Cigna TotalCare Plus (HMO D-SNP) offered by Cigna Healthcare

ANNUAL NOTICE OF CHANGES FOR 2025

You are currently enrolled as a member of Cigna TotalCare Plus (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.cignamedicare.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

What to do now

1. ASK: Which changes apply to you

- ☐ Check the changes to our benefits and costs to see if they affect you.
  - ☐ Review the changes to medical care costs (doctor, hospital).
  - ☐ Review the changes to our drug coverage, including coverage restrictions and cost sharing.
  - ☐ Think about how much you will spend on premiums, deductibles, and cost sharing.
  - ☐ Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- ☐ Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- ☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- ☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- ☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Cigna TotalCare Plus (HMO D-SNP).
- To **change to a different plan,** you can switch plans between October 15 and December 7. Your new coverage will start on January 1, 2025. This will end your enrollment with Cigna TotalCare Plus (HMO D-SNP).
- Look in Section 3.2, page 09 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 1-800-668-3813 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. This call is free.
- To get information from us in a way that works for you, please call Customer Service. We can give you information in braille, in large print, and other alternate formats if you need it.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Cigna TotalCare Plus (HMO D-SNP)

- Subsidiaries of The Cigna Group contract with Medicare to offer Medicare Advantage HMO and PPO plans and Part D Prescription Drug Plans (PDP) in select states, and with select State Medicaid programs. Enrollment in a Cigna Healthcare℠ product depends on contract renewal.
- When this document says "we," "us," or "our," it means Cigna Healthcare. When it says "plan" or "our plan," it means Cigna TotalCare Plus (HMO D-SNP).
- Cigna Healthcare may reach out to you via phone regarding the administration of your plan benefits. This communication helps us let you know about scheduled services or available programs, so you get the most out of your plan. You can opt-out of these calls at any time by contacting Customer Service.

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Cigna TotalCare Plus (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Agency For Health Care Administration (Florida Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 1.1 for details.	$0 or $26.60*	$0 or $16.70*
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $0 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $0 copayment per visit
Inpatient hospital stays	$0 per stay	$0 per stay
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 or $545* Copayments or Coinsurance during the Initial Coverage Stage: □ Drug Tier 1: 25% of coinsurance or $0/$1.55/$4.50* copay for generics or $0/$4.60/$11.20* copay for all other drugs per one-month supply You will pay no more than $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: □ During this payment stage, the plan pays most of the cost for your covered drugs. You pay nothing.	Deductible: $0 or $590* Copayments or Coinsurance during the Initial Coverage Stage: □ Drug Tier 1: 25% of coinsurance or $0/$1.60/$4.90* copay for generics or $0/$4.80/$12.15* copay for all other drugs per one-month supply You will pay no more than $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: □ During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$1,500 If you are eligible for Medicare cost-sharing assistance under Agency For Health Care Administration (Florida Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$1,500 If you are eligible for Medicare cost-sharing assistance under Agency For Health Care Administration (Florida Medicaid), you are not responsible for paying out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

*Cost sharing is based on your level of Medicaid eligibility or “Extra Help.”

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or $26.60*	$0 or $16.70*

*Cost sharing is based on your level of Medicaid eligibility.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket during the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$1,500	$1,500 Once you have paid $1,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.cignamedicare.com/resources. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider and Pharmacy Directory* (www.cignamedicare.com/resources) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider and Pharmacy Directory* (www.cignamedicare.com/resources) to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Prior authorization	Prior authorization may be required for the following services: □**Cardiac rehabilitation services** □**Pulmonary rehabilitation services** □**Outpatient rehabilitation services** ○ **Occupational therapy**	Prior authorization is not required for the following services: □**Cardiac rehabilitation services** □**Pulmonary rehabilitation services** □**Outpatient rehabilitation services** ○ **Occupational therapy**
Health and wellness education programs	**Health Information Line** You pay a copayment of $0 for 24-Hour Health Information Line. **HealthWise** You pay a copayment of $0 for access to online health-related educational videos and written content.	**Health Information Line** Not covered. **HealthWise** Benefit name is changing to **Health Education**. You pay a copayment of $0 for access to online health-related educational videos and written content.
Healthy Grocery and Utility Services Allowance	You receive an allowance of $300 every 3 months combined with Utility Assistance applied to your Cigna Healthy Today benefit card. Allowance can be used toward healthy grocery items at participating retailers or utility services for your home.	The benefit name is changing to **Value-Based Insurance Design (VBID) Model: Living Needs Allowance** and the allowance can be applied to additional items. You receive an allowance of $325 every 3 months combined applied to your Cigna Healthy Today benefit card. This allowance can be used toward the purchase of healthy grocery items at participating retailers, utility services for your home, transportation services (fuel, public transportation, rideshare etc.) and to purchase cleaning supplies for your home from participating retailers. The allowance amount can be used for any of these benefits or all, whatever works best for your situation. Allowance must be used in the quarter provided and does not roll over to the next quarter or the following year. You have the right to decline this benefit for any reason. If you decline the benefit, this will not affect your eligibility to the plan or any other benefit in your plan. If you decide to decline this benefit, you can do so by calling Customer Service.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	You pay a copayment of $0 for Medicare-covered lab services. You pay a coinsurance of 0% or 20% for Medicare-covered genetic tests. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a copayment of $0 for Medicare-covered lab services. You pay a copayment of $0 or $50 for Medicare-covered genetic tests. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Over-the-Counter Items and Services	$125 every 3 months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.	$100 every 3 months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.

Section 1.5 Changes to Part D Prescription Drug Coverage

Changes to our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically. The Drug List includes many but not all, of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Customer Service (see the back cover) or visiting our website (www.cignamedicare.com).

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Because this plan participates in the Value-Based Insurance Design (VBID) model, your Part D cost-sharing will be $0. You will pay $0 for Medicare-covered prescriptions, regardless of what level LIS you are in.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Your deductible amount is $0 or $545. If you are eligible for Medicare-cost-sharing assistance under Medicaid, your deductible is $0.	Your deductible amount is $0 or $590. If you are eligible for Medicare-cost-sharing assistance under Medicaid, your deductible is $0.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. The costs in the chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **All Formulary Drugs:** You pay 25% of the total cost or a $0/$1.55/$4.50* copayment for generics or $0/$4.60/$11.20* copayment for all other drugs. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **All Formulary Drugs:** You pay 25% of the total cost or a $0/$1.60/$4.90* copayment for generics or $0/$4.80/$12.15* copayment for all other drugs. _____ Once you have paid $2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

*Cost sharing is based on your level of "Extra-Help."

Changes to your VBID Part D Benefit

Cost	2024 (this year)	2025 (next year)
Part D VBID Benefit	Because this plan participates in the Value-Based Insurance Design (VBID) model, your Part D cost-sharing will be $0. You will pay $0 for Medicare-covered prescriptions, regardless of what level LIS you are in.	Because this plan participates in the Value-Based Insurance Design (VBID) model, your Part D cost-sharing will be $0. You will pay $0 for Medicare-covered prescriptions, regardless of what level LIS you are in.

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers

under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage.*

SECTION 2 Administrative Changes

Please see the table below for other important changes to your plan.

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at 1-800-668-3813 (TTY 711) or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in Cigna TotalCare Plus (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Cigna TotalCare Plus (HMO D-SNP).

Section 3.2 If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- — *OR* — You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Cigna Healthcare offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
  - — *OR* — Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Agency For Health Care Administration (Florida Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time.** You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE (Serving Health Insurance Needs of Elders) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE (Serving Health Insurance Needs of Elders) at 1-800-963-5337.

For questions about your Agency For Health Care Administration (Florida Medicaid) benefits, contact Agency For Health Care Administration (Florida Medicaid) at 1-877-711-3662. TTY users should call 1-866-467-4970. Hours are Mon. - Thur. 8 a.m. - 8 p.m., Fri. 7 a.m. - 7 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Agency For Health Care Administration (Florida Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the Florida AIDS Drug Assistance Program at 1-850-245-4422 or 1-800-352-2437. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**
- "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-800-668-3813 (TTY 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 Getting Help from Cigna TotalCare Plus (HMO D-SNP)

Questions? We're here to help. Please call Customer Service at 1-800-668-3813 (TTY only, call 711). We are available for phone calls October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.

Read your 2025 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the 2025 *Evidence of Coverage* for Cigna TotalCare Plus (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.cignamedicare.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.cignamedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

Section 7.3 Getting Help from Agency For Health Care Administration (Florida Medicaid)

To get information from Medicaid, you can call Agency For Health Care Administration (Florida Medicaid) at 1-877-711-3662. TTY users should call 1-866-467-4970.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-668-3813. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-668-3813. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-668-3813。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-668-3813。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagapagsaling-wika, tawagan lamang kami sa 1-800-668-3813. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-668-3813. Un interlocuteur parlant français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-668-3813 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-668-3813. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-668-3813번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-668-3813. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة على أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-800-668-3813، وسيقوم شخص يتحدث العربية بمساعدتك. هذه الخدمة مجانية.

Hindi: हमारी स्वास्थ्य या दवा योजना से संबंधित आपके किसी भी प्रश्न का जवाब देने के लिए हमारे पास मुफ़्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया सेवाएँ प्राप्त करने के लिए हमें 1-800-668-3813 पर फ़ोन करें। हिन्दी बोलने वाला कोई भी व्यक्ति आपकी मदद कर सकता है। यह एक मुफ़्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-668-3813. Un nostro incaricato che parla italiano Le l'assistenza necessaria. Il servizio è gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que possa ter acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-668-3813. Irá encontrar alguém que fale português para o(a) ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-668-3813. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-668-3813. Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と薬品プランに関するご質問にお答えするために、無料の通訳サービスがございます。通訳をご用命になるには、1-800-668-3813 にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。