br>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br>Treatment must be discontinued if the patient is not improving or is regressing.<br>Provider Requirements:<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.<br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:<br>□a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>□a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.<br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. | **Prior authorization may be required.**<br>In-Network<br>$20 copayment for each Medicare-covered acupuncture visit<br>Out-of-Network<br>$40 copayment for each Medicare-covered acupuncture visit |
| **Additional telehealth services: Physical therapy and Speech and Language Pathology**<br>Covered services include: virtual physical therapy and virtual speech language therapy. | $0 copayment for Medicare-covered virtual Physical Therapy |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| | $0 copayment for Medicare-covered virtual Speech and Language Pathology |
| **Ambulance services**<br>Covered ambulance services include, whether for an emergency or non-emergency situation, fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.<br>If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.<br>**Non-emergency ambulance transportation:**<br>• Medically-necessary, non-emergency transportation by ambulance is only covered to the closest facility that can provide care.<br>• Prior authorization is required for non-emergency, Medicare-covered ambulance services (such as transport from home to your doctor's office for routine visits, transport from home to a Medicare-certified dialysis facility for prescribed hemodialysis, or transport beyond the closest facility capable of providing care when transferring between facilities or levels of care).<br>• Out-of-network, non-emergency ambulance services will be reviewed after the service is rendered to ensure service was medically and reasonably necessary.<br>**Worldwide ambulance services:**<br>• Ambulance transportation outside the United States or its territories is only covered to the closest, most appropriate facility that can provide care.<br>• Return to the United States by ambulance is not a covered service unless that is where the closest, most appropriate, facility is located.<br>• See **Emergency care** or **Urgently needed services** in this chart for additional information about **Worldwide transportation** services. | **Prior authorization may be required for non-emergency ambulance services.**<br>In-Network and Out-of-Network<br>$250 copayment for each one-way Medicare-covered ground ambulance trip<br>20% coinsurance for each one-way Medicare-covered air ambulance trip |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| **Annual physical exam**<br>The annual physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare Preventive Visit. Limited to one physical exam per year. Separate cost-sharing amounts may apply to any additional lab or diagnostic procedures that are ordered during the annual physical exam.<br>**Note:** You will be responsible for cost sharing amounts for any additional services during this exam. | In Network<br>$0 copayment for annual physical exam<br>Out-of-Network<br>$15 copayment for annual physical exam |
| **Annual wellness visit**<br>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.<br>**Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.<br>**Note:** You will be responsible for cost sharing amounts for any additional services during this exam. | In-Network<br>There is no coinsurance, copayment, or deductible for the annual wellness visit.<br>Out-of-Network<br>$15 copayment for the annual wellness visit. |
| **Bone mass measurement**<br>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | In-Network<br>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.<br>Out-of-Network<br>$15 copayment for Medicare-covered bone mass measurement. |
| **Breast cancer screening (mammograms)**<br>Covered services include:<br>□ One baseline mammogram between the ages of 35 and 39<br>□ One screening mammogram every 12 months for women aged 40 and older<br>□ Clinical breast exams once every 24 months | In-Network<br>There is no coinsurance, copayment, or deductible for covered screening mammograms.<br>Out-of-Network<br>$15 copayment for Medicare-covered screening mammograms. |
| **Cardiac rehabilitation services**<br>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | **Prior authorization may be required.**<br>In-Network<br>$10 copayment for each Medicare-covered cardiac rehabilitative therapy visit |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| | $10 copayment for each Medicare-covered intensive cardiac rehabilitative therapy visit<br>One copayment will apply when multiple therapies are provided by the same provider on the same date and at the same place of service.<br>Out-of-Network<br>30% coinsurance for each Medicare-covered cardiac rehabilitative therapy visit<br>30% coinsurance for each Medicare-covered intensive cardiac rehabilitative therapy visit |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**<br>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. | In-Network<br>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.<br>Out-of-Network<br>$15 copayment for the intensive behavioral therapy cardiovascular disease preventive benefit. |
| **Cardiovascular disease testing**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | In-Network<br>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.<br>Out-of-Network<br>$15 copayment for cardiovascular disease testing that is covered once every 5 years. |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>□ For all women: Pap tests and pelvic exams are covered once every 24 months<br>□ If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months | In-Network<br>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.<br>Out-of-Network<br>$15 copayment for Medicare-covered preventive Pap and pelvic exams. |
| **Chiropractic services**<br>Covered services include: | **Prior authorization may be required.**<br>In-Network |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| □We cover only manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position) if you get it from a chiropractor. | $15 copayment for each Medicare-covered chiropractic visit.<br>Out-of-Network<br>50% coinsurance for each Medicare-covered chiropractic visit. |
| **Colorectal cancer screening**<br>The following screening tests are covered:<br>□Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.<br>□Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.<br>□Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>□Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>□Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>□Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.<br>□Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.<br>Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.<br>**Note:** If you receive a colonoscopy without previous symptoms, this is considered preventive or screening, and there will be no copayment or coinsurance. If your doctor is performing the colonoscopy because you have shown symptoms of a medical condition, this is considered outpatient surgery and cost share may apply (see **Outpatient Surgery** benefit in this chart for more information). | In-Network<br>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.<br>$0 copayment for Medicare-covered diagnostic exams and any surgical procedures (i.e., polyp removal) during a colorectal screening.<br>Out-of-Network<br>$15 copayment for Medicare-covered colorectal cancer screening exam, excluding barium enemas. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.<br>30% coinsurance for Medicare-covered diagnostic exams and any surgical procedures (i.e., polyp removal) during a colorectal screening. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| **Dental services (Medicare-covered)**<br>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.<br>See **Physician/Practitioner services, including doctor's office visits** benefit in this chart for more information on Medicare-covered non-routine dental services. | **Prior authorization may be required for Medicare-covered dental services.**<br>In-Network<br>$30 copayment for Medicare-covered dental benefits<br>Out-of-Network<br>$40 copayment for Medicare-covered dental benefits |
| **Dental services (Routine)**<br>This plan provides additional dental coverage not covered by Original Medicare. The plan provides a Dental Allowance to reimburse routine preventive and comprehensive dental services.<br>You can choose a Cigna Dental Allowance network provider or any licensed dental provider who is not on the Medicare preclusion or exclusion list. To review the exclusion list, go to: https://exclusions.oig.hhs.gov or call Dental Customer Service. Your dental provider will submit a claim for reimbursement.<br>Unused balance of the allowance amount does not carry forward to future benefit years. Cosmetic procedures are not covered. Limitations, exclusions, and restrictions may apply.<br>For details about your dental allowance and list of excluded services, go to cignamedicare.com/resources to review the Cigna Dental Allowance Guide, or call Dental Customer Service at 1-866-213-7295 (TTY 711). | In-Network and Out-of-Network<br>*$2,500 combined allowance for routine preventive and comprehensive dental services every year*. Customer is responsible for any amount over and above the allowance amount. |
| **Depression screening**<br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | In-Network<br>There is no coinsurance, copayment, or deductible for an annual depression screening visit.<br>Out-of-Network<br>$15 copayment for an annual depression screening visit. |
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.<br>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. | In-Network<br>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.<br>Out-of-Network<br>$15 copayment for Medicare-covered diabetes screening tests. |
| **Diabetes self-management training, diabetic services and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include: | **Prior authorization may be required.**<br>In-Network |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips.<br>□Lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.<br>□For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.<br>□Diabetes self-management training is covered under certain conditions.<br>**Note:** Syringes and needles are covered under our Part D benefit. Please refer to Chapter 6 of this *Evidence of Coverage* for cost sharing information.<br>For more information and a list of preferred brand diabetic supplies, please see your Customer Handbook or call Customer Service. | $0 copayment for preferred brand Medicare-covered diabetic monitoring supplies. Non-preferred brands are not covered.<br>You are eligible for one preferred brand glucose monitor and one preferred brand continuous glucose monitoring device every two years. You are also eligible for 200 preferred brand glucose test strips or three preferred brand sensors per 30-day period depending on your monitor.<br>20% coinsurance for Medicare-covered therapeutic shoes and inserts<br>$0 copayment for Medicare-covered diabetes self-management training<br>Out-of-Network<br>30% coinsurance for Medicare-covered diabetic monitoring supplies.<br>30% coinsurance for Medicare-covered therapeutic shoes and inserts<br>$0 copayment for Medicare-covered diabetes self-management training |
| **Durable medical equipment (DME) and related supplies**<br>(For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.)<br>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.<br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Prior authorization may be required for special orders. The most recent list of suppliers is available on our website at www.cignamedicare.com. | **Prior authorization is required for all Medicare-covered rental items, including oxygen equipment.**<br>**There are a limited number of DME items where the total rental price cannot exceed the purchase price and once that amount has been paid you will no longer pay for that item.**<br>In-Network<br>20% coinsurance for Medicare-covered items<br>Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance every month.<br>After 36 months, you should no longer have a coinsurance for the oxygen equipment. The equipment is eligible for replacement after the maximum expected useful life of 5 years, unless |

| Services that are covered for you | What you must pay<br>when you get these services |
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| | it is not functioning and cannot be repaired before 5 years. If you join or leave our plan the 5-year cycle starts over.<br>Out-of-Network<br>30% coinsurance for Medicare-covered items |
| **Emergency care**<br>Emergency care refers to services that are:<br>□Furnished by a provider qualified to furnish emergency services, and<br>□Needed to evaluate or stabilize an emergency medical condition.<br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.<br>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.<br>Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or discharged. Observation services may be given in the emergency department or another area of the hospital. For information about the observation services cost sharing, please see the **Outpatient hospital observation** section of this *Evidence of Coverage*.<br>*Emergency care is covered worldwide.*<br>See **Ambulance services** benefit in this chart for additional information about Worldwide ambulance services. | In-Network and Out-of-Network<br>$135 copayment for Medicare-covered emergency room visits<br>*$135* copayment *for worldwide emergency room visits and worldwide emergency transportation*<br>*$50,000 (USD) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.*<br>Emergency transportation must be medically necessary.<br>If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit.<br>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost sharing you would pay at a network hospital. |
| **Health and wellness education programs**<br>**Health Information Line**<br>Use Cigna Healthcare's 24-Hour Health Information Line to talk one-on-one with a Nurse Advocate.* This resource is available any time, day or night, 7 days a week, 365 days a year to help answer your medical and prescription drug questions or direct you to the appropriate provider, program or online tools to care for your health issue. You can also listen to recorded audio tapes from our Health Information Library. The Health Information Line is not a substitute for calling 911. If you are experiencing a health care emergency, please call 911 or go to your nearest emergency room. To access Cigna Healthcare's 24-Hour Health Information Line, call 1-866-576-8773 (TTY 711).<br>*Nurse Advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing medical advice in any capacity as a health advocate. | In-Network and Out-of-Network<br>*$0 copayment for these health and wellness programs:*<br>*– 24-Hour Health Information Line*<br>*– HealthWise*<br>*–Membership in Health Club/Fitness Classes* |

| Services that are covered for you | What you must pay<br>when you get these services |
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| **HealthWise**<br>You will have access to video and written content on a variety of health and wellness topics through the Cigna Healthcare Medicare website.<br>**Fitness**<br>The fitness benefit provides several options to help you stay active. You are eligible for a fitness membership at participating fitness locations in the standard fitness network. At these locations you can take advantage of exercise equipment, amenities and, where available, group exercise classes tailored to meet the needs of older adults. If you prefer to exercise in the privacy of your home, you can select one Home Fitness Kit per benefit year from a variety of kit options, including a wearable fitness tracker.<br>You can also take advantage of personalized Workout Plans; access thousands of on-demand workout videos available on the program's website; get one-on-one Healthy Aging Coaching by phone, video or chat, track your fitness activity; and enjoy many other digital resources through the Well-Being Club.<br>Non-standard services that call for an added fee are not part of the fitness program and will not be reimbursed.<br>For more information on your fitness benefit, please refer to the Extra Benefits Guide or contact Cigna Healthcare's fitness vendor at 1-888-886-1992 (TTY 711). | |
| **Hearing services (Medicare-covered)**<br>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. | A separate PCP/Specialist cost share may apply if additional services requiring cost sharing are rendered.<br>In-Network<br>$25 copayment for Medicare-covered diagnostic hearing exams<br>Out-of-Network<br>50% coinsurance for Medicare-covered diagnostic hearing exams |
| **Hearing services (Routine)**<br>This plan covers the following routine services:<br>□up to one routine hearing exam every year<br>□fitting evaluation for hearing aid(s)<br>□hearing aid(s)<br>Hearing aid evaluations are part of the routine hearing exam. Multiple fittings are allowed with the original provider if necessary to ensure hearing aids are accurately fitted. A routine hearing exam needs to be performed prior to hearing aids being dispensed. Hearing aid devices are limited to those worn externally and do not include assisted listening devices, amplifiers or disposable devices.<br>Customers are required to contact Cigna Healthcare's hearing vendor to access the routine hearing exam and routine hearing aid benefits. A 60-day evaluation period is granted to determine the effectiveness of a hearing aid. A 4-year supply of batteries (up to 256 cells per hearing aid) is included with a hearing aid that is acquired through Cigna Healthcare's hearing vendor. Hearing aids purchased from anyone outside Cigna | In-Network<br>*$0 copayment for one routine hearing exam every year*<br>*$0 copayment for fitting evaluations for hearings aids every year*<br>*$399 - $1,800 copayment per device for Hearing Aids.* Limited to two (2) devices every year. Actual cost-share will depend on hearing aid selected.<br>Out-of-Network<br>*50% for one routine exam every year*<br>*50% for one fitting evaluation for hearing aid every year*<br>Customers are required to contact Cigna Healthcare's hearing vendor to access hearing aid benefits. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| Healthcare's hearing vendor will not be covered. Over-the-counter hearing aid devices are not covered.<br>For more information on your routine hearing benefits, please refer to your Extra Benefits Guide or contact Cigna Healthcare's hearing vendor at 1-866-872-1001 (TTY 711). | |
| **HIV screening**<br>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:<br>□One screening exam every 12 months<br>For women who are pregnant, we cover:<br>□Up to three screening exams during a pregnancy | In-Network<br>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.<br>Out-of-Network<br>$15 copayment for members eligible for Medicare-covered preventive HIV screening. |
| **Home-Delivered Meals**<br>When released from an inpatient hospital stay or skilled nursing facility, members can get 14 healthy, medical diet appropriate, frozen meals delivered to their home. This benefit is available up to three (3) times each year. Releases from an emergency department, observation stay or outpatient visit are not eligible. Members meeting this requirement will receive a call from Cigna Healthcare's meal provider to schedule delivery.<br>For more information on your home delivered meals benefit, please refer to your Extra Benefits Guide or call Customer Services.<br>**Meals for ESRD members**<br>Members diagnosed with End-Stage Renal Disease (ESRD) and enrolled in an ESRD care management program can get up to 56 healthy frozen meals delivered to their home. Members are eligible for this benefit once per year. Members meeting this requirement will receive a call from Cigna Healthcare's meal provider to schedule delivery. | *$0 copayment for the home delivered meals benefit*<br>*$0 copayment for 56 meals over 28 days, once each year for ESRD members* |

| Services that are covered for you | What you must pay<br>when you get these services |
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| **Home health agency care**<br>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but are not limited to:<br>□Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)<br>□Physical therapy, occupational therapy, and speech therapy<br>□Medical and social services<br>□Medical equipment and supplies | **Prior authorization may be required.**<br>In Network<br>$0 copayment for Medicare-covered home health visits<br>Out-of-Network<br>30% coinsurance for Medicare-covered home health visits |
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<br>Covered services include, but are not limited to:<br>□Professional services, including nursing services, furnished in accordance with the plan of care<br>□Patient training and education not otherwise covered under the durable medical equipment benefit<br>□Remote monitoring<br>□Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | You pay the applicable cost sharing for each service obtained. Please refer to the *Durable medical equipment and related supplies and Medicare Part B Prescription Drugs* benefit listings for related cost share amounts. |
| **Hospice care**<br>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br>Covered services include:<br>□Drugs for symptom control and pain relief<br>□Short-term respite care<br>□Home care<br>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.<br>**For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your | **When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.**<br>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.<br>Hospice Consultation<br>You pay the applicable cost sharing for the provider of the service (for example, physician services). Please refer to the applicable benefit in this section of this *Evidence of Coverage*. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.<br>**For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).<br>□ If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services<br>□ If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)<br>**For services that are covered by our plan but are not covered by Medicare Part A or B:** Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services.<br>**For drugs that may be covered by the plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice)*.<br>**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.<br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | |
|  **Immunizations**<br>Covered Medicare Part B services include:<br>□ Pneumonia vaccine<br>□ Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary<br>□ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B<br>□ COVID-19 vaccine<br>□ Other vaccines if you are at risk and they meet Medicare Part B coverage rules<br>We also cover some vaccines under our Part D prescription drug benefit. | In-Network<br>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.<br>Out-of-Network<br>$15 copayment for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines. |
| **Inpatient hospital care**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.<br>Our plan covers days 1 through 90 of inpatient hospital care for each benefit period.<br>Covered services include but are not limited to: | **Prior authorization may be required.**<br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.<br>In-Network<br>For each Medicare-covered hospital stay, your copayment is: |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Semi-private room (or a private room if medically necessary)<br>□Meals including special diets<br>□Regular nursing services<br>□Costs of special care units (such as intensive care or coronary care units)<br>□Drugs and medications<br>□Lab tests<br>□X-rays and other radiology services<br>□Necessary surgical and medical supplies<br>□Use of appliances, such as wheelchairs<br>□Operating and recovery room costs<br>□Physical, occupational, and speech language therapy<br>□Inpatient substance abuse services<br>□ Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.<br>This travel benefit is not applicable for corneal transplants. Reimbursement is provided for up to $10,000 of eligible transportation and lodging expenses for an approved transplant at least 100 miles away from your legal home address to the transplant center. This benefit only covers transportation and lodging expenses for you and one companion for the initial and annual evaluation, stem cell injection and cell collection, and the actual transplant. The lodging and transportation benefit is not applicable for follow-up or post-operative visits or transplant related inpatient admissions after you receive your transplant, except for readmissions occurring during sequestering (time required to be near a facility and away from your home) immediately after a covered transplant.<br>□Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>□Physician services<br>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. | $300 per day for days 1-6;<br>$0 per day for days 7-90<br>For each Medicare-covered hospital stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted.<br>In some instances, a readmission policy may apply in which the benefit will continue from original admission.<br>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If you use more than 90 days within a benefit period, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. There is a $0 copayment per lifetime reserve day.<br>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.<br>Out-of-Network<br>For each Medicare-covered hospital stay, your coinsurance is:<br>40% per stay<br>Additional days are not covered. |

| **Services that are covered for you** | **What you must pay** when you get these services |
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| You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the website at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | |
| **Inpatient services in a psychiatric hospital**<br>Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. | **Prior authorization may be required.**<br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.<br>In-Network<br>For each Medicare-covered hospital stay, your copayment is:<br>$300 per day for days 1-6;<br>$0 per day for days 7-90<br>For each Medicare-covered hospital stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted.<br>In some instances, a readmission policy may apply in which the benefit will continue from original admission.<br>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If you use more than 90 days within a benefit period, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. There is a $0 copayment per lifetime reserve day.<br>Out-of-Network<br>For each Medicare-covered inpatient mental hospital stay, your coinsurance is:<br>40% per stay |
| **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**<br>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:<br>□Physician services<br>□Diagnostic tests (like lab tests) | You pay the applicable cost sharing for other services as though they were provided on an outpatient basis. Please refer to the applicable benefit in this section of this *Evidence of Coverage*. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □X-ray, radium, and isotope therapy including technician materials and services<br>□Surgical dressings<br>□Splints, casts, and other devices used to reduce fractures and dislocations<br>□Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices<br>□Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition<br>□Physical therapy, speech therapy, and occupational therapy | |
| **Medical nutrition therapy**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.<br>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | In-Network<br>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.<br>Out-of-Network<br>$15 copayment for members eligible for Medicare-covered medical nutrition therapy services. |
| **Medicare Diabetes Prevention Program (MDPP)**<br>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.<br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. | In-Network<br>There is no coinsurance, copayment, or deductible for the MDPP benefit.<br>Out-of-Network<br>$15 copayment for the MDPP benefit. |
| **Medicare Part B prescription drugs**<br>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:<br>□Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services<br>□Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)<br>□Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan<br>□Clotting factors you give yourself by injection if you have hemophilia<br>□Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>□Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug | **Prior authorization may be required.**<br>Medicare Part B drugs may be subject to step therapy requirements.<br>In-Network<br>0-20% coinsurance; up to $35 for Medicare-covered Part B insulin drugs. You will pay no more than $35 for one-month's supply of covered insulin. Any plan deductible does not apply.<br>0 - 20% coinsurance for Medicare-covered Part B Chemotherapy/ Radiation drugs<br>0 - 20% coinsurance for other Medicare-covered Part B drugs<br>Out-of-Network |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Antigens<br>□Certain oral anti-cancer drugs and anti-nausea drugs<br>□Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epoetin Alfa)<br>□Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.cigna.com/medicare/member-resources/drug-list-formulary.<br>We also cover some vaccines under our Part B and Part D prescription drug benefit.<br>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. | 30% coinsurance for Medicare-covered Part B insulin drugs. You will pay no more than $35 for one-month's supply of covered insulin. Any plan deductible does not apply.<br>30% coinsurance for Medicare-covered Part B Chemotherapy/ Radiation drugs<br>30% coinsurance for other Medicare-covered Part B drugs |
| **Obesity screening and therapy to promote sustained weight loss**<br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan.<br>Talk to your primary care doctor or practitioner to find out more. | In-Network<br>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.<br>Out-of-Network<br>$15 copayment for preventive obesity screening and therapy. |
| **Opioid treatment program services**<br>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br>□U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.<br>□Dispensing and administration of MAT medications (if applicable)<br>□Substance use counseling<br>□Individual and group therapy<br>□Toxicology testing<br>□Intake activities<br>□Periodic assessments | **Prior authorization may be required.**<br>In-Network<br>$30 copayment for Medicare-covered opioid treatment services<br>Out of-Network<br>$40 copayment for Medicare-covered opioid treatment services |
| **Outpatient diagnostic tests and therapeutic services and supplies**<br>Covered services include, but are not limited to:<br>□X-rays<br>□Radiation (radium and isotope) therapy including technician materials and supplies<br>□Surgical supplies, such as dressings<br>□Splints, casts and other devices used to reduce fractures and dislocations<br>□Laboratory tests<br>□Medicare-covered genetic tests will only be covered once per the member's lifetime unless the test is specifically approved by the U.S. Food and Drug Administration (FDA) to be performed more than once. | **Prior authorization may be required.**<br>A separate PCP/Specialist cost share will apply if additional services requiring cost sharing are rendered. A facility fee may also apply.<br>In-Network<br>$0 or $50 for Medicare-covered diagnostic procedures and tests. $0 copayment for EKG and diagnostic colorectal screenings. $50 copayment |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>□Other outpatient diagnostic tests | for all other diagnostic procedures and tests.<br>0% coinsurance for Medicare-covered lab services.<br>20% coinsurance for Medicare-covered genetic tests.<br>$0 copayment for Medicare-covered blood services<br>$0 or $150 copayment for Medicare-covered diagnostic radiology services (not including X-rays). $0 copayment for mammography and ultrasounds. $150 copayment for all other diagnostic and nuclear medicine radiological services<br>If multiple test types (such as CT and PET) are performed in the same day, multiple copayments will apply. If multiple tests of the same type (for example, CT scan of the head and CT scan of the chest) are performed in the same day one copayment will apply.<br>$60 copayment for Medicare-covered therapeutic radiology services<br>$10 copayment for Medicare-covered X-rays.<br>Out-of-Network<br>30% coinsurance for Medicare-covered diagnostic procedures and tests<br>30% coinsurance for Medicare-covered lab services.<br>30% coinsurance for Medicare-covered genetic tests.<br>Coinsurance of 30% with deductible waived for first three pints for Medicare-covered blood services.<br>30% coinsurance for Medicare-covered diagnostic and nuclear medicine radiological services (not including X-rays).<br>30% coinsurance for Medicare-covered therapeutic radiology services. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| | 30% coinsurance for Medicare-covered X-rays. |
| **Outpatient hospital observation**<br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.<br>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | **Prior authorization may be required.**<br>In-Network<br>$300 copayment for Medicare-covered outpatient hospital observation<br>Out-of-Network<br>30% coinsurance for Medicare-covered outpatient hospital observation |
| **Outpatient hospital services**<br>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br>Covered services include, but are not limited to:<br>□Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery<br>□Laboratory and diagnostic tests billed by the hospital<br>□Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>□X-rays and other radiology services billed by the hospital<br>□Medical supplies such as splints and casts<br>□Certain drugs and biologicals that you can't give yourself<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. | **Prior authorization may be required.**<br>You pay the applicable cost sharing for these services. Please refer to the applicable benefit in this section of this *Evidence of Coverage*.<br>Self-administered drugs (medication you would normally take on your own) are not covered in an outpatient hospital setting.<br>These drugs may be covered under your Part D benefit. Please contact Customer Service for more information. |
| **Outpatient mental health care**<br>Covered services include: | **Prior authorization may be required.**<br>In-Network |

| Services that are covered for you | What you must pay<br>when you get these services |
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| Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner, (NP), physician assistant, (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.<br>Behavioral health telehealth services are available through Cigna Healthcare's telehealth vendor. For more information see the Extra Benefits Guide or call Customer Service. | $0 copayment for each Medicare-covered individual or group therapy visit<br>$0 copayment for each Medicare-covered individual or group therapy visit with a psychiatrist<br>$0 copayment for each Medicare-covered Behavioral health telehealth visit obtained from Cigna Healthcare's telehealth vendor.<br>Out-of-Network<br>$40 copayment for each Medicare-covered individual or group therapy visit<br>$40 copayment for each Medicare-covered individual or group therapy visit with a psychiatrist<br>Telehealth services must be obtained from Cigna Healthcare's telehealth vendor. |
| **Outpatient rehabilitation services**<br>Covered services include physical therapy, occupational therapy, and speech language therapy in-person visits.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | **Prior authorization may be required.**<br>One copayment will apply when multiple therapies (such as PT, OT, ST) are provided by the same provider on same date and at the same place of service.<br>In-Network<br>$30 copayment for Medicare-covered Occupational Therapy visits<br>$30 copayment for Medicare-covered Physical Therapy in-person visits<br>$30 copayment for Medicare-covered Speech and Language Pathology in-person visits<br>Out-of-Network<br>$40 copayment for Medicare-covered Occupational Therapy visits<br>$40 copayment for Medicare-covered Physical Therapy in-person visits<br>$40 copayment for Medicare-covered Speech and Language Pathology in-person visits |
| **Outpatient substance abuse services** | **Prior authorization may be required.** |

| Services that are covered for you | What you must pay<br>when you get these services |
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| Covered services include: Substance abuse outpatient services including Partial Hospitalization Program, Opioid Treatment Programs (OTP), outpatient evaluation, outpatient therapy and medication management provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified behavioral health care professional as allowed under applicable state laws. | In-Network<br>$30 copayment for Medicare-covered individual or group substance abuse outpatient treatment visits<br>Out-of-Network<br>$40 copayment for Medicare-covered individual or group substance abuse outpatient treatment visits |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br>**Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. | **Prior authorization may be required.**<br>In-Network<br>$0 or $300 copayment for each Medicare-covered outpatient hospital facility visit. $0 copayment for any surgical procedures (i.e., polyp removal) during a colorectal screening. $300 copayment for all other Outpatient Services not provided in an Ambulatory Surgical Center.<br>$0 or $260 copayment for each Medicare-covered ambulatory surgical center visit. $0 copayment for any surgical procedures (i.e., polyp removal) during a colorectal screening. $260 copayment for all other Ambulatory Surgical Center (ASC) services.<br>Out-of-Network<br>30% coinsurance for each Medicare-covered outpatient hospital facility visit<br>30% coinsurance for each Medicare-covered ambulatory surgical center visit |
| **Over-the-Counter Items and Services**<br>The Over-the-Counter allowance will be applied to your Cigna Heathy Today benefit card each quarter. Customers can use the full quarterly allowance any time throughout the quarter. You can use the benefit card to make online, phone, or mail orders from Cigna Healthcare's OTC catalog. Or you can purchase approved OTC items at participating retail locations.<br>The OTC allowance applies to a specified quarterly amount and does not carry over to the next quarter or the following year. Exceptions may apply. Some OTC items require a doctor's recommendation for a specific diagnosable condition. Catalog orders limited to one per member per month. | *$65 every three months for specific over-the-counter drugs and other health-related pharmacy products.* |

| Services that are covered for you | What you must pay<br>when you get these services |
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| Please visit CignaHealthyToday.com to see our list of covered Over-the-Counter items and participating retail locations. For more information on your OTC benefit, please refer to your Extra Benefits Guide or contact Cigna Healthcare's OTC customer service at 1-866-851-1579 (TTY 711). | |
| **Partial hospitalization services and Intensive outpatient services**<br>Partial hospitalization is a structured program of active psychiatric treatment provided a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.<br>Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. | **Prior authorization may be required.**<br>In-Network<br>$100 copayment for Medicare-covered partial hospitalization program services and intensive outpatient services<br>Out-of-Network<br>30% coinsurance for Medicare-covered partial hospitalization program services and intensive outpatient services |
| **Physician/Practitioner services, including doctor's office visits**<br>Covered services include:<br>□ Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>□ Consultation, diagnosis, and treatment by a specialist<br>□ Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment<br>□ Certain telehealth services, including urgent care (treating symptoms like allergies, cough, headache, nausea, and other low-risk illnesses), mental health therapy, and dermatology.<br>o You have the option of receiving these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who offers the service by telehealth.<br>o The telehealth benefit is applicable to providers who partner with Cigna Healthcare's telehealth vendor for telehealth services. Customers will be required to complete registration and a brief medical history upon first use of telehealth and provide applicable copay at time of the telehealth visit. Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include video. For more information on your telehealth benefits, see your Extra Benefits Guide or call Customer Service.<br>□ Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare<br>□ Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home<br>□ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location | **Prior authorization may be required.**<br>In-Network<br>$0 copayment for each Medicare-covered primary care physician visit<br>$30 copayment for each Medicare-covered specialist visit<br>$0 copayment in a PCP office or $30 copayment in a Specialist Office for each Medicare-covered Other Health Care Professional Service.<br>Out-of-Network<br>$15 copayment for each Medicare-covered primary care physician visit<br>$40 copayment for each Medicare-covered specialist visit<br>$15 copayment in a PCP office or $40 copayment in a Specialist office for each Medicare-covered Other Health Care Professional Service |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location<br>□Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>o You have an in-person visit within 6 months prior to your first telehealth visit<br>o You have an in-person visit every 12 months while receiving these telehealth services<br>o Exceptions can be made to the above for certain circumstances<br>□Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>□Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:<br>o You're not a new patient **and**<br>o The check-in isn't related to an office visit in the past 7 days **and**<br>o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>□Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:<br>o You're not a new patient **and**<br>o The evaluation isn't related to an office visit in the past 7 days **and**<br>o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>□Consultation your doctor has with other doctors by phone, internet, or electronic health record<br>□Second opinion by another network provider prior to surgery<br>□Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)<br>□Wound care services (including clinic) are provided to manage acute and chronic wounds through debridement, local wound care and specialized dressings.<br>□Medicare covers services provided by other health providers, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Health professional means—<br>–a physician who is a doctor of medicine or osteopathy; or<br>–a physician assistant, nurse practitioner, or clinical nurse specialist; or<br>–a medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician<br>**Note:** Costs for services provided by other health providers (such as a nurse practitioner or physician assistant) will be based on the supervising physician's specialty. For example, if you are seeing a nurse practitioner and the supervising physician is a PCP, you will pay the PCP cost. If you are seeing a nurse practitioner and supervising physician is a Specialist, you will pay the Specialist cost. | |

| Services that are covered for you | What you must pay<br>when you get these services |
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| **Podiatry services**<br>Covered services include:<br>□Diagnosis and the medically necessary treatment of injuries and diseases of the feet (such as hammer toe, bunion deformities or heel spurs)<br>□Routine foot care for members with certain medical conditions affecting the lower limbs | In-Network<br>$30 copayment for each Medicare-covered podiatry visit.<br>Out-of-Network<br>$40 copayment for each Medicare-covered podiatry visit |
| **Prostate cancer screening exams**<br>For men age 50 and older, covered services include the following – once every 12 months:<br>□Digital rectal exam<br>□Prostate Specific Antigen (PSA) test | In-Network<br>There is no coinsurance, copayment, or deductible for an annual PSA test.<br>Out-of-Network<br>$15 copayment for an annual PSA test. |
| **Prosthetic devices and related supplies**<br>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail.<br>**Note:** Medical supply quantities will be reviewed to ensure they are medically necessary and reasonable. Total monthly quantity limits may apply for medical supplies. | **Prior authorization may be required.**<br>In-Network<br>20% coinsurance for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices<br>Out-of-Network<br>30% coinsurance for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices |
| **Pulmonary rehabilitation services**<br>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | **Prior authorization may be required.**<br>One copayment will apply when multiple therapies are provided by the same provider on the same date and at the same place of service.<br>In-Network<br>$10 copayment for each Medicare-covered pulmonary rehabilitative therapy visit<br>Out-of-Network<br>30% coinsurance for each Medicare-covered pulmonary rehabilitative therapy visit |
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. | In-Network<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. |

| Services that are covered for you | What you must pay<br>when you get these services |
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| If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | Out-of-Network<br>$15 copayment for Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. |
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>For qualified individuals, a LDCT is covered every 12 months.<br>**Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.<br>*For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | In-Network<br>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.<br>Out-of-Network<br>$15 copayment for Medicare-covered counseling and shared decision-making visit or for the LDCT. |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.<br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | In-Network<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.<br>Out-of-Network<br>$15 copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |
| **Services to treat kidney disease**<br>Covered services include:<br>□ Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.<br>□ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3), or when your provider for this service is temporarily unavailable or inaccessible)<br>□ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) | **Prior authorization may be required for Medicare-covered renal dialysis.**<br>In-Network<br>$0 copayment for Medicare-covered kidney disease education services<br>20% coinsurance for Medicare-covered renal dialysis<br>Out-of-Network<br>$0 copayment for Medicare-covered kidney disease education services<br>30% coinsurance for Medicare-covered renal dialysis |

| Services that are covered for you | What you must pay<br>when you get these services |
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| □Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)<br>□Home dialysis equipment and supplies<br>□Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)<br>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section, Medicare Part B prescription drugs. | |
| **Skilled nursing facility (SNF) care**<br>(For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.)<br>Plan covers up to 100 days each benefit period. An inpatient hospital stay is **not** required prior to SNF admission.<br>Covered services include but are not limited to:<br>□Semiprivate room (or a private room if medically necessary)<br>□Meals, including special diets<br>□Skilled nursing services<br>□Physical therapy, occupational therapy, and speech therapy<br>□Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)<br>□Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.<br>□Medical and surgical supplies ordinarily provided by SNFs<br>□Laboratory tests ordinarily provided by SNFs<br>□X-rays and other radiology services ordinarily provided by SNFs<br>□Use of appliances such as wheelchairs ordinarily provided by SNFs<br>□Physician/Practitioner services<br>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.<br>□A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)<br>□An SNF where your spouse or domestic partner is living at the time you leave the hospital | **Prior authorization may be required.**<br>In-Network<br>For Medicare-covered SNF stay, the copayment is:<br>$20 per day for days 1-20;<br>$203 per day for days 21-100<br>In some instances, a readmission policy may apply in which the benefit will continue from original admission.<br>For each Medicare-covered SNF stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted.<br>Out-of-Network<br>For each Medicare-covered SNF stay, your coinsurance is:<br>30% per stay |
|  **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. | In-Network<br>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br>Out-of-Network |

| Services that are covered for you | What you must pay<br>when you get these services |
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| If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. | $15 copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits. |
| **Supervised Exercise Therapy (SET)**<br>SET is covered for members who have symptomatic peripheral artery disease (PAD) and are recommended for treatment by the responsible physician.<br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br>The SET program must:<br>□Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication<br>□Be conducted in a hospital outpatient setting or a physician's office<br>□Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD<br>□Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques<br>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | **Prior authorization may be required.**<br>In-Network<br>$10 copayment for each Medicare-covered Supervised Exercise Therapy visit<br>One copayment will apply when multiple therapies are provided by the same provider on the same date and at the same place of service.<br>Out-of-Network<br>30% coinsurance for each Medicare-covered Supervised Exercise Therapy visit |
| **Urgently needed services**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.<br>*Urgently needed services are covered worldwide.*<br>See **Ambulance services** benefit in this chart for additional information about Worldwide ambulance services. | In-Network and Out-of-Network<br>$30 copayment for Medicare-covered urgently needed service visit<br>*$135 copayment for worldwide emergency/urgent coverage and worldwide emergency transportation*<br>*$50,000 (USD) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.*<br>Emergency transportation must be medically necessary.<br>If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the urgently needed services visit. |
|  **Vision care (Medicare-covered)**<br>Covered services include: | A separate PCP/Specialist cost share may apply if additional services requiring cost sharing are rendered (e.g., but not limited to, if a medical |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| □Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.<br>□For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older<br>□For people with diabetes, screening for diabetic retinopathy is covered once per year<br>□One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)<br>For more information on your Medicare-covered vision benefits, call Customer Service. | eye condition is discovered during a preventive routine eye exam).<br>For surgical procedures performed in an outpatient surgical center, a separate physician cost share or facility fee may apply.<br>In-Network<br>$0 or $30 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screenings and diabetic retinal exams. $30 copayment for all other Medicare-covered vision services.<br>$0 copayment for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens)<br>Out-of-Network<br>$0 or $40 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screenings and diabetic retinal exams. $40 copayment for all other Medicare-covered vision services.<br>30% coinsurance for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens) |
| **Vision care (Routine)**<br>This plan covers: one (1) non-Medicare-covered routine eye exam (including eye refraction) per year. Eye refractions outside of the annual routine eye exams are not covered.<br>□ One (1) routine eye exam (including eye refraction) per year. Eye refractions outside of the annual routine eye exams are not covered. | A separate PCP/Specialist cost share may apply if additional services requiring cost sharing are rendered (e.g., but not limited to, if a medical eye condition is discovered during a preventive routine eye exam). |

| Services that are covered for you | What you must pay<br>when you get these services |
|---|---|
| □Eyeglasses and frames or contact lenses up to the plan allowance amount. The plan specified allowance may be applied to one set of the customer's choice of eyewear, to include the eyeglass frame/lenses/lens options combination or contact lenses and contact lens fitting (to include related professional fees) in lieu of eyeglasses. Routine annual eyewear allowance applied to the retail value only. Applicable taxes are not covered. Unused balance of the allowance amount does not carry forward to future benefit years.<br>For routine eye exams and eyewear services, customers are encouraged to select a provider within Cigna Healthcare's vision vendor network but are not required to do so. Customers have the option to select doctors and benefits both in- and out-of-network with no referrals required, however, out-of-pocket costs may be higher for out-of-network services.<br>There are limitations on the number of covered services within a service category. Frequency limits vary depending on the type of covered service. Medically necessary contact lenses are not covered by the routine vision benefit. Some exclusions may apply.<br>For more information on your routine eye exam and eyewear benefit, please refer to your Extra Benefits Guide or contact Cigna Healthcare's vision vendor at 1-888-886-1995 (TTY 711). | In-Network<br>*$0 copayment for one routine eye exam every year (routine eye exam does not include a contact lens fitting)*<br>Out-of-Network<br>*50% coinsurance up to one routine eye exam every year (routine eye exam does not include a contact lens fitting)*<br>In-Network and Out-of-Network<br>*$0 copayment up to the eyewear allowance for:*<br>*– up to one pair of eyeglasses (lenses and frames) every year*<br>*– unlimited contact lenses up to plan coverage limit*<br>*– up to one pair of eyeglass lenses every year*<br>*– up to one eyeglass frame every year upgrades*<br>$150 allowance for routine eyewear every year. Customer is responsible for all costs over and above the allowance amount. |
| **Welcome to Medicare Preventive Visit**<br>The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.<br>**Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit, | In-Network<br>There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.<br>Out-of-Network<br>$15 copayment for the Welcome to Medicare preventive visit. |

## SECTION 3 What services are not covered by the plan?

### Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Acupuncture. | | □Available for people with chronic low back pain under certain circumstances. |
| Air ambulance for transportation to return to the United States. | | □Return or repatriation to the United States during a medical injury or illness is not covered unless the closest appropriate facility to stabilize and treat the injury or illness is in the United States. Once stabilized, return air ambulance transportation to the United States is not covered. |
| Cosmetic surgery or procedures. | | □Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.<br>□Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. |
| Custodial care.<br>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing. | **Not covered under any condition.** | |
| Experimental medical and surgical procedures, equipment and medications.<br>Experimental procedures and items are those items and procedures determined Original Medicare to not be generally accepted by the medical community. | | □May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.<br>(See Chapter 3, Section 5 for more information on clinical research studies.) |
| Fees charged for care by your immediate relatives or members of your household. | **Not covered under any condition.** | |
| Full-time nursing care in your home. | **Not covered under any condition.** | |
| Home-delivered meals. | | □Please refer to Home-delivered meals in the Medical Benefits Chart for more information. |
| Homemaker services include basic household assistance, including light housekeeping or light meal preparation. | **Not covered under any condition.** | |
| Incontinence supplies including pads, pull-ups and gloves | **Not covered under any condition.** | |

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|---|---|
| Naturopath services (uses natural or alternative treatments). | **Not covered under any condition.** | |
| Non-routine dental care. | | □Dental care required to treat illness or injury may be covered as inpatient or outpatient care. |
| Obstetrical services. | **Not covered under any condition.** | |
| Orthopedic shoes or supportive devices for the feet. | | □Shoes that are part of a leg brace and are included in the cost of the brace.<br>□Orthopedic or therapeutic shoes for people with diabetic foot disease. |
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television. | **Not covered under any condition.** | |
| Private room in a hospital. | | □Covered only when medically necessary. |
| Reversal of sterilization procedures and/or non-prescription contraceptive supplies. | **Not covered under any condition.** | |
| Routine chiropractic care. | | □Manual manipulation of the spine to correct a subluxation is covered. |
| Routine foot care. | | □Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). |
| Radial keratotomy, LASIK surgery and other low vision aids. (Please refer to the Medical Benefits Chart for vision services covered by our plan.) | | □Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. |
| Services considered not reasonable and necessary, according to Original Medicare standards. | **Not covered under any condition.** | |

# CHAPTER 5:

## *Using the plan's coverage for Part D prescription drugs*

## SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

### Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

## SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

### Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's "Drug List."

### Section 2.2 Network pharmacies

**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (www.cignamedicare.com), and/or call Customer Service.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider and Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out about how your out-of-pocket costs could vary for different drugs.

**What if the pharmacy you have been using leaves the network?**

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Service or use the *Provider and Pharmacy Directory*. You can also find information on our website at www.cignamedicare.com.

**What if you need a specialized pharmacy?**

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider

coordination, or education on their use. (*Note:* This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Customer Service.

## Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **a 30-day, 60-day or 90-day supply.**

You may go to any of our network mail-order pharmacies. However, your costs may be even less for your covered drugs if you use a network mail-order pharmacy that offers preferred cost sharing rather than a network mail-order pharmacy that offers standard cost sharing. The *Provider and Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us.

To get information about filling your prescriptions by mail, please visit our website (www.cignamedicare.com) or contact Customer Service.

Usually a mail-order pharmacy order will get to you in no more than 14 days. In the event a mail order package is delayed, the mail-order pharmacy will assist you to coordinate a short-term fill with a retail pharmacy that is near you. You can also contact Customer Service for assistance.

**New prescriptions the pharmacy receives directly from your doctor's office.**

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling 1-877-860-0982 (TTY 711) or logging in to www.myCigna.com.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-877-860-0982 (TTY 711) or logging in to www.myCigna.com.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling 1-877-860-0982 (TTY 711) or logging in to www.myCigna.com.

**Refills on mail order prescriptions.** For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail order refills, please contact us by calling 1-877-860-0982 (TTY 711) or logging in to www.myCigna.com.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

## Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's "Drug List." (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost sharing) at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you will be responsible for the difference in price. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2 for more information.

### Section 2.5 When can you use a pharmacy that is not in the plan's network?

**Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You travel outside the plan's service area and run out of or lose covered Part D drugs, or become ill and need a covered Part D drug and cannot access a network pharmacy.
- You are unable to obtain a covered Part D drug in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24/7 service.
- You are filling a prescription for a covered Part D drug and that particular drug is not regularly stocked at an accessible network retail or mail order pharmacy.
- The Part D drugs are dispensed by an out-of-network institution-based pharmacy while in an emergency facility, provider-based clinic, outpatient surgery, or other outpatient setting.

**How do you ask for reimbursement from the plan?**

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

## SECTION 3 Your drugs need to be on the plan's "Drug List"

### Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the "Drug List" are only those covered under Medicare Part D.

We will generally cover a drug on the plan's "Drug List" as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- — *or* — Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug List" includes both brand name and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List," when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

**What is *not* on the "Drug List?"**

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the "Drug List." For more information, please see Chapter 9.

### Section 3.2 There are 5 cost sharing tiers for drugs on the Drug List

Every drug on the plan's "Drug List" is in one of 5 cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug:

| | Cost Sharing Tier | Drugs Included in Cost Sharing Tier |
|---|---|---|
| **Lowest Cost Sharing Tier** | 1 | Preferred Generic Drugs |
| | 2 | Generic Drugs |
| | 3 | Preferred Brand Drugs |
| | 4 | Non-Preferred Drugs |
| **Highest Cost Sharing Tier** | 5 | Specialty Drugs |

To find out which cost sharing tier your drug is in, look it up in the plan's "Drug List."

The amount you pay for drugs in each cost sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs).*

### Section 3.3 How can you find out if a specific drug is on the "Drug List"?

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically. (Please note: The "Drug List") we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the plan's website (www.cignamedicare.com). The "Drug List" on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (cigna.com/member-resources, then select "Find a Drug or Pharmacy" or by calling Customer Service). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

## SECTION 4 There are restrictions on coverage for some drugs

### Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List." If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once on our "Drug List." This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

### Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** Contact Customer Service to learn what you or your provider would need to do to get coverage for the