



# 2024 Summary of Benefits

January 1, 2024 - December 31, 2024

**Cigna Preferred Medicare (HMO)**  
**H2108-042-002**

No referrals required

**Service Area:**

District of Columbia (DC)



# Introduction

This *Summary of Benefits* gives you a summary of what **Cigna Preferred Medicare (HMO)** covers and what you pay. It doesn't list every service that we cover or every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage* (EOC) online at **CignaMedicare.com**, or call us to request a copy.

## To Join

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

## Comparing coverage

If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits*. Or use the *Medicare Plan Finder* on **www.medicare.gov**.

## More about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook.

View the handbook online at:

**www.medicare.gov**

Get a copy of the handbook 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**.

## Need help?

### Already a customer

Call toll-free **1-800-668-3813 (TTY 711)**.

Customer Service is available 8 a.m. to 8 p.m. local time: 7 days a week, October – March; and Monday – Friday, April – September. Our automated phone system may answer your call during weekends, holidays, and after hours.

### Not a customer

Call toll-free **1-800-313-0973 (TTY 711)**.

Licensed agents are available 8 a.m. to 8 p.m. local time: 7 days a week, October – March; and Monday – Friday, April – September. Our automated phone system may answer your call during weekends, holidays, and after hours.

You can also visit our website at:

**CignaMedicare.com**.

# 1 | About This Plan

## Which doctors, hospitals, and pharmacies can I use?

**Cigna Preferred Medicare (HMO)** has a network of doctors, hospitals, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

- › You can see our plan's *Provider and Pharmacy Directory* at our website **CignaMedicare.com**.

## What do we cover?

Like all Medicare health plans, we cover everything Original Medicare covers—and more.

- › Our customers get all the benefits covered by Original Medicare.
- › Our customers also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this *Summary of Benefits*.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- › You can see the plan's complete *Comprehensive Prescription Drug List*, which lists the Part D prescription drugs along with any restrictions on our website, **CignaMedicare.com**.
- › Or call us, and we will send you a copy of the plan's *Comprehensive Prescription Drug List*.

## 2 | Monthly Premium, Deductible, and Limits

Benefit	Cigna Preferred Medicare (HMO)
<b>Monthly Plan Premium</b>	<p><b>\$0</b> per month.</p> <p>In addition, you must keep paying your Medicare Part B premium.</p>
<b>Medical Deductible</b>	<p>This plan does not have a deductible.</p>
<b>Maximum Out-of-Pocket Amount (does not include prescription drugs)</b>	<p>Your yearly out-of-pocket limit(s) in this plan:</p> <p><b>\$5,900</b> applies to in-network Medicare-covered benefits</p> <p>This limit is the most you pay for copays, coinsurance, and other costs for Medicare-covered services for the year. If you reach the limit on out-of-pocket costs, you will keep getting in-network Medicare-covered hospital and medical services, and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums, if any, and cost-sharing for your Part D prescription drugs.</p>

# 3 | Covered Medical and Hospital Benefits

Benefit	What You Pay
<p><b>Note:</b> Services with a <sup>1</sup> may require prior authorization.            Services with a <sup>2</sup> may require a referral from your doctor.</p>	
<p><b>Inpatient Hospital Coverage<sup>1</sup></b></p>	
<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>For each Medicare-covered hospital stay, you are required to pay the applicable cost sharing, starting with Day 1, each time you are admitted.</p>	<p><b>\$290</b> copay per day for days 1-5  <b>\$0</b> copay per day for days 6-90</p>
<p><b>Outpatient Hospital Services</b></p>	
<p>Outpatient Hospital<sup>1</sup></p>	<p><b>\$0-\$340</b> copay</p>
<p>Outpatient Observation<sup>1</sup></p>	<p><b>\$340</b> copay per stay</p>
<p><b>Ambulatory Surgical Center (ASC) Services</b></p>	
<p>ASC Services<sup>1</sup></p>	<p><b>\$0-\$250</b> copay</p>
<p><b>Doctor Visits</b></p>	
<p>Primary Care Provider (PCP)</p>	<p><b>\$10</b> copay for primary care doctor in-person or telehealth visits</p>
<p>Specialists<sup>1</sup></p>	<p><b>\$40</b> copay</p>

Benefit	What You Pay
<b>Preventive Care</b>	
<p>Our plan covers many Medicare-covered preventive services, including:</p> <ul style="list-style-type: none"> <li>› Abdominal aortic aneurysm screening</li> <li>› Alcohol misuse screenings and counseling</li> <li>› Bone mass measurement</li> <li>› Breast cancer screening (mammogram)</li> <li>› Cardiovascular disease (behavioral therapy)</li> <li>› Cardiovascular screenings</li> <li>› Cervical and vaginal cancer screening</li> <li>› Colorectal cancer screening (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy)</li> <li>› Depression screenings</li> <li>› Diabetes screenings</li> <li>› Diabetes self-management training</li> <li>› Glaucoma tests</li> <li>› Hepatitis B Virus (HBV) infection screening</li> <li>› Hepatitis C screening</li> <li>› HIV screening</li> <li>› Lung cancer screening with low-dose computed tomography (LDCT)</li> <li>› Medical nutrition therapy services</li> <li>› Obesity screening and counseling</li> <li>› Prostate cancer screenings (PSA)</li> <li>› Sexually transmitted infections screening and counseling</li> <li>› Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>› Vaccines, including COVID-19, flu shots, hepatitis B shots, and pneumococcal shots</li> <li>› Welcome to Medicare preventive visit (one time)</li> <li>› Yearly Wellness visit</li> </ul>	<p><b>\$0</b> copay</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. Please see your <i>EOC</i> for frequency of covered services.</p>

Benefit	What You Pay
<b>Emergency Care</b>	
Emergency Care Services	<b>\$120</b> copay If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care.
Worldwide Emergency/Urgent Coverage/Emergency Transportation	<b>\$120</b> copay Maximum worldwide coverage amount <b>\$50,000</b>
<b>Urgently Needed Services</b>	
Urgent Care Services	<b>\$50</b> copay If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for urgent care.
<b>Diagnostic Services, Labs, and Imaging</b> Costs for these services may vary based on place of service or type of service	
Diagnostic Procedures and Tests <sup>1</sup>	<b>\$0–\$50</b> copay
Lab Services <sup>1</sup>	<b>\$0</b> copay
Genetic Testing <sup>1</sup>	<b>20%</b> coinsurance
Diagnostic Radiological Services (MRIs, CT scans, etc.) <sup>1</sup>	<b>\$0–\$250</b> copay
Therapeutic Radiological Services <sup>1</sup>	<b>\$60</b> copay
X-ray Services	<b>\$35</b> copay
<b>Hearing Services</b>	
Hearing Exams (Medicare-covered) 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 physician cost-share will apply if additional services requiring cost-sharing are rendered.	<b>\$30</b> copay
Routine Hearing Exams	<b>\$0</b> copay for one routine hearing exam every year

Benefit	What You Pay
Hearing Aid Fitting/Evaluation	<b>\$0</b> copay for one fitting/evaluation for hearing aid every year
Hearing Aids	<b>\$399–\$1,800</b> copay per device, limited to 2 devices every year. Actual cost-share will depend on hearing aid selected.
<b>Dental Services (Medicare-covered)<sup>1</sup></b>	
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	<b>\$40</b> copay
<b>Preventive Dental Services (Routine)</b>	
Oral exams (4 every year)	<b>\$0</b> copay
Cleanings (2 every year)	<b>\$0</b> copay
Fluoride treatments	<b>\$0</b> copay
Dental x-rays	<b>\$0</b> copay
Maximum Coverage Amount	<p><b>\$5,000</b> allowance for routine preventive dental services every year</p> <p>This plan offers comprehensive dental benefits as an Optional Supplemental Benefit. Please see the Optional Supplemental Benefits – Comprehensive Dental section within this <i>Summary of Benefits</i> for more information.</p>
<b>Vision Services</b>	
<p>Eye Exams (Medicare-covered)</p> <p>A separate physician 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). A facility cost-share may apply for procedures performed at an outpatient surgical center.</p>	<p><b>\$0</b> copay for Medicare-covered diabetic retinopathy screening</p> <p><b>\$40</b> copay for all other Medicare-covered vision services</p>
<p>Routine Eye Exam</p> <p>One routine eye exam (including eye refraction) per year. Eye refractions outside of the annual routine eye exam are not covered. Vision services must be obtained from a provider within Cigna Healthcare's<sup>SM</sup> vision vendor network to be covered.</p>	<b>\$0</b> copay for one routine exam every year
Glaucoma Screening (Medicare-covered)	<b>\$0</b> copay



Benefit	What You Pay
Eyewear (Medicare-covered)	<b>\$0</b> copay
Routine Eyewear > Eyeglasses (lenses and frames) > Eyeglass lenses > Eyeglass frames > Contact lenses (including contact lens fitting) > Upgrades	<b>\$0</b> copay up to plan maximum coverage amount of <b>\$200</b> every year  The plan-specified allowance may be applied to one set of the member's choice of eyewear once per year, to include the eyeglass frame/lenses/lens options combination or contact lenses (to include related professional fees) in lieu of eyeglasses.
<b>Mental Health Services</b>	
Inpatient <sup>1</sup>  Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.  For each Medicare-covered hospital stay, you are required to pay the applicable cost sharing, starting with Day 1, each time you are admitted.	<b>\$290</b> copay per day for days 1-5  <b>\$0</b> copay per day for days 6-90
Outpatient Individual or Group Therapy Visit <sup>1</sup>	<b>\$0</b> copay
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	
Our plan covers up to 100 days per benefit period.	<b>\$10</b> copay per day for days 1-20 <b>\$203</b> copay per day for days 21-100
<b>Rehabilitation Services</b>	
Cardiac (Heart) Rehab Services <sup>1</sup>	<b>\$0</b> copay
Intensive Cardiac (Heart) Rehab Services <sup>1</sup>	<b>\$0</b> copay
Pulmonary Rehab Services <sup>1</sup>	<b>\$0</b> copay
Occupational Therapy Services <sup>1</sup>	<b>\$40</b> copay
Physical Therapy and Speech/Language Therapy Services	<b>\$40</b> copay
Physical Therapy and Speech/Language Therapy Telehealth Services	<b>\$0</b> copay
<b>Ambulance<sup>1</sup></b>	
Ground Service (one-way trip)	<b>\$205</b> copay
Air Service (one-way trip)	<b>20%</b> coinsurance

Benefit	What You Pay
<b>Transportation (Routine)</b>	
Routine Transportation	Not covered
<b>Medicare Part B Drugs</b>	
Medicare Part B Insulin Drugs	0%–20% coinsurance; up to a <b>\$35</b> copay
Medicare Part B Chemotherapy/Radiation Drugs <sup>1</sup>	0%–20% coinsurance
Other Medicare Part B Drugs <sup>1</sup> Medicare-covered Part B Drugs may be subject to step therapy requirements.	0%–20% coinsurance This plan has Part D prescription drug coverage. See Section 4 in the <i>Summary of Benefits</i> .
<b>Acupuncture Services</b>	
Acupuncture Services (Medicare-covered) <sup>1</sup> Services for chronic lower back pain.	<b>\$20</b> copay
Acupuncture Services (Routine)	Not covered
<b>Chiropractic Care</b>	
Chiropractic Services (Medicare-covered) <sup>1</sup>	<b>\$20</b> copay
Routine Chiropractic Services	Not covered
<b>Fitness and Wellness Programs</b>	
The Silver&Fit <sup>®</sup> Healthy Aging and Exercise program offers the flexibility of a fitness center membership, digital fitness tools, and one home fitness kit from a variety of kit options, including a wearable fitness tracker. You can also take advantage of digital workout plans available on the program's website, get one-on-one Healthy Aging Coaching by phone, video, or chat, and enjoy many other digital resources through the Well-Being Club.	<b>\$0</b> copay
<b>Foot Care (Podiatry Services)</b>	
Podiatry Services (Medicare-covered)	<b>\$40</b> copay
Routine Podiatry Services	Not covered

Benefit	What You Pay
<b>Health Information Line</b>	
<p>Talk one-on-one with a Nurse Advocate* to get timely answers to your health-related questions at no additional cost, anytime day or night. 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.</p> <p>*Nurse Advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing any medical advice.</p>	<p><b>\$0</b> copay</p>
<b>Home-Delivered Meals</b>	
	<p><b>\$0</b> copay for home-delivered meals</p> <p>Limited to 14 meals per discharge from a qualified hospital stay or skilled nursing facility (up to 3 stays per year). ESRD care management is limited to 56 meals once per year.</p>
<b>Home Health Care<sup>1</sup></b>	
Home Health	<b>\$0</b> copay
<b>Hospice</b>	
<p>Hospice care must be provided by a Medicare-certified hospice program.</p> <p>Our plan covers hospice consultation services (one time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.</p>	<p><b>\$0</b> copay</p>
<b>Medical Equipment and Supplies</b>	
Durable Medical Equipment (wheelchairs, oxygen, etc.) <sup>1</sup>	<b>20%</b> coinsurance
Prosthetic Devices (braces, artificial limbs, etc.) <sup>1</sup>	<b>20%</b> coinsurance
Medical Supplies <sup>1</sup>	<b>20%</b> coinsurance

Benefit	What You Pay
<p>Diabetic Services and Supplies</p> <p>Brand limitations apply to certain supplies.</p> <p>Blood sugar monitor/continuous glucose monitor (CGM) preferred brands include:</p> <ul style="list-style-type: none"> <li>➤ Abbott Diabetes Care: FreeStyle Lite, FreeStyle Freedom Lite, FreeStyle Precision Neo, FreeStyle Libre 2 (CGM), and FreeStyle Libre 14-Day (CGM)</li> <li>➤ Life Scan Diabetes Care: OneTouch Ultra 2, OneTouch Verio Flex, and OneTouch Verio Reflect</li> <li>➤ Dexcom: Dexcom G6 (CGM), Dexcom G7 (CGM)</li> </ul>	<p><b>\$0</b> copay for diabetes self-management training</p> <p><b>20%</b> coinsurance for therapeutic shoes or inserts<sup>1</sup></p> <p><b>\$0</b> copay for diabetic monitoring supplies<sup>1</sup></p>
<b>Opioid Treatment Services<sup>1</sup></b>	
<p>FDA-approved treatment medications in addition to testing, counseling, and therapy.</p>	<p><b>\$40</b> copay</p>
<b>Outpatient Substance Abuse<sup>1</sup></b>	
<p>Individual or Group Therapy Visit</p>	<p><b>\$40</b> copay</p>
<b>Over-the-Counter (OTC) Allowance</b>	
<p>Allowance for covered OTC drugs and other health-related pharmacy products</p>	<p><b>\$70</b> every 3 months</p>
<b>Telehealth Services (Medicare-covered)</b>	
<p>For non-emergency urgent care, talk with a telehealth doctor via smart phone, computer, or tablet for care, including allergies, cough, headache, sore throat, and other minor illnesses. Benefit also includes telehealth mental health therapy and dermatology services.</p>	<p><b>\$10</b> copay for non-emergency urgent care virtual visits</p> <p><b>\$0</b> copay for mental health therapy virtual visits<sup>1</sup></p> <p><b>\$40</b> copay for dermatology care virtual visits<sup>1</sup></p>
<b>Extra Benefits Included in Your Plan</b>	
<p><b>Annual Physical Exam</b></p>	<p><b>\$0</b> copay</p>
<p><b>Cigna Healthy Today Card</b></p> <p>Use your pre-loaded Cigna Healthy Today card for easy access to incentives, rewards, and select benefits* that may be part of your plan.</p> <p>*Benefits, coverage, and amounts vary by plan. Limitations, exclusions, and restrictions may apply.</p>	<p>Based on your plan's allowance and frequency amounts, funds will be loaded on your Cigna Healthy Today card automatically.</p> <p>Allowance amounts do not carry over to the next quarter or the following year.</p>

## Extra Benefits Included in Your Plan

### **Cigna Medicare Advantage Incentives**

With the Cigna Medicare Advantage incentives program, you can earn money for completing certain healthy activities. After completing your yearly health check-up, you can qualify for additional incentives as determined by your plan and provider. Reward dollars are intended to be used on health and wellness products only.

You can earn up to **\$100**, which is loaded on your Cigna Healthy Today card, for completing certain healthy activities.

# 4 | Prescription Drug Benefits

## Medicare Part D Drugs

### Pharmacy (Part D) Deductible

This plan does not have a deductible.

### Initial Coverage

The following charts show the cost-sharing amounts for Part D drugs covered under this plan. After you pay any yearly Part D deductible, you pay the following until your total yearly drug costs reach **\$5,030**. Total yearly drug costs are

the total drug costs paid by both you and a Part D plan.

Your costs may be different if you qualify for *Extra Help*. Your copay or coinsurance is based on the drug tier for your medication, which you can find in the plan *Comprehensive Prescription Drug List* on our website **CignaMedicare.com**. Or call us, and we will send you a copy of the *Comprehensive Prescription Drug List*.

Tier	Supply	Mail Order Cost-Sharing		Retail Cost-Sharing	
		Preferred	Standard	Preferred	Standard
Tier 1 Preferred Generic Drugs	30-day	\$0	\$9	\$0	\$9
	60-day	\$0	\$18	\$0	\$18
	90-day	\$0	\$27	\$0	\$27
Tier 2 Generic Drugs	30-day	\$4	\$15	\$4	\$15
	60-day	\$8	\$30	\$8	\$30
	90-day	\$0	\$45	\$12	\$45
Tier 3 Preferred Brand Drugs	30-day	\$45	\$47	\$45	\$47
	60-day	\$90	\$94	\$90	\$94
	90-day	\$135	\$141	\$135	\$141
Tier 4 Non-Preferred Drugs	30-day	\$95	\$100	\$95	\$100
	60-day	\$190	\$200	\$190	\$200
	90-day	\$285	\$300	\$285	\$300
Tier 5 Specialty Drugs	30-day	33%	33%	33%	33%
	60-day	Not available	Not available	Not available	Not available
	90-day	Not available	Not available	Not available	Not available

Cost-sharing may vary depending on the customer's Part D coverage phase. Costs may differ based on pharmacy type or status, for example, preferred/non-preferred, mail order, long-term care (LTC), home infusion, and 30- or 90-day supply.

You may get your drugs at preferred or standard network retail pharmacies or preferred mail order pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy because it has a preferred agreement with your plan.

You can get your prescription from an out-of-network pharmacy, but you may pay more than you would pay at an in-network pharmacy. If you reside in a long-term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.

### Coverage Gap

Most Medicare prescription drug plans have a Coverage Gap (also called the Donut Hole). This means there is a temporary change in what you will pay for your Part D drugs. The Coverage Gap begins after your total yearly prescription drug costs (including what a Part D plan has paid and what you have paid) reach **\$5,030**. Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay a maximum of **25%** of the plan's cost for covered brand name drugs and covered generic drugs until your costs total **\$8,000**, which is the end of the Coverage Gap.

This plan offers some additional prescription drug coverage for Tier I drugs in the Coverage Gap. See the table below to find out how much you will pay.

### Catastrophic Coverage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$8,000** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will pay **\$0** for all covered Part D drugs through the end of the calendar year.

Tier	Supply	Mail Order Cost-Sharing		Retail Cost-Sharing	
		Preferred	Standard	Preferred	Standard
Tier I Preferred Generic Drugs	30-day	\$0	\$9	\$0	\$9
	60-day	\$0	\$18	\$0	\$18
	90-day	\$0	\$27	\$0	\$27

### What You Pay for Insulin

- You won't pay more than **\$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
- If your insulin is on a tier where cost-sharing is lower than **\$35**, you will pay the lower cost for your insulin.
- If your plan has a Part D deductible, the above will apply even if you haven't paid your deductible.

# 5 | Optional Supplemental Benefits — Comprehensive Dental

## Package I: Comprehensive Dental

You must pay an additional premium each month for these benefits

<b>Monthly Premium</b>	<b>\$22</b>
<b>Non-routine Services</b>	<b>\$0–\$285</b> copay
<b>Diagnostic</b>	<b>\$0</b> copay
<b>Restorative</b> — Fillings, Crowns	<b>\$0–\$550</b> copay
<b>Endodontics</b>	<b>\$0–\$675</b> copay
<b>Periodontics</b> — Scaling and root planing, Full-mouth debridement, Maintenance	<b>\$0–\$595</b> copay
<b>Extractions</b>	<b>\$0</b> copay
<b>Prosthodontics</b> — Dentures (removable only), Partials/Bridges (removable only)	<b>\$0–\$615</b> copay
<b>Oral/Maxillofacial Surgery &amp; Other Services</b>	
<b>Annual Maximum Coverage Amount</b>	<b>\$20,000</b>

### Comprehensive Dental Benefits

Our plan offers some extra comprehensive dental benefits that are not covered by Original Medicare and not included in your standard plan. These extra comprehensive dental benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them, and you will have to pay an additional premium of **\$22** per month for them. This Optional Supplemental Benefits premium does not count towards your maximum out-of-pocket amount.

There are limitations on the number of covered services within a service category. Frequency limits and cost-sharing vary depending on the type of covered service. Please see your EOC for frequency limits and cost-sharing for covered services.

The plan has a maximum coverage amount of **\$20,000** for comprehensive dental services. Unused amounts do not carry forward to future benefit years.



If you want to purchase these Optional Supplemental Benefits, please check the box on the Enrollment Form. If you have already enrolled in a plan, call Customer Service and request an Optional Supplemental Benefits Enrollment Form. The effective date of your Optional Supplemental Benefits will be the first day of the month after we receive your completed form. You will be allowed to enroll and disenroll only *once* per calendar year. If you disenroll from the Optional Supplemental Benefits during the year and want to receive benefits again, you will have to wait until the start of the next year.

Select benefits may not be available in all service areas without a monthly premium. Some plans may include these benefits under the monthly premium. Benefits, features, and/or devices vary by plan/service area. Limitations, exclusions, and restrictions may apply. Contact the plan for more information.

Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Individuals may enroll in a plan only during specific times of the year and must have Medicare Parts A and B.

Out-of-network/non-contracted providers are under no obligation to treat plan members except in emergency situations. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE, are owned by Cigna Intellectual Property, Inc.

To file a marketing complaint, contact Cigna Healthcare at the Customer Service number below or call **I-800-MEDICARE** (24 hours a day/7 days a week). Please include the agent/broker name if possible.

Subsidiaries of The Cigna Group contract with Medicare to offer Medicare Advantage HMO and PPO plans and Part D Prescription Drug Plans (PDPs) in select states and with select state Medicaid programs. Enrollment in a Cigna Healthcare product depends on contract renewal.

You must live in the plan's service area to enroll in a Cigna Healthcare Medicare Advantage plan. Prior authorization and/or referrals are required for certain services. This information is not a complete description of benefits. Benefits vary by plan.

Call Customer Service at **I-800-668-3813 (TTY 711)**, 8 a.m. to 8 p.m. local time: 7 days a week, October – March; and Monday – Friday, April – September. Our automated phone system may answer your call during weekends, holidays, and after hours.