

Summary of Benefits

2024

January 1, 2024 to
December 31, 2024

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

A4

TO JOIN

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

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

- ① About this Plan
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This Summary of Benefits gives you a summary of what **Cigna True Choice Medicare (PPO)** 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) 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 the handbook online at www.medicare.gov.

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. Messaging service used weekends, after hours, and on federal holidays.

You can also visit our website at:

[**CignaMedicare.com/group/MAresources**](http://CignaMedicare.com/group/MAresources)

1 About this plan

Which doctors, hospitals and pharmacies can I use?

Cigna True Choice Medicare (PPO) has a network of doctors, hospitals, and other providers and pharmacies. 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 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/group/MAresources

What do we cover?

Like all Medicare health plans, we cover everything that 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/group/MAresources.
- > Or, call us and we will send you a copy of the Enhanced Drug List.

2 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 <i>Evidence of Coverage Snapshot</i> for a list of those services.
Is there any limit on how much I will pay for my covered services?	Your yearly limit(s) in this plan: \$500 for services you receive from in-network and out-of-network providers combined for 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 pay for prescription drugs?	\$750 per year for Part D prescription drugs.

3 Covered Medical & Hospital Benefits

Benefit	What you Pay
	In-Network and Out-of-Network
Note: Services with a ¹ may require prior authorization.	
Inpatient Hospital Coverage¹	
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 copay per admission
Outpatient Hospital Services	
Outpatient Hospital ¹	\$0 copay
Outpatient Observation ¹	\$0 copay
Ambulatory Surgical Center (ASC) Services	
ASC Services (ASC) ¹	\$0 copay
Doctors Visits¹	
Primary Care Physician	\$10 copay \$0 copay for virtual visits
Specialists	\$10 copay \$0 copay for virtual visits
Preventive Care	
Our plan covers many Medicare-covered preventive services, including: <ul style="list-style-type: none"> › 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 	\$0 copay Any additional preventive services approved by Medicare during the contract year will be covered. Please see your <i>Evidence of Coverage</i> (EOC) for frequency of covered services.

Benefit	What you Pay
	In-Network and Out-of-Network
<ul style="list-style-type: none"> › 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 › 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 If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Diagnostic Services, Labs and Imaging <i>(Costs for these services may vary based on place of service or type of service)</i>	
Diagnostic Procedures and Tests ¹	\$0 copay
Lab Services ¹	\$0 copay
Genetic Testing ¹	\$0 copay
Diagnostic Radiological Services (MRIs, CT scans, etc.) ¹	\$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 in other outpatient locations
Hearing Services	
Hearing Exams (Medicare-covered)	\$10 copay

Benefit	What you Pay
	In-Network and Out-of-Network
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.	
Routine Hearing Exams	\$0 copay for one routine exam every year
Hearing Aid Evaluation/Fitting	\$0 copay for one fitting evaluation per hearing aid every 2 years
Hearing Aids	\$0 copay \$3,000 maximum coverage amount for hearing aids every 2 years.
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) 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.	\$0 copay for diabetic retinopathy screening \$10 copay for all other Medicare-covered vision services.
Routine Eye Exam One routine eye exam (including eye refraction) per year. Eye refractions outside of the annual non-Medicare-covered routine eye exam are not covered. For routine eye exams and eyewear services, customers are encouraged to select a provider within Cigna Healthcare's vision vendor network	\$0 copay for one routine exam every year

Benefit	What you Pay
	In-Network and Out-of-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.	
Glaucoma Screening (Medicare-covered)	\$0 copay
Eyewear (Medicare-covered)	\$0 copay
Routine Eyewear <ul style="list-style-type: none"> › Eyeglasses (lenses and frames) › Eyeglass lenses › Eyeglass frames › Contact lenses (including contact lens fittings) › Upgrades 	\$0 copay Plan maximum coverage amount of \$250 . 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.
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.	\$0 copay per admission
Outpatient ¹ Individual or Group Therapy Visit	\$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
Intensive 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
Ambulance¹	
Ground Service (one-way trip)	20% coinsurance

Benefit	What you Pay
	In-Network and Out-of-Network
Air Service (one-way trip)	20% coinsurance
Transportation¹	
	Not Covered
Medicare Part B Drugs	
Medicare Part B Insulin Drugs	\$0 copay
Medicare Part B Chemotherapy/Radiation Drugs ¹	\$0 copay
Other Medicare Part B Drugs ¹	\$0 copay
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 <i>Summary of Benefits</i> .
Acupuncture Services	
Acupuncture Services (Medicare-Covered) ¹	\$10 copay
Routine Acupuncture Services	Not Covered
Chiropractic Care	
Chiropractic Services (Medicare-Covered) ¹	\$10 copay
Routine Chiropractic Services	\$10 copay up to 6 visits per year One set of X-rays per year (up to 3 views)
Fitness & Wellness Programs	
The Silver&Fit® 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.	\$0 copay
Foot Care (Podiatry Services)	
Podiatry Services Medicare-covered	\$10 copay
Routine Podiatry Services	Not Covered
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. The Health Information Line is not a substitute for	\$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
<p>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>	
Home Delivered Meals	
	<p>\$0 copay</p> <p>Limited to 14 meals per discharge from qualified hospital stay or skilled nursing facility (up to 3 stays per year). ESRD care management is limited to 56 meals per benefit period.</p>
Home Health Care¹	
	\$0 copay
Hospice	
<p>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.</p>	\$0 copay
Medical Equipment and Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	20% coinsurance after deductible
Prosthetic Devices (braces, artificial limbs, etc.)	20% coinsurance after deductible
Related Medical Supplies ¹	20% coinsurance after deductible
Diabetes Supplies & Services ¹ Brand limitations apply to certain supplies.	<p>\$0 copay for diabetes self-management training</p> <p>\$0 copay for therapeutic shoes or inserts</p> <p>\$0 copay for diabetes monitoring supplies</p>
Opioid Treatment Services¹	
FDA-approved treatment medications in addition to testing, counseling, and therapy.	\$0 copay
Outpatient Substance Abuse¹	
Individual or Group Therapy Visit	\$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
Over-the-Counter Items (OTC)	
	Not Covered
Telehealth Services	
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 through MDLive.	<p>\$0 copay for non-emergency urgent care virtual visits</p> <p>\$0 copay for mental health therapy virtual visits¹</p> <p>\$0 copay for dermatology care virtual visits¹</p>
Extra Benefits Included in your plan	
Annual Physical Exam ¹	\$0 copay
<p>Cigna Healthy Today Card</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>
Gradient Compression Stockings	\$10 copay after deductible
<p>Home Life Referrals</p> <p>With our Home Life Referrals program, customers have quick and convenient access to trusted local resources to assist them with everyday needs such as finding childcare, eldercare, pet care, home repairs, and more.</p>	\$0 copay
Outpatient Private Duty Nursing	\$10 copay after deductible with a coverage limit of 14 hours per year
<p>Support for Caregiver of Enrollee</p> <p>Services include one-on-one coaching and personalized resources for customers and caregivers.</p>	\$0 copay
Wigs for Hair Loss Due to Cancer Treatment	\$350 allowance per year
<p>Naturopath Services</p> <p>Uses natural or alternative treatments</p>	\$10 copay
<p>Weight Loss Surgery</p> <p>Includes enhanced coverage that is less strict than Original Medicare criteria</p>	Covered same as any other illness

Benefit	What you Pay
	In-Network and Out-of-Network
Home Infusion Therapy includes enhanced home infusion therapy coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met	20% coinsurance after deductible

4 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 \$5,030. 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 will 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 Enhanced Drug List (Formulary) on our website [CignaMedicare.com/group/MAresources](https://www.cigna.com/medicare/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	30-day	\$5	\$5
	60-day	\$10	\$10
	90-day	\$10	\$10
Tier 2	30-day	\$20	\$20
	60-day	\$40	\$40
	90-day	\$40	\$40
Tier 3	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*	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 \$5,030. 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 \$8,000, 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 **\$8,000**, the plan will pay the cost for your drugs. Your share of the cost of covered drugs will be **\$0**.

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.

Additional Benefits Offered

Erectile Dysfunction Drugs[^]
Cough and Cold Drugs
Prescription Vitamins
Fertility Drugs[^]
Weight Loss Weight Gain Drugs[^]

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 2024 Formulary document for details. The cost-share you pay on these drugs do not count toward your annual TrOOP

[^]Some drugs are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories.

Contraceptive Drugs and Devices

You pay \$0 for contraceptive drugs and devices. This includes OTC drugs and supplies and male and female contraceptives. Members can get up to a 12-month supply dispensed at one time.

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

Covered Inhaler Assisting Devices

You will not pay more than \$0 for this benefit.

Your plan includes the following clinical management edits. Refer to your 2024 Formulary for more information.

PA	This drug requires prior authorization.
QL	This drug has quantity limits.
ST	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.

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