January 1 - December 31, 2024

EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Services as a Member of Cigna True Choice Courage 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 Courage Medicare (PPO), is offered by Cigna Healthcare[SM]. (When this *Evidence of Coverage* says "we," "us," or "our," it means Cigna Heathcare. When it says "plan" or "our plan," it means Cigna True Choice Courage 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 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 benefits;
- 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.

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

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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 Courage Medicare (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Cigna True Choice Courage 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 Courage Medicare (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Cigna True Choice Courage Medicare (PPO) does not include Part D prescription drug coverage.

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* booklet about?

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, 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 word coverage and covered services refers to the medical care and services available to you as a member of Cigna True Choice Courage 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 or 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 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 in your 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 2.3 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 and Missouri: IL: Madison, Monroe, St. Clair
MO: Crawford, Franklin, Jefferson, St. Charles, St. Louis, St. Louis City, Warren, Washington

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service 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.

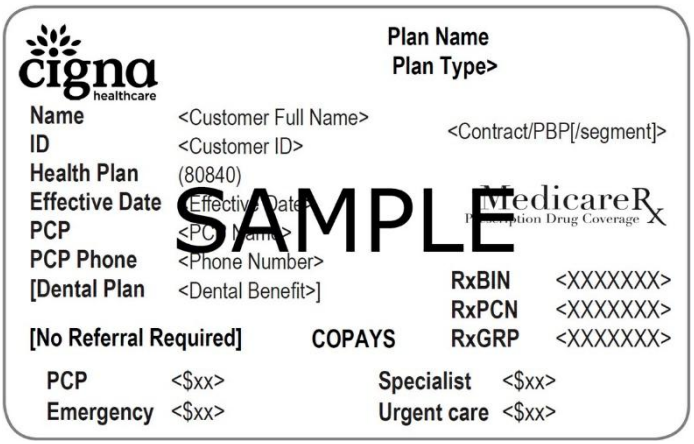
Section 2.3 U.S. Citizen or Lawful Presence

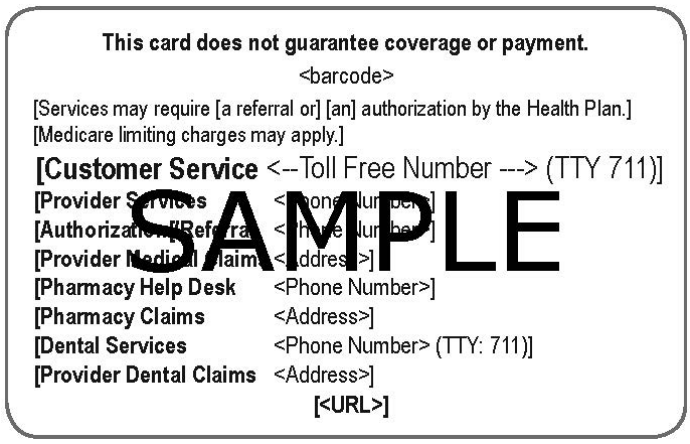
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna Healthcare if you are not eligible to remain a member on this basis. Cigna Healthcare must disenroll you if you do not meet this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

SECTION 3 Important membership materials 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 any services covered by this plan. 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 Courage 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 search 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 *Provider and Pharmacy Directory*: Your guide to all 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 Directories will be mailed to you within three business days.

SECTION 4 Your monthly costs for your plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs.* If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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.

As a member of our plan, we will reduce your monthly Medicare Part B premium by up to $75.00.

SECTION 5 More information about your monthly premium

Section 5.1 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.

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, 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 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

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 us to collect information from you about any other medical insurance coverage and/or drug insurance coverage that you may have. This is 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 Member Services. 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)

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 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. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 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 about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 *(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 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 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 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: Precertification Department, P.O. Box 20002, Nashville, TN 37202

How to contact us when you are making a complaint about your medical care

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 7 (*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 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 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 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 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 5 *(Asking us to pay our share of a bill you have received for covered medical services)*.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
WRITE	Cigna Healthcare, Attn: Direct Member Reimbursement, Medical Claims, P.O. Box 20002, Nashville, TN 37202
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 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov 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.

Method	Medicare – Contact Information
	You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: □ **Medicare Eligibility Tool:** Provides Medicare eligibility status information. □ **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. You can also use the website to tell Medicare about any complaints you have about our plan: □ **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. 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 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 answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

□ In Illinois, the SHIP is called Senior Health Insurance Program (SHIP)

□ In Missouri, the SHIP is called CLAIM - State Health Insurance Assistance Program

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

The State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. Hey 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. The State Health Insurance Assistance Program (SHIP) counselors can also 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) (Illinois's SHIP)
CALL	1-800-252-8966
TTY	711 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

Method	CLAIM - State Health Insurance Assistance Program (Missouri's SHIP)
CALL	1-800-390-3330
WRITE	CLAIM - State Health Insurance Assistance Program, 1105 Lakeview Avenue, Columbia, MO 65201
WEBSITE	www.missouriclaim.org

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- In Illinois, the Quality Improvement Organization is called Livanta
- In Missouri, the Quality Improvement Organization is called Livanta

The Quality Improvement Organization 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. The Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization 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)
CALL	1-888-524-9900 Hours are Mon. - Fri. 9:00 a.m. - 5:00 p.m., 24 hour voicemail service is available
TTY	1-888-985-8775 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

Method	Livanta (Missouri's Quality Improvement Organization)
CALL	1-888-755-5580 Hours are Mon. - Fri. 9:00 a.m. - 5:00 p.m., 24 hour voicemail service is available
TTY	1-888-985-9295 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 ESRD 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.

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 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. 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 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., 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** are:

- **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 it's programs, contact:

- In Illinois, the Medicaid Agency is called Illinois Department of Healthcare and Family Services
- In Missouri, the Medicaid Agency is called MO HealthNet Division

Method	Illinois Department of Healthcare and Family Services – Contact Information
CALL	1-877-456-1233 Hours are Mon. - Fri. 8:00 a.m. - 4:45 p.m.
TTY	1-800-447-6404 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

Method	MO HealthNet Division (Missouri's Medicaid program) – Contact Information
CALL	1-573-751-3425 or 1-800-392-2161 Hours are Mon. - Fri. 8:00 a.m. - 5:00 p.m.
TTY	1-800-735-2966 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Missouri Dept of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65102-6500
WEBSITE	http://dss.mo.gov/mhd

SECTION 7 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 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. 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 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 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.

CHAPTER 3:

Using the plan for your medical services

SECTION 1 Things to know about getting your medical care covered 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, Part B 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, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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 only required it it's listed in the in-network and out-of-network services in the Medical Benefit Chart; 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 booklet).

How do you choose your PCP?

You can select your 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 approval in advance 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 booklet.

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 only required if it's listed in the in-network and out-of-network services in the Medical Benefit Chart; however, if we later determine that the out-of-network 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?

It is important that you know that 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 7.

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 in-