January 1 – December 31, 2024

Evidence of Coverage Snapshot

University of Vermont
H7787 – 801_Enhanced Drug List_A4

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

For detailed descriptions of the tables included in this document, please see Chapter 4 and Chapter 6 in your 2024 Evidence of Coverage booklet. You can view a copy of the Evidence of Coverage online at **Cignamedicare.com/group/MAresources.**

Please note: This Evidence of Coverage Snapshot gives you the details about your Medicare health care and prescription drug coverage from January 1, 2024 – December 31, 2024. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

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

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet). We can give you information in braille, in large print, and other alternate formats if you need it.

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

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

If you have any questions, customer service is here to help. We go above and beyond to make sure you have everything you need to understand and get the most from your plan. **1-888-281-7867 (TTY 711)**

October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call on weekends, holidays and after hours. Customer service also has free language interpreter services available for non-English speakers.

Cignamedicare.com/group/MAresources

You can also visit us online to find a provider or pharmacy, view plan information and more.

This document provides you with cost-share information for your medical benefits and your Part D prescription drugs. For more detailed information please refer to Chapters 4 and 6 of your 2024 Evidence of Coverage.

With Cigna Medicare Advantage PPO plans, our provider network covers you beyond your neighborhood for routine care. You can travel and receive care at in-network rates in all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Standard network rates apply. Please go to our website at: **CignaMedicare.com/group/MAresources** or call Customer Service for assistance locating an in-network PPO provider.

If you plan to move out of the service area, please contact customer service (phone numbers are printed back page of this document). 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 prescription drug plan that is available in your new location.

Section: 1 - Medical Benefits Chart (what is covered and what you pay)

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
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?	Your deductible is $100. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copay or coinsurance amount) for the rest of the calendar year. See details on the next page for a list of items the deductible does not apply to.
How much is the Pharmacy (Part D) Deductible?	$0 per year for Part D prescription drugs
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: **$500** which applies to in-network and out-of-network Medicare-covered and non-covered benefits. As a member of our plan, the most you will have to pay out-of-pocket for in-network and out-of-network covered Part A and Part B services in 2024 is **$500**. The amounts you pay for deductibles, copays, and coinsurance for in-network and out-of-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are italicized in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$500**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network and out-of-network covered and non-covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't met your deductible yet. The deductible does not apply to the following services:

- Acupuncture
- Additional Medicare Preventive Care Services
- Ambulance
- Ambulatory Surgery Center
- Annual Physical Exam
- Chiropractic Care
- Diabetes Self-Management Training and Diabetic Services and Supplies
- Dialysis Services
- Emergency Services and Urgent Care including Worldwide Coverage
- Hearing Services
- Home Health Care
- Inpatient Hospital Care
- Inpatient Mental Health and Substance Abuse
- Lab Services
- Mammograms
- Medicare-covered Dental Services
- Naturopath Services
- Outpatient Surgical Services including Colorectal Screenings
- Outpatient Mental Health and Substance Abuse Services
- Outpatient Rehabilitation Services – Cardiac Rehab
- Outpatient Diagnostic Procedures and Tests
- Partial Hospitalization
- Part B Drugs Including Chemotherapy Drugs
- Physician/Practitioner Services including PCP and Specialist Services
- Physical Therapy
- Pulmonary Rehab
- Radiology Services
- Radiation Therapy and Ultrasounds
- Routine Chiropractic Care
- Routine Hearing Services
- Routine Vision Services
- Supervised Exercise Therapy (SET)
- Skilled Nursing Facility (SNF)
- Speech and Language Therapy
- Virtual Visits through MD LIVE
- Vision Care Services including Medicare-Covered Exams and Eye Wear
- "Welcome to Medicare" Preventive Visit
- Wigs

The table below provides you with your medical benefits and cost as a member of the plan. Please refer to Chapter 4, Section 2 of the *Evidence of Coverage* for detailed information on the medical benefits chart below.

 You will see this apple next to the preventive services in the benefits chart.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get an order for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copay, or deductible for beneficiaries eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer. • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infections, etc. disease). • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may	**Prior authorization may be required.** $10 copay for each Medicare-covered acupuncture visit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Additional telehealth services; Physical therapy and Speech and Language Pathology Covered services include: virtual physical therapy and virtual speech language therapy.	**Prior authorization may be required.** $0 copay for Medicare-covered virtual Physical Therapy. $0 copay for Medicare-covered virtual Speech and Language Pathology.
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**Prior authorization may be required for non-emergency ambulance services.** 20% coinsurance for each one-way Medicare-covered ambulance trip.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Non-emergency transportation: • Medically necessary, non-emergency transportation by ambulance is only covered to the closest facility that can provide care. • Prior authorization is required for non-emergency, Medicare-covered ambulance services (such as transport from home to your doctor's office for routine visits, transport from home to a Medicare-certified dialysis facility for prescribed hemodialysis, or transport beyond the closest facility capable of providing care when transferring between facilities or levels of care). • See Transportation benefit in this chart for additional information about non-emergency transportation services (if applicable). **Worldwide ambulance services:** • Ambulance transportation outside the United States or its territories is only covered to the closest, most appropriate facility that can provide care. • Return to the United States by ambulance is not a covered service unless that is where the closest, most appropriate, facility is located. • See **Emergency care** or **Urgently needed services** in this chart for additional information about **Worldwide transportation services**.	
Annual physical exam The annual physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" Preventive Visit. Limited to one physical exam per year. Separate cost-sharing amounts may apply to any additional lab or diagnostic	$0 copay for annual physical exam.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
procedures that are ordered during the annual physical exam. **Note:** You will be responsible for cost-sharing amounts for any additional services during this exam.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you do not need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. **Note:** You will be responsible for cost-sharing amounts for any additional services during this exam.	There is no coinsurance, copay, or deductible for the annual wellness visit. A separate copay may apply if a non-preventive screening lab test or other non-preventive services are provided at the time of an annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copay, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copay, or deductible for covered screening mammograms.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**Prior authorization may be required.** $0 copay for each Medicare-covered cardiac rehabilitative and intensive cardiac rehabilitative therapy visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copay, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copay, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or are of childbearing age and have had an abnormal Pap test within the past 3 years one Pap test every 12 months.	There is no coinsurance, copay, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • manual manipulation of the spine to correct subluxation (when one or more of the bones of	**Prior authorization may be required.** $10 copay for each Medicare-covered chiropractic visit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
your spine move out of position) if you get it from a chiropractor. • In addition, you are also covered for six (6) routine chiropractic visits per year. The routine visits must be medically needed as determined by Cigna Healthcare's contracted chiropractic administrator, American Specialty Health Network (ASHN).	*$10 copay* *Up to 6 visits per year for routine chiropractic services.* *$0 copayment for an annual set of X-rays (up to three views) when performed by a chiropractor.*
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high-risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and who do not meet high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and who do not meet high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high-risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high-risk and 45 years or older. Once at least 48 months following	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. $0 copayment for Medicare-covered diagnostic exams and any surgical procedures (i.e., polyp removal) during a colorectal screening.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
the last screening barium enema or screening flexible sigmoidoscopy. As of January 1, 2023, colorectal cancer screening tests include a follow-up on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. In addition to Medicare-covered colorectal cancer screening exams, we cover Medicare-covered diagnostic exams and any surgical procedures (i.e., polyp removal) during a colorectal screening for a $0 copayment. **Note:** If you receive a colonoscopy without previous symptoms, this is considered preventive or a screening, and there will be no copayment or coinsurance. If your doctor is performing the colonoscopy because you have shown symptoms of a medical condition, this is considered outpatient surgery and a cost-share may apply (see Outpatient Surgery benefit in this chart for more information).	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw or oral exams preceding kidney transplantation.	**Prior authorization may be required for non-emergency Medicare-covered services.** $10 copay for Medicare-covered dental services.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Depression screening We cover one screening for depression per year. The screening must be done a primary care setting that can provide follow-up treatment and orders.	There is no coinsurance, copay, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension). • History of abnormal cholesterol and triglyceride levels (dyslipidemia). • Obesity, or a history of high blood sugar (glucose). • Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copay, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips. • Lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	**Prior authorization may be required.** $0 copay for preferred brand Medicare-covered diabetic monitoring supplies. Non-preferred brands may be covered in medically necessary situations and are subject to the Durable Medical Equipment cost-share. You are eligible for one glucose monitor and one continuous glucose monitoring device every two years. You are also eligible for 200 glucose test strips or three sensors per 30-day period depending on your monitor.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Diabetes self-management training is covered under certain conditions. **Note:** Syringes and needles are covered under our Part D benefit. Please refer to Chapter 6 of the 2024 *Evidence of Coverage* for cost-sharing information. For more information and a list of preferred brand diabetic supplies, please see your Customer Handbook or call Customer Service.	$0 copay for Medicare-covered therapeutic shoes and inserts. $0 copay for Medicare-covered diabetes self-management training.
Durable medical equipment and related supplies (For a definition of "durable medical equipment (DME)," see Chapter 12 of the *Evidence of Coverage* booklet.) Covered items include, but are not limited to: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • IV infusion pumps • Speech generating devices • Oxygen equipment • Nebulizers • Walkers We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **CignaMedicare.com/group/MAresources**.	**Prior authorization may be required.** 20% coinsurance after deductible for Medicare-covered items.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and	$0 copay for Medicare-covered emergency room visits. *$0 copay for worldwide emergency room visits and*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or discharged. Observation services may be given in the emergency department or another area of the hospital. For information about the observation services cost-sharing, please see the **Outpatient hospital observation** section of this Evidence of Coverage. *Emergency care is covered worldwide.* See **Ambulance services** benefit in this Medical Benefits chart for additional information about Worldwide ambulance services.	*worldwide emergency transportation.* *$50,000 (USD) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.* Emergency transportation must be medically necessary.
Health and wellness education programs **Health Information Line** Use Cigna Healthcare's 24-Hour Health Information Line to talk one-on-one with a Nurse Advocate*. This resource is available any time, day or night, 7 days a week, 365 days a year to help answer your medical and prescription drug questions or direct you to the appropriate provider to care for your health issue. You may also call to listen to recorded audio tapes from our Health Information Library. The Health Information Line is not a substitute for calling 911. If you are experiencing a health care emergency, please call 911 or go to your nearest emergency room. To access Cigna Healthcare's 24-Hour Health Information Line, call 1-866-576-8773 (TTY 711).	*$0 copay for these health and wellness programs:* *– 24 Hour Health Information Line* *– HealthWise* *– Membership in Health Club/Fitness Classes*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
* 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. **HealthWise** You will have access to video and written content on a variety of health and wellness topics through the Cigna Medicare Website. **Fitness** The fitness benefit provides several options to help you stay active. You are eligible for a fitness membership at participating fitness locations in the standard fitness network. At these locations you can take advantage of exercise equipment, amenities and, where available, group exercise classes tailored to meet the needs of older adults. If you prefer to exercise in the privacy of your home, you can select one Home Fitness Kit per benefit year from a variety of kit options, including a wearable fitness tracker. You can also take advantage of personalized Workout Plans; access thousands of on-demand workout videos available on the program's website; get one-on-one Healthy Aging Coaching by phone, video or chat; track your fitness activity; and enjoy many other digital resources through the Well-Being Club. Non-standard services that call for an added fee are not part of the fitness program and will not be reimbursed. For more information on your fitness benefit, please refer to the Customer Handbook or contact Cigna Healthcare's fitness vendor at 1-888-886-1992 (TTY 711).	
Hearing services 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. Hearing services (Routine)	A separate PCP/Specialist cost-share will apply if additional services requiring cost-sharing are rendered. $10 copay for Medicare-covered Hearing Exams.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
This plan covers the following routine hearing services: • up to one routine hearing exam every year • fitting evaluation for a hearing aid(s) • hearing aid(s) Hearing aid evaluations are part of the routine hearing exam once every three years. Multiple fittings are allowed with the original provider if necessary to ensure hearing aids are accurately fitted. A routine hearing exam needs to be performed prior to hearing aids being dispensed. Hearing aid devices are limited to those worn externally and do not include assisted listening devices, amplifiers or disposable devices. Customers are encouraged to select a provider within Cigna Healthcare's hearing vendor network but are not required to do so. Customers have the option to select doctors both in- and out-of-network with no referrals required. You are responsible for all costs over the maximum coverage amount. A 60-day evaluation period is granted to determine the effectiveness of a hearing aid. A 4-year supply of batteries (up to 256 cells per hearing aid) is included with a hearing aid that is acquired through Cigna Healthcare's hearing vendor. For more information on your supplemental hearing benefits, please refer to your plan's Extra Benefits Guide or contact Cigna Healthcare's hearing vendor at 1-866-872-1001 (TTY 711).	*$0 copay for 1 routine hearing test every year.* *$0 copay for one fitting evaluation per hearing aid every 2 years.* *$3,000 allowance for hearing aids every 2 years.* Members are responsible for all costs over and above the allowance amount.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months. For women who are pregnant, we cover: • Up to three screening exams during a pregnancy.	There is no coinsurance, copay, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.
Home-delivered meals When released from an inpatient hospital stay or skilled nursing facility, members can get 14 healthy frozen meals delivered to their home. This benefit is	*$0 copay for the home-delivered meals benefit.*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
available up to three (3) times each year. Releases from an emergency department, observation stay or outpatient visit are not eligible. Members meeting this requirement will receive a call from Cigna Healthcare's meal provider to schedule delivery. For more information on your home delivered meals benefit, please refer to your Extra Benefits Guide or call Customer Service. **Meals for ESRD members** Members diagnosed with End-Stage Renal Disease (ESRD) and enrolled in an ESRD care management program can get up to 56 healthy frozen meals delivered to their home. Members are eligible for this benefit once per year. Members meeting this requirement will receive a call from Cigna Healthcare's meal provider to schedule delivery.	*$0 copay for 56 meals over 28 days, once each year for ESRD members.*
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**Prior authorization may be required.** $0 copay for Medicare-covered home health visits.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to	You pay the applicable cost-sharing for each service obtained. Please refer to the *Durable medical equipment and*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit. • Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	*related supplies and Medicare Part B Prescription Drugs* benefit listings for related cost-share amounts.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the Cigna Healthcare owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. **For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis**: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B	**When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. Hospice Consultation You pay the applicable cost-share for the provider of the service (for example, physician services). Please refer to the applicable benefit in this Medical Benefits Chart.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis**: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For services that are covered by our plan but are not covered by Medicare Part A or B**: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by the plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition you pay your cost-share. If they are related to your terminal hospice condition, then you pay Original Medicare cost-share amounts. Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to the Evidence of Coverage Chapter 5, Section 9.4 (What if you're in Medicare-certified hospice). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
🍎 **Immunizations** Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. **Note:** Pneumonia vaccines are limited to two (2) per lifetime; the initial immunization and one booster. There must be at least 11 months between the initial and booster vaccinations.. We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copay, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Our plan covers an unlimited number of days for an inpatient hospital stay. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications	**Prior authorization may be required.** 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, your copay is: $0 copay per admission. Our plan covers an unlimited number of days for a Medicare-covered hospital stay. In some instances, a readmission policy may apply in which the benefit will continue from original admission.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network

• Lab tests
• X-rays and other radiology services
• Necessary surgical and medical supplies
• Use of appliances, such as wheelchairs
• Operating and recovery room costs
• Physical, occupational, and speech language therapy
• Inpatient substance abuse services
• Under certain conditions, the following types of transplants are covered:
  • corneal
  • kidney
  • kidney-pancreatic
  • heart, liver
  • lung, heart/lung
  • bone marrow, stem cell
  • intestinal/multivisceral.
 	
If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Reimbursement is provided for up to $10,000 of eligible transportation and lodging expenses for an approved transplant at least 100 miles away from your home address.
 	
This travel benefit is not applicable for corneal transplants. Reimbursement is provided for up to $10,000 of eligible transportation and lodging expenses for an approved transplant at least 100
	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a network hospital.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
miles away from your legal home address to the transplant center. This benefit only covers transportation and lodging expenses for you and one companion for the initial and annual evaluation, stem cell injection and cell collection, and the actual transplant. The lodging and transportation benefit is not applicable for follow-up or post-operative visits or transplant related inpatient admissions after you receive your transplant, except for readmissions occurring during sequestering (time required to be near a facility and away from your home) immediately after a covered transplant. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available online at https://www.medicare.gov/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit	**Prior authorization may be required.** Except in an emergency, your doctor must tell the plan that

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
does not apply to inpatient mental services provided in a general hospital.	you are going to be admitted to the hospital. For each Medicare-covered hospital stay, your copay is: $0 copay per admission. In some instances, a readmission policy may apply in which the benefit will continue from the original admission. Cost-sharing does not apply on day of discharge. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. There is a $0 copay per lifetime reserve day.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services.	You pay the applicable cost-share for other services as though they were provided on an outpatient basis. Please refer to the applicable benefit in this section of this *Evidence of Coverage.*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copay, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-	There is no coinsurance, copay, or deductible for the MDPP benefit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
term dietary change, increased physical activity and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Aranesp®). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **CignaMedicare.com/group/MAresources**	**Prior authorization may be required.** Medicare Part B drugs may be subject to step therapy requirements. $0 copay/coinsurance for Medicare-covered Part B Chemotherapy / radiation drugs and other Part B drugs.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of the 2024 *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the same document.	
🍎 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copay, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable). • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**Prior authorization may be required.** $0 copay for Medicare-covered opioid treatment services**.**

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Medicare-covered genetic tests will only be covered once per the member's lifetime unless the test is specifically approved by the U.S. Food and Drug Administration (FDA) to be performed more than once. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests.	**Prior authorization may be required.** Authorization not required for COVID-19 related testing**.** A separate PCP/Specialist cost-share will apply if additional services requiring cost-sharing are rendered. A facility fee may also apply. $0 copay for EKG and diagnostic colorectal screenings. $0 copay for all other diagnostic procedures and tests. $0 copay for Medicare-covered lab services. $0 copay for Medicare-covered genetic test. $0 copay for Medicare-covered blood services. $0 copayment for Medicare-covered diagnostic radiology services (not including X-rays). $0 copayment for mammography and ultrasounds. $0 copay for all other diagnostic and nuclear medicine radiological services. $0 copay for Medicare-covered therapeutic radiology services. $0 copay for Medicare-covered X-rays. Authorization not required.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-share amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**Prior authorization may be required.** $0 copay for Medicare-covered outpatient hospital observation.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital	**Prior authorization may be required.** $0 copay for non-surgical visits. In addition, you pay the applicable cost-share for these services. Please refer to the applicable benefit in this section of this *Evidence of Coverage*. Self-administered drugs (medication you would normally

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it. • X-rays and other radiology services billed by the hospital. • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/publications/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	take on your own) are not covered in an outpatient hospital setting. These drugs may be covered under your Part D benefit. Please contact Customer Service for more information.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Behavioral health telehealth services are available through Cigna Healthcare's telehealth vendor. For more information see the Extra Benefits Guide or call Customer Service.	**Prior authorization may be required.** $0 copay for each Medicare-covered group therapy visit. $0 copay for each Medicare-covered individual therapy visit. $0 copay for each Medicare-covered virtual Behavioral health visit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Outpatient rehabilitation services Covered services include: • Physical therapy • Occupational therapy • Speech language therapy Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**Prior authorization may be required.** $0 copay for Medicare-covered Occupational Therapy visits. $0 copay for Medicare-covered Physical Therapy in-person visits. $0 copay for Speech and Language Pathology in-person visits. $0 copay for virtual Physical Therapy and Speech and Language Pathology Therapy visits.
Outpatient substance abuse services Covered services include substance abuse outpatient services including: • Partial Hospitalization Program • Opioid Treatment Programs (OTP) • Outpatient evaluation • Outpatient therapy and medication management provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified behavioral health care professional as allowed under applicable state laws.	**Prior authorization may be required.** $0 copay for Medicare-covered group substance abuse outpatient treatment visits. $0 copay for Medicare-covered individual substance abuse outpatient treatment visits.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if	**Prior authorization may be required.** $0 copay for any surgical procedures (i.e., polyp removal) during a colorectal screening in a hospital facility or ambulatory surgical center.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
you stay in the hospital overnight, you might still be considered an "outpatient."	$0 copay for all other Ambulatory Surgical Center (ASC) services. $0 copay for all other outpatient services not provided in an Ambulatory Surgical Center.
Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**Prior authorization may be required.** $0 copay for Medicare-covered partial hospitalization program services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment. • Certain telehealth services, including urgent care (treating symptoms like allergies, cough, headache, nausea, and other low-risk illnesses), mental health therapy, and dermatology.	$10 copay for each Medicare-covered Primary Care Doctor visit $0 copay for virtual visits with a Primary Care Doctor. $10 copay for each Medicare-covered Specialist visit. $0 copay for virtual visits with a Specialist. $10 copay in a Primary Care Physician office or $10 copay in a Specialist office for Medicare-covered Other Health Care Professional Service.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• You have the option of receiving these services through an in-person visit or virtually. If you choose to receive one of these services by telehealth, you must use a network provider who offers the service virtually. • The telehealth benefit is applicable to providers who partner with Cigna Healthcare's telehealth vendor for telehealth services. Customers will be required to complete registration and a brief medical history upon first use of telehealth and provide applicable copay at time of the telehealth visit. Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include video. For more information on your telehealth benefits, see your Extra Benefits Guide or call Customer Service. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: • You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and**	$0 copay for each Medicare-covered virtual doctor visit through MDLive. Please contact MDLive at 1-866-918-7836 (TTY711) or visit the MDLive website at www.MDLive.com/CignaMedicare for more information on this benefit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment if you are an established patient. • Second opinion by another network provider prior to surgery. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). • Wound care services (including clinic) are provided to manage acute and chronic wounds through debridement, local wound care and specialized dressings. • Medicare covers services provided by other health providers, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Health professional means— - a physician who is a doctor of medicine or osteopathy; or - a physician assistant, nurse practitioner, or clinical nurse specialist; or - a medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a	

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
team of such medical professionals, working under the direct supervision of a physician. **Note:** Costs for services provided by other health providers (such as a nurse practitioner or physician assistant) will be based on the supervising physician's specialty. For example, if you are seeing a nurse practitioner and the supervising physician is a PCP, you will pay the PCP cost. If you are seeing a nurse practitioner and supervising physician is a Specialist, you will pay the Specialist cost.	
Podiatry services Covered services include: • Diagnosis and the medically necessary treatment of injuries and diseases of the feet (such as hammer toe, bunion deformities or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	$10 copay for each Medicare-covered podiatry visit.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copay, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: • colostomy bags and supplies directly related to colostomy care. • pacemakers • braces • prosthetic shoes • artificial limbs • breast prostheses (including a surgical brassiere after a mastectomy).	**Prior authorization may be required.** 20% coinsurance after deductible for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **Note:** Medical supply quantities will be reviewed to ensure they are medically necessary and reasonable. Total monthly quantity limits may apply for medical supplies.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**Prior authorization may be required.** $0 copayment for each Medicare-covered pulmonary rehabilitative therapy visit.
🍎 **Screening and counseling to reduce alcohol misuse** We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copay, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
🍎 **Screening for lung cancer with low dose computed tomography (LDCT)** For qualified individuals, an LDCT is covered every 12 months. Qualified members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, and who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that	There is no coinsurance, copay, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
meets the Medicare criteria for such visits when furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening; the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
🍎 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copay, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease, we cover up to six sessions of kidney disease education services per lifetime, when ordered by their doctor.	**Prior authorization may be required for Medicare-covered renal dialysis.** $0 copay for Medicare-covered kidney disease education services. $0 copay for Medicare-covered renal dialysis.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the 2024 *Evidence of Coverage*). • Inpatient dialysis treatments (if you are admitted to a hospital as an inpatient for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of the Evidence of Coverage. Skilled nursing facilities are sometimes called "SNFs.") Plan covers unlimited days each benefit period. An inpatient hospital stay is **not** required prior to SNF admission. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All	**Prior authorization may be required.** For Medicare-covered SNF stays, the copay is: – Days 1-100: $0 copay per day – Days 101 and beyond: $0 copay per day

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/Practitioner services	
🍎 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-share. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copay, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and are recommended for treatment by the responsible physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication	**Prior authorization may be required.** $0 copay for each Medicare-covered Supervised Exercise Therapy visit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
• Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out-of-network are: i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. *Urgently needed services are covered worldwide.* See **Ambulance services** benefit in this chart for additional information about Worldwide ambulance services.	$10 copay for Medicare-covered urgently needed service visit. *$0 copay for worldwide emergency/urgent coverage and worldwide emergency transportation.* *$50,000 (U.S. currency) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.* Emergency transportation must be medically necessary. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the urgently needed services visit.

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • Original Medicare does not cover routine eye exams (eye refractions) for eyeglasses/contacts. • One glaucoma screening each year for people who are at high risk of glaucoma: • People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are ago 50 and older, and Hispanic Americans who are 65 or older. • One screening for diabetic retinopathy each year for people with diabetes. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery). For more information on your Medicare-covered vision benefits, call Customer Service. **Vision care (Routine)** This plan covers: • One (1) routine eye exam (including eye refraction) per year. Eye refractions outside of the annual routine eye exam are not covered. • Eyeglasses and frames or contact lenses up to the plan allowance amount. The plan specified allowance may be applied to one set of the customer's choice of eyewear, to include the eyeglass frame/lenses/lens options combination or contact lenses and contact lens fitting (to include related professional fees) in lieu of eyeglasses. Routine annual eyewear allowance applied to the retail value only. Applicable taxes are not covered. Unused balance of the allowance amount does not carry forward to future benefit years.	A separate PCP/Specialist cost-share will apply if additional services requiring cost-share are rendered. (e.g., but not limited to, if a medical eye condition is discovered during a preventive routine eye exam). For surgical procedures performed in an outpatient surgical center, a separate physician cost-share or facility fee may apply. $0 or $10 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copay for glaucoma screening and diabetic retinal exam. $10 copay for all other Medicare-covered vision services. $0 copay for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens). *– up to 1 supplemental routine eye exam every year.* *$0 copay:* *– up to 1 pair of eyeglasses (lenses and frames) every year.* *– unlimited contact lenses up to plan coverage limit.* *– up to 1 pair of eyeglass lenses every year.*

Medical Services that are covered for you	**What you must pay** when you get these medical services In-Network and Out-of-Network
For routine eye exams and eyewear services, customers are encouraged to select a provider within Cigna Healthcare's vision vendor network, but are not required to do so. You have the option to select doctors and benefits both in- and out-of-network with no referrals required. There are limitations on the number of covered services within a service category. Frequency limits vary depending on the type of covered service. Medically necessary contact lenses are not covered by the routine vision benefit. Some exclusions may apply. For more information on your routine eye exam and eyewear benefit, please refer to your Extra Benefits Guide or contact Cigna Healthcare's vision vendor at 1-888-886-1995 (TTY 711).	*– up to 1 eyeglass frame every year.* *– upgrades* *$250 allowance for routine eyewear every year. Customer is responsible for all costs over and above the allowance amount.*
🍎 **"Welcome to Medicare" Preventive Visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and orders for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copay, or deductible for the "Welcome to Medicare" preventive visit.

Extra "optional supplemental" benefits not covered by Original Medicare but included in your plan	
Caregiver Support Services include one-on-one coaching and personalized resources for customers and caregivers. For questions and more details, see your Extra Benefits Guide or call Customer Service.	$0 copay for caregiver support services benefit. No limits or maximum.
Gradient Compression Stockings	$10 copay after deductible
Home Life Referrals With our Home Life Referrals program, you'll have quick and convenient access to trusted local resources to assist you with your everyday needs such as finding childcare, eldercare, pet care, home repairs, and more.	$0 copay for home life referrals
Outpatient Private Duty Nursing	$10 copayment, after deductible, with a coverage limit of 14 hours per year.
Wigs for Hair Loss Due to Cancer Treatment	$350 allowance per year
Naturopath Services Uses natural or alternative treatments	$10 copayment
Weight Loss Surgery Original Medicare covers weight loss surgery under strict criteria.The plan requirements are less strict. We will cover it when the following criteria are met: • BMI (body mass index) of: • 40 or greater • 35 with at least one co-morbidity directly related to your obesity, i.e., sleep apnea, high blood pressure, diabetes, etc. • 30 to 34.9 if you are of Asian origin with co-morbidity of diabetes or metabolic syndrome • Participation in a medically supervised weight loss program within 12 months preceding surgery.	Covered the same as any other illness

Extra "optional supplemental" benefits not covered by Original Medicare but included in your plan	
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% after deductible

Section 2 – Medicare Prescription Drug Plan - What you pay for your Part D prescription drugs

Your Costs	Cigna True Choice Medicare (PPO)
Monthly Premium	Contact your plan sponsor.
Annual Deductible	$0 / year
Out of Pocket Maximum	$750 After you pay $750 for covered prescriptions, you will pay $0 for covered prescriptions.

What you pay for a drug depends on which drug payment stage you are in when you get the drug.

Please see Chapter 6, Section 2.1 in your Evidence of Coverage booklet for a detailed description of the table shown below.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you. (Details are in Section 4 of Chapter 6 in your Evidence of Coverage booklet.)	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $5,030. (Details are in Section 5 of Chapter 6 in your Evidence of Coverage booklet.)	You pay the same copays/coinsurance as the initial level stage. You stay in this stage until your year-to-date **"out of pocket costs"** (your payments) reach a total of $8,000. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of Chapter 6 in your Evidence of Coverage booklet.)	During this stage, **the plan will pay the cost** of your drugs for the rest of the calendar year (through December 31, 2024). For a 30-day supply, you pay **$0**.

Your Medicare Prescription Drug Coverage as a member of Cigna True Choice Medicare (PPO).

Please see Chapter 6, section 5.2 in your Evidence of Coverage booklet for a detailed description of the table shown below.

Your share of the cost when you get a *one-month* (up to a 30-day or 31-day supply in a network long-term care pharmacy) supply of a covered Part D prescription drug from:

Cost-Share Tier	Network pharmacy	The plan's mail-order service	Network long-term care pharmacy	Out-of-network pharmacy*
Tier 1	$5	$5	$5	$5
Tier 2	$20	$20	$20	$20
Tier 3	$5 Generics; $40 Brand	$5 Generics; $40 Brand	$5 Generics; $40 Brand	$5 Generics; $40 Brand
Tier 4	$5 Generics; $40 Brand	$5 Generics; $40 Brand	$5 Generics; $40 Brand	$5 Generics; $40 Brand

*Coverage is limited to certain situations; see Chapter 5 of the Evidence of Coverage booklet for details.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. If your insulin is on a tier where cost-sharing is lower than $35, you will pay the lower cost for your insulin.

Please see Section 8 of chapter 6 of the Evidence of Coverage booklet for more information on Part D vaccines cost-sharing for Part D vaccines.

Please see Section 5.4 of Chapter 6, in your Evidence of Coverage booklet for a detailed description of the table shown below.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

Cost-Share Tier	**Network pharmacy** (60-day / 90-day supply)	**The plan's mail-order service** (60-day / 90-day supply)
Tier 1	$10 / $10	$10 / $10
Tier 2	$40 / $40	$40 / $40
Tier 3	$10 Generics;$80 Brand / $10 Generics;$80 Brand	$10 Generics;$80 Brand / $10 Generics;$80 Brand
Tier 4**	N/A / N/A	N/A / N/A

**Specialty drugs are limited to a 30-day supply

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. If your insulin is on a tier where cost-sharing is lower, you will pay the lower cost for your insulin.

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 12-month supply dispensed at one time.	
Covered Diabetic Test Strips and Meters You will not pay more than $0 for preferred products.	

Additional Benefits Offered
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.

Clinical Management Edits

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 one-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.

Method	Customer Service – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m. local time; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call on weekends, holidays and after hours. 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, 7 days a week, 8 a.m. – 8 p.m. local time; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call on weekends, holidays and after hours.
WEBSITE	**CignaMedicare.com/group/MAresources**