Summary of Benefits

2022

January 1, 2022 to
December 31, 2022

Cigna True Choice Medicare (PPO) H7849-056

Freedom to choose your own doctor with no referrals required; out-of-network coverage available

What's Inside

To Join

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

Service Area

Southwest: Collier and Lee counties, FL

Introduction

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 list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage* (EOC) online at **CignaMedicare.com**, or call us to request a copy.

Comparing coverage

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

More about Original Medicare

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

View the handbook online at:
www.medicare.gov

Get a copy of the handbook by calling:
1-800-MEDICARE (1-800-633-4227),
24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Need help?

Already a customer

Call toll-free **1-800-668-3813 (TTY 711)**. Customer Service is available October 1 to March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 to September 30, Monday to Friday 8 a.m. to 8 p.m. local time. Our automated phone system may answer your call during weekends, holidays and after hours.

Not a customer

Call toll-free **1-866-623-8056 (TTY 711)**, licensed agents are available October 1 to March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 to September 30, Monday to Friday 8 a.m. to 8 p.m. local time. Our automated phone system may answer your call during weekends, holidays and after hours.

You can also visit our website at:
CignaMedicare.com

1 | About this Plan

Which doctors, hospitals and pharmacies can I use?

Cigna True Choice Medicare (PPO) has a network of doctors, hospitals, pharmacies and other providers. You may also choose to use providers that are out-of-network for a higher 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**.

What do we cover?

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

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

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

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

2 | Monthly Premium, Deductible and Limits

Benefit	Cigna True Choice Medicare (PPO)
Monthly Premium	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
Medical Deductible	This plan does not have a deductible
Pharmacy (Part D) Deductible	**$150** per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2 and Tier 3 which are excluded from the deductible
Is there any limit on how much I will pay for my covered services?	Original Medicare does not have annual limits on out-of-pocket costs. Your yearly limit(s) in this plan: **$5,500** for services you receive from in-network providers for Medicare-covered benefits. **$10,000** which applies to in-network and out-of-network Medicare-covered benefits combined. If you reach the in-network limit on out-of-pocket costs, you will keep getting in-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.

3 | Covered Medical and Hospital Benefits

Benefit	What You Pay	
	In-Network	Out-of-Network
Note: Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.		
Inpatient Hospital Coverage[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.	**$225** per day for days 1–6 **$0** per day for days 7–90	**40%** coinsurance
Outpatient Surgery		
Ambulatory Surgical Center (ASC)[1]	**$0–$150** copay	**40%** coinsurance
Outpatient Services[1]	**$0–$250** copay	**40%** coinsurance
Outpatient Observation[1]	**$0** copay	**40%** coinsurance
Doctors Visits		
Primary Care Physician (PCP)	**$0** copay	**$50** copay
Specialists[1]	**$35** copay	**$60** copay

Benefit	What You Pay	
	In-Network	Out-of-Network
Preventive Care		
Our plan covers many Medicare-covered preventive services, including: › Abdominal aortic aneurysm screening › Alcohol misuse screenings and counseling › Bone mass measurement › Breast cancer screening (mammogram) › Cardiovascular disease (behavioral therapy) › Cardiovascular screenings › Cervical and vaginal cancer screening › Colorectal cancer screening (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy) › Depression screenings › Diabetes screenings › Diabetes self-management training › Glaucoma tests › Hepatitis B Virus (HBV) infection screening › Hepatitis C screening › HIV screening › Lung cancer screening with low dose computed tomography (LDCT) › Medical nutrition therapy services › Obesity screening and counseling › Prostate cancer screenings (PSA) › Sexually transmitted infections screening and counseling › 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 and Pneumococcal shots › Welcome to Medicare preventive visit (one-time) › Yearly Wellness visit	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered. Please see your *Evidence of Coverage* (EOC) for frequency of covered services.	**$0** copay

Benefit	What You Pay	
	In-Network	Out-of-Network
Emergency Care		
Emergency Care Services	**$90** copay If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care.	Same as in-network
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$90** copay Maximum worldwide coverage amount **$50,000**	Same as in-network
Urgently Needed Services		
Urgent Care Services	**$25** copay If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for urgent care.	Same as in-network
Diagnostic Services, Labs and Imaging Costs for these services may vary based on place of service or type of service		
Diagnostic Procedures and Tests[1]	**$0–$100** copay	**40%** coinsurance
Lab Services[1] For COVID-19 testing a prior authorization is not required.	**$0–$20** copay	**40%** coinsurance **0%** coinsurance for COVID-19 testing
Therapeutic Radiological Services[1]	**20%** coinsurance	**40%** coinsurance
X-ray Services	**$0–$20** copay	**40%** coinsurance
Diagnostic Radiological Services (MRIs, CT scans, etc.)[1]	**$0–$250** copay	**40%** coinsurance
Hearing Services		
Hearing Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	**$25** copay	**$60** copay
Routine Hearing Exams	**$0** copay for one routine exam every year	**$60** copay for one routine exam every year

Benefit	What You Pay	
	In-Network	Out-of-Network
Hearing Aid Evaluation/Fitting	**$0** copay for one hearing aid fitting evaluation every three years	**$60** copay for one hearing aid fitting evaluation every three years
Hearing Aids	**$0** copay up to plan maximum coverage amount for hearing aids of **$700** per ear per device every three years	Combined with in-network
Dental Services (Medicare-covered)[1]		
Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth)	**$35** copay	**$60** copay
Preventive and Comprehensive Dental Services		
Dental Allowance Supplemental dental services with licensed dentist.* Provider submits claim to Cigna Dental Health. Includes Preventive and Comprehensive Services. Benefit does not cover cosmetic services. *Dentist is not on the exclusion/preclusion list.	**$0** copay up to allowance amount **$1,000** combined Preventive and Comprehensive allowance every year	Combined with in-network
Vision Services		
Eye Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered. A facility cost-share may apply for procedures performed at an outpatient surgical center.	**$0** copay for Medicare-covered diabetic retinopathy screening **$35** copay for all other Medicare-covered vision services	**$0** copay for Medicare-covered diabetic retinopathy screening **$60** copay for all other Medicare-covered vision services
Routine Eye Exam	**$0** copay for one routine exam every year	**$60** copay for one routine exam every year
Glaucoma Screening (Medicare-covered)	**$0** copay	**$0** copay

Benefit	What You Pay	
	In-Network	Out-of-Network
Eyewear (Medicare-covered)	**$0** copay	**40%** coinsurance
Routine Eyewear › Contact lenses › Eyeglasses-lenses and frames › Eyeglass lenses › Eyeglass frames › Upgrades	**$0** copay up to plan maximum coverage amount of **$100** every year The plan specified allowance may be applied to one set of the member's choice of eyewear once per year, to include the eyeglass frame/lenses/lens options combination or contact lenses (to include related professional fees) in lieu of eyeglasses.	Combined with in-network
Mental Health Services		
Inpatient[1] Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with Day 1 each time you are admitted. There is a **$0** copayment per lifetime reserve day.	**$310** per day for days 1–5 **$0** per day for days 6–90	**40%** coinsurance
Outpatient[1] Individual or Group Therapy Visit	**$0** copay	**$60** copay
Skilled Nursing Facility (SNF)[1]		
Our plan covers up to 100 days in the SNF.	**$0** per day for days 1–20 **$188** per day for days 21–100	**$250** per day for days 1–58 **$0** per day for days 59–100
Rehabilitation Services		
Cardiac (Heart) Rehab Services[1]	**$35–$50** copay	**40%** coinsurance
Pulmonary Rehab Services[1]	**$25–$30** copay	**40%** coinsurance
Occupational Therapy Services[1]	**$10–$40** copay	**$60** copay

Benefit	What You Pay	
	In-Network	Out-of-Network
Physical Therapy, Speech and Language Therapy Services[1]	**$10–$40** copay	**$60** copay
Physical Therapy, Speech and Language Therapy Telehealth Services[1]	**$0** copay	Not Covered
Ambulance[1]		
Ground Service (one-way trip)	**$240** copay	**$240** copay
Air Service (one-way trip)	**20%** coinsurance	**20%** coinsurance
Transportation		
	Not Covered	Not Covered
Prescription Drugs[1]		
Medicare Part B Drugs Medicare-covered Part B Drugs may be subject to step therapy requirements.	**20%** coinsurance This plan has Part D prescription drug coverage. See Section 4 in the *Summary of Benefits*.	**40%** coinsurance
Foot Care (Podiatry Services)		
Podiatry Services (Medicare-covered)	**$30** copay	**$60** copay
Routine Podiatry Services	**$30** copay	**$60** copay
Medical Equipment and Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**20%** coinsurance	**40%** coinsurance
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**20%** coinsurance	**40%** coinsurance
Diabetes Supplies and Services[1] Brand limitations apply to certain supplies.	**$0** copay for diabetes self-management training **$10** copay for therapeutic shoes or inserts **0%** or **20%** coinsurance for diabetic monitoring supplies	**$0** copay for diabetes self-management training **40%** coinsurance for therapeutic shoes or inserts **40%** coinsurance for diabetic monitoring supplies
Fitness and Wellness Programs		
Fitness Program The program offers the flexibility of a fitness center membership, digital fitness tools, and a home fitness kit.	**$0** copay	Combined with in-network

Benefit	What You Pay	
	In-Network	Out-of-Network
Health Information Line		
Talk one-on-one with a Nurse Advocate* to get timely answers to your health-related questions at no additional cost, anytime day or night. *Nurse Advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.	**$0** copay	Combined with in-network
Chiropractic Care[1]		
Chiropractic Services (Medicare-covered)	**$10** copay	**$60** copay
Routine Chiropractic Services	Not Covered	Not Covered
Home Health[1]		
	$0 copay	**40%** coinsurance
Hospice		
Hospice care must be provided by a Medicare-certified hospice program. Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.	**$0** copay	Same as in-network
Outpatient Substance Abuse[1]		
Individual or Group Therapy Visit	**$35–$40** copay	**40%** coinsurance
Opioid Treatment Services[1]		
FDA-approved treatment medications in addition to testing, counseling and therapy.	**$35–$40** copay	**40%** coinsurance
Over-the-Counter Items (OTC)		
Over-the-counter drugs and other health-related pharmacy products, as listed in the *OTC Catalog*.	**$70** quarterly allowance	Combined with in-network

Benefit	What You Pay	
	In-Network	Out-of-Network
Home Delivered Meals[1]		
	$0 copayment for home delivered meals Limited to 14 meals per discharge from a qualified hospital stay or skilled nursing facility (up to three stays per year), ESRD care management is limited to 56 meals per benefit period.* *Authorization and/or referral applies to ESRD meals.	Combined with in-network
Telehealth Services (Medicare-covered)		
For nonemergency care, talk with a telehealth doctor via phone or video for certain telehealth services, including: allergies, cough, headache, sore throat, and other minor illnesses.	**$0** copay	**$50** copay
Acupuncture Services		
Acupuncture Services (Medicare-covered)[1] Services for chronic lower back pain.	**$20** copay	**$60** copay
Supplemental Acupuncture Services	Not Covered	Not Covered
Additional Benefits Enjoy these extra benefits included in your plan.		
Annual Physical Exam	**$0** copay	**$50** copay

4 | Prescription Drug Benefits

Medicare Part D Drugs Initial Coverage

The following charts show the cost-sharing amounts for covered drugs under this plan. After you pay your yearly Part D deductible, you pay the following until your total yearly drug costs reach **$4,430.** Total yearly drug costs are the total drug costs paid by both you and our plan.

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

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

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

		Mail Order Cost-Sharing		Retail Cost-Sharing	
Tier	**Supply**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 Preferred Generic Drugs	30-day	**$0**	**$10**	**$0**	**$10**
	60-day	**$0**	**$20**	**$0**	**$20**
	90-day	**$0**	**$30**	**$0**	**$30**
Tier 2 Generic Drugs	30-day	**$10**	**$20**	**$10**	**$20**
	60-day	**$20**	**$40**	**$20**	**$40**
	90-day	**$0**	**$60**	**$30**	**$60**
Tier 3 Preferred Brand Drugs	30-day	**$45**	**$47**	**$45**	**$47**
	60-day	**$90**	**$94**	**$90**	**$94**
	90-day	**$135**	**$141**	**$135**	**$141**
Tier 4 Non-Preferred Drugs	30-day	**$100**	**$100**	**$100**	**$100**
	60-day	**$200**	**$200**	**$200**	**$200**
	90-day	**$300**	**$300**	**$300**	**$300**
Tier 5 Specialty Drugs	30-day	**30%**	**30%**	**30%**	**30%**
	60-day	**Not Available**	**Not Available**	**Not Available**	**Not Available**
	90-day	**Not Available**	**Not Available**	**Not Available**	**Not Available**

Coverage Gap

Most Medicare prescription 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 your total yearly prescription drug cost (including what our plan has paid and what you have paid) reaches **$4,430.** Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay **25%** of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your costs total **$7,050,** which is the end of the Coverage Gap.

This plan offers some additional prescription drug coverage for Tier 1 and Tier 2 drugs in the Coverage Gap. See the table that follows to find out how much you will pay.

Catastrophic Coverage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$7,050** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Your share of the cost of covered drugs will be the greater of:

- Coinsurance of **5%** of the cost of the drug, or
- **$3.95** for a generic drug or a drug that is treated like a generic and **$9.85** for all other drugs.
  - Our plan pays the rest of the cost.

		Mail Order Cost-Sharing		Retail Cost-Sharing	
Tier	**Supply**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 Preferred Generic Drugs	30-day	**$0**	**$10**	**$0**	**$10**
	60-day	**$0**	**$20**	**$0**	**$20**
	90-day	**$0**	**$30**	**$0**	**$30**
Tier 2 Generic Drugs	30-day	**$10**	**$20**	**$10**	**$20**
	60-day	**$20**	**$40**	**$20**	**$40**
	90-day	**$0**	**$60**	**$30**	**$60**