SUMMARY OF BENEFITS

2023
January 1, 2023 to
December 31, 2023

A4

TO JOIN
You must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Cigna True Choice Medicare (PPO)
University of Vermont
H7787- 801
Enhanced Drug List
Freedom to choose your own doctor with no referrals required
Out-of-network coverage available

The Cigna True Choice Medicare (PPO) service area includes all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Introduction

What's Inside

This Summary of Benefits gives you a summary of what **Cigna True Choice Medicare (PPO)** covers and what you pay. This information is not a complete description of benefits. Call 1-888-281-7867 (TTY 711) for more information. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage (EOC) Snapshot* online at myCigna.com or call us to request a copy.

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 it online at **www.medicare.gov** or get 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.

Need help?
Call toll-free **1-888-281-7867 (TTY 711).** Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call during weekends, holidays, and after hours.

CignaMedicare.com/group/MAresources
You can also visit us online to find a provider or pharmacy, view plan information, and more.

❶ About this plan

Which doctors, hospitals and pharmacies can I use?
Cigna True Choice Medicare (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You may also choose to use providers that are out-of-network and there will not be a change to your copay or coinsurance.

You can see our plan's *Provider and Pharmacy Directory* at our website, CignaMedicare.com/group/MAresources.

What do we cover?
Like all Medicare health plans, we cover everything that Original Medicare covers-and more.

- Our customers get all of 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/group/MAresources.
- Or, call us and we will send you a copy of the Enhanced Drug List.

❷ Monthly Premium, Deductible & Limits

Benefit	Cigna True Choice Medicare (PPO)
How much is the monthly premium?	Please contact your Plan Sponsor. In addition, you must keep paying your Medicare Part B premium.
How much is the medical deductible?	**$100** per year for medical services. Some services are not subject to the deductible. Refer to the *Evidence of Coverage Snapshot* for a list of those services.
Is there any limit on how much I will pay for my covered services?	Original Medicare does not have annual limits on out-of-pocket costs. Your yearly limit(s) in this plan: **$500** for services you receive from in-network and out-of-network providers combined for Medicare-covered and non-Medicare covered benefits. This limit is the most you pay for copays, coinsurance and other costs for Medicare services for the year. If you reach the limit on out-of-pocket costs, you keep getting in-network and out-of-network covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
How much is the Prescription Drugs Deductible?	**$0** per year for Part D prescription drugs.
Is there a limit on how much I will pay for my covered drugs?	**$750** After you pay $750 for covered prescriptions, you will pay $0 for covered prescriptions**.**

❸ Covered Medical & Hospital Benefits

Benefit	What you Pay In-Network and Out-of-Network
Covered Medical and Hospital Benefits **Note**: Services with a [1] may require prior authorization.	
Inpatient Hospital Coverage[1]	
Our plan covers an unlimited number of days for an inpatient hospital stay. For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with day 1 each time you are admitted.	**$0** per admission
Outpatient Surgery	
Ambulatory Surgical Center (ASC)[1]	**$0** copay
Outpatient Services[1]	**$0** copay
Outpatient Observation[1]	**$0** copay
Doctors Visits[1]	
Primary Care Physician	**$10** copay
Specialists	**$10** copay
Preventive Care	
Our plan covers many Medicare-covered preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma tests • Hepatitis B Virus (HBV) infection screening • Hepatitis C screening • HIV screening • Lung cancer screening with low dose computed tomography (LDCT) • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered. Please see your *Evidence of Coverage* (EOC) for frequency of covered services.

Benefit	What you Pay
	In-Network and Out-of-Network
• Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines; including COVID-19, Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit	
Emergency Care	
Emergency Care Services	**$0** copay
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$0** copay Maximum worldwide coverage amount $50,000
Urgently Needed Services	
Urgent Care Services	**$10** copay
Diagnostic Services, Labs and Imaging ***(Costs for these services may vary based on place of service or type of service)***	
Diagnostic Procedures and Tests[1]	**$0** copay
Lab Services[1] For COVID-19 testing a prior authorization is not required.	**$0** copay
Therapeutic Radiological Services[1]	**$0** copay
X-ray Services[1]	**$0** copay in a Primary Care Physician office **$0** copay in a Specialist office **$0** copay or coinsurance in other outpatient locations
Diagnostic Radiological Services (MRIs, CT Scans, etc.)[1]	**$0** copay
Hearing Services	
Hearing Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	**$10** copay
Routine Hearing Exams	**$0** copay for one routine exam every year
Hearing Aid Evaluation/Fitting	**$0** copay hearing aid evaluation and fitting
Hearing Aids	**$0** copay up to plan maximum coverage amount for hearing aids of $3,000 every two years.
Dental Services	
Dental Services (Medicare-covered)[1] Limited dental services (this does not include services in connection with care, treatment, filling removal or replacement of teeth)	**$10** copay
Preventive and Comprehensive Dental Services	
	Not Covered
Vision Services	
Eye Exams (Medicare-covered)	**$0** copay for diabetic retinopathy screening

Benefit	What you Pay
	In-Network and Out-of-Network
A separate physician cost-share will apply if additional services requiring cost-sharing are rendered. A facility cost-share may apply for procedures performed at an outpatient surgical center.	**$10** copay for all other Medicare-covered vision services.
Routine Eye Exam Non-Medicare covered routine eye exam (including eye refraction) per year. Eye refractions outside of the annual non-Medicare covered routine eye exam are Not covered.	**$0** copay for one routine exam every year
Glaucoma Screening (Medicare-covered)	**$0** copay
Eyewear (Medicare-covered)	**$0** copay
Routine Eyewear	**$0** copay up to the plan maximum coverage amount of **$250** every year: –eyeglasses (lenses and frames) –contact lenses (including contact lens fitting) –upgrades
Mental Health Services	
Inpatient[1] 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. There is a **$0** copayment per lifetime reserve day.	**$0** per admission
Outpatient[1] Individual or Group Therapy Visit Including Licensed Mental Health Professional Counselors	**$0** copay
Skilled Nursing Facility *(SNF)*[1]	
Our plan covers unlimited days in the SNF.	**$0** copay per day
Rehabilitation Services	
Cardiac (heart) Rehab Services[1]	**$0** copay
Pulmonary Rehab Services[1]	**$0** copay
Occupational Therapy Services[1]	**$0** copay
Physical Therapy, Speech and Language Therapy Services[1]	**$0** copay
Physical Therapy, Speech and Language Therapy Virtual Services[1]	**$0** copay
Ambulance[1]	
Ground Service (one-way trip)	**20%** coinsurance
Air Service (one-way trip)	**20%** coinsurance
Transportation[1]	
	Not covered
Prescription Drugs	
Medicare Part B Drugs[1]	**$0** copay

Benefit	What you Pay
	In-Network and Out-of-Network
Medicare-covered Part B Drugs may be subject to step therapy requirements.	This plan has Part D prescription drug coverage. See Section 4 in this *Summary of Benefits*.
Foot Care *(Podiatry Services)*	
Podiatry Services Medicare-covered	**$10** copay
Routine Podiatry Services	Not Covered
Medical Equipment and Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**20%** coinsurance after deductible
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**20%** coinsurance after deductible
Diabetes Supplies & Services[1] Brand limitations apply to certain supplies	**$0** copay for diabetes self-management training **$0** for therapeutic shoes or inserts **$0** for diabetes monitoring supplies.
Fitness & Wellness Programs	
The program offers the flexibility of a fitness center membership, digital fitness tools, and one Home Fitness kit per benefit year.	**$0** copay
24-Hour Health Information Line	
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. *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.	**$0** copay
Chiropractic Care[1]	
Chiropractic Services (Medicare-covered)	**$10** copay
Routine Chiropractic Services	**$10** copay up to 6 visits per year One set of X-rays per year (up to 3 views)
Home Health Care[1]	
	$0 copay
Hospice	
Hospice care must be provided by a Medicare-certified hospice program. 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.	**$0** copay
Outpatient Substance Abuse[1]	
Individual or Group Therapy Visit	**$0** copay
Opioid Treatment Services[1]	
FDA-approved treatment medications in addition to testing, counseling and therapy.	**$0** copay

Benefit	What you Pay In-Network and Out-of-Network
Over-the-Counter Items *(OTC)*	
Quarterly allowance to cover the cost of over-the-counter drugs and other health-related pharmacy products. Items can be purchased online, by phone or mail, or at participating retail locations	Not covered
Home Delivered Meals	
	$0 copay Limited to 14 meals per discharge from qualified hospital stay or skilled nursing facility (up to three stays per year). ESRD care management is limited to 56 meals per benefit period.* *Authorization applies to ESRD meals.
Telehealth Services	
For nonemergency care, talk with a doctor via phone or video for certain telehealth services, including: allergies, cough, headache, sore throat and other minor illnesses through MDLive.	**$0** copay
Acupuncture	
Acupuncture Services (Medicare-covered)[1] Services for chronic lower back pain.	**$10** copay
Supplemental Acupuncture Services	Not covered
Additional Benefits **Enjoy these extra benefits included in your plan.**	
Annual Physical Exam[1]	**$0** copay
Caregiver Support Services include one-on-one coaching and personalized resources for customers and caregivers.	**$0** copay
Gradient Compression Stockings	**$10** copay after deductible
Home Life Referrals	**$0** copay
Naturopath Services Uses natural or alternative treatments	**$10** copay
Outpatient Private Duty Nursing	**$10** copay after deductible with a coverage limit of 14 hours per year
Weight Loss Surgery Includes enhanced coverage that is less strict that Original Medicare criteria	Covered same as any other illness
Wigs for Hair Loss Due to Cancer Treatment	**$350** allowance per year

❹ Prescription Drug Benefits

Medicare Part D Drugs - Initial Coverage

The following chart shows the cost-share amounts for covered drugs under this plan. After you pay your yearly deductible (if applicable), you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our plan.

If you get your drug at an out-of-network pharmacy, you will pay the same cost-share you would pay for a 30-day supply at an in-network retail pharmacy. If you reside in a long-term care facility, you would pay the standard retail cost-share at an in-network pharmacy.

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 Prescription drug List (Formulary) on our website **CignaMedicare.com/group/MAresources.** Or, call us and we will send you a copy of the formulary.

Tier	Supply	Retail Cost-Share	Mail-Order Cost Share
Tier 1 Generic Drugs	30-day	$5	$5
	60-day	$10	$10
	90-day	$10	$10
Tier 2 Preferred Brand Drugs	30-day	$20	$20
	60-day	$40	$40
	90-day	$40	$40
Tier 3 Non-Preferred Drugs	30-day	$5 Generics;$40 Brand	$5 Generics;$40 Brand
	60-day	$10 Generics;$80 Brand	$10 Generics;$80 Brand
	90-day	$10 Generics;$80 Brand	$10 Generics;$80 Brand
Tier 4* Specialty Drugs	30-day	$5 Generics;$40 Brand	$5 Generics;$40 Brand
	60-day	N/A	N/A
	90-day	N/A	N/A
***Specialty drugs are limited to a 30-day supply**			

Coverage Gap

Most Medicare drug plans have a Coverage Gap (also called the "Donut Hole"). This means that there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay the same copays/coinsurance you paid during the initial coverage stage until your costs total $7,400, which is the end of the Coverage Gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) have reached **$7,400**, the plan will pay most of the cost for your drugs. Your share of the cost of covered drugs will be:

$4.15 copayment for generic drugs.

$10.35 copayment for brand drugs.

Additional Benefits Offered	
Erectile Dysfunction^ **Cough and Cold** **Prescription Vitamins** **Fertility Drugs^** **Weight Loss/Weight Gain^**	Your plan covers additional drugs not normally covered in a Medicare Prescription Drug Plan as indicated in the Formulary Drug List by the **+** symbol. Please see your 2023 Formulary document for details. The cost-share you pay on these drugs do not count toward your annual TrOOP ^Sexual dysfunction medications are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories.

Important Message About 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 plan has a Part D deductible, this will apply even if you haven't paid your deductible. If your insulin is on a tier where cost-sharing is lower than $35, you will pay the lower cost for your insulin.

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. Call Customer Service for more information.

State Mandated Coverage
If you live in a state that requires insurance companies to provide additional coverage, that coverage is outlined below.
Residents of Utah will have a $27 maximum monthly charge for insulin drugs.

Contraceptive Drugs and Devices
You pay $0 for contraceptive drugs and devices. I**ncludes coverage for oral contraceptives, implantable contraceptives, diaphragms, jellies, foams, cervical caps, and intrauterine devices.**

Covered Diabetic Test Strips and Meters
You will not pay more than $0 for Preferred Products

Covered Diabetic Lancets and Control Solutions
You will not pay more than $0 for this benefit.

Covered Non-sedating Antihistamines
$5 Generics; $40 Brand Drugs per 30 day supply.

Your plan includes the following clinical management edits. Refer to your 2023 Formulary for more information.	
Prior Authorization	This drug requires prior authorization.
Quantity Limits	This drug has quantity limits.
Step Therapy	This drug has step therapy requirements.
*****	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a month supply.
+	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
^	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
HRM PA	This high risk medication requires prior authorization
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
LA	Limited Availability drug. This drug may be available only at certain pharmacies.