*Cigna-HealthSpring Traditions (HMO SNP) offered by Cigna-HealthSpring*

# ANNUAL NOTICE OF CHANGES FOR 2018

You are currently enrolled as a member of Cigna-HealthSpring Traditions (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

**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.
- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.
- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider and Pharmacy Directory.*

☐ Think about your overall health care costs.
- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

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**2. COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.
- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

**3. CHOOSE: Decide whether** you want to change your plan
- If you want to **keep** Cigna-HealthSpring Traditions (HMO SNP), you don't need to do anything. You will stay in Cigna-HealthSpring Traditions (HMO SNP).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

**4. ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**
- If you **don't join by December 7, 2017**, you will stay in Cigna-HealthSpring Traditions (HMO SNP).
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

**Additional Resources**
- To get information from us in a way that works for you, please call Customer Service (phone numbers are in Section 7.1 of this booklet). We can give you information in Braille, in large print, and other alternate formats if you need it.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

**About Cigna-HealthSpring Traditions (HMO SNP)**
- Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select State Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Cigna-HealthSpring. When it says "plan" or "our plan," it means Cigna-HealthSpring Traditions (HMO SNP).

## Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Cigna-HealthSpring Traditions (HMO SNP) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Monthly plan premium*** <br>*Your premium may be higher or lower than this amount. See Section 1.1 for details. | $33.20 | $30.70 |
| **Maximum out-of-pocket amount** <br>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.) | $6,700 | $6,700 |
| **Doctor office visits** | Primary care visits: $0 copayment per visit <br>Specialist visits: 20% coinsurance per visit | Primary care visits: $0 copayment per visit <br>Specialist visits: 15% coinsurance per visit |
| **Inpatient hospital stays** <br>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. | Days 1-7: $279 copayment per day <br>Days 8-90: $0 copayment per day | Days 1-6: $300 copayment per day <br>Days 7-90: $0 copayment per day |
| **Part D prescription drug coverage** <br>(See Section 1.6 for details.) | Deductible: $400 <br>Copayments or Coinsurance during the Initial Coverage Stage: <br>• Drug Tier 1: 25% coinsurance or $0/$1.20/$3.30/15%* copay for generics or $0/$3.70/$8.25/15%* copay for all other drugs per one-month supply <br>*Cost-sharing is based on your level of "Extra Help." | Deductible: $405 <br>Copayments or Coinsurance during the Initial Coverage Stage: <br>• Drug Tier 1: 25% coinsurance or $0/$1.25/$3.35/15%* copay for generics or $0/$3.70/$8.35/15%* copay for all other drugs per one-month supply <br>*Cost-sharing is based on your level of "Extra Help." |

## *Annual Notice of Changes* for 2018
## Table of Contents

**Summary of Important Costs for 2018** ..... **3**

**SECTION 1** **Changes to Benefits and Costs for Next Year** ..... **5**
Section 1.1 Changes to the Monthly Premium ..... 5
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount ..... 5
Section 1.3 Changes to the Provider Network ..... 5
Section 1.4 Changes to the Pharmacy Network ..... 6
Section 1.5 Changes to Benefits and Costs for Medical Services ..... 6
Section 1.6 Changes to Part D Prescription Drug Coverage ..... 8

**SECTION 2** **Administrative Changes** ..... **10**

**SECTION 3** **Deciding Which Plan to Choose** ..... **10**
Section 3.1 If you want to stay in Cigna-HealthSpring Traditions (HMO SNP) ..... 10
Section 3.2 If you want to change plans ..... 10

**SECTION 4** **Deadline for Changing Plans** ..... **10**

**SECTION 5** **Programs That Offer Free Counseling about Medicare** ..... **10**

**SECTION 6** **Programs That Help Pay for Prescription Drugs** ..... **11**

**SECTION 7** **Questions?** ..... **11**
Section 7.1 Getting Help from Cigna-HealthSpring Traditions (HMO SNP) ..... 11
Section 7.2 Getting Help from Medicare ..... 12

## SECTION 1 Changes to Benefits and Costs for Next Year

### Section 1.1 Changes to the Monthly Premium

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $33.20 | $30.70 |

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

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

To protect you, 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 | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $6,700 | $6,700<br>Once you have paid $6,700 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 Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2018 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

## Section 1.4 Changes to the Pharmacy Network

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.

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2018 *Provider and Pharmacy Directory* to see which pharmacies are in our network.**

## Section 1.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*.

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Chiropractic services** | You pay a copayment of $0 for each Medicare-covered chiropractic visit. | You pay a copayment of $15 for each Medicare-covered chiropractic visit. |
| **Dental services** | You pay a coinsurance of 20% for Medicare-covered dental services<br>The plan has a max coverage amount of $1,200 every two years for comprehensive dental services. Unused amounts do not carry forward to future benefit years. | You pay a coinsurance of 15% for Medicare-covered dental services.<br>The plan has a max coverage amount of $2,000 per year for comprehensive dental services. Unused amounts do not carry forward to future benefit years. |
| **Emergency care** | You pay a copayment of:<br>$75 for Medicare-covered emergency room visits.<br>$75 for worldwide emergency room visits and worldwide emergency transportation. | You pay a copayment of:<br>$80 for Medicare-covered emergency room visits.<br>$80 for worldwide emergency room visits and worldwide emergency transportation. |
| **Hearing services** | You pay a coinsurance 0% or 20% for Medicare-covered hearing exams. 0% coinsurance in a Primary Care Physician office or 20% coinsurance in a Specialist office for Medicare-covered diagnostic hearing exams. | You pay a coinsurance 0% or 15% for Medicare-covered hearing exams. 0% coinsurance in a Primary Care Physician office or 15% coinsurance in a Specialist office for Medicare-covered diagnostic hearing exams. |
| **Inpatient hospital care** | You pay a copayment of:<br>– Days 1-7: $279 per day<br>– Days 8-90: $0 per day<br>For each Medicare-covered hospital stay. | You pay a copayment of:<br>– Days 1-6: $300 per day<br>– Days 7-90: $0 per day<br>For each Medicare-covered hospital stay. |
| **Inpatient mental health care** | You pay a copayment of:<br>– Days 1-7: $210 per day<br>– Days 8-90: $0 per day<br>For each Medicare-covered Inpatient mental hospital stay. | You pay a copayment of:<br>– Days 1-5: $324 per day<br>– Days 6-90: $0 per day<br>For each Medicare-covered Inpatient mental hospital stay. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Medicare Diabetes Prevention Program (MDPP)** | Not offered by Medicare in 2017. | There is no coinsurance, copayment, or deductible for the MDPP benefit.<br>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.<br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. |
| **Outpatient mental health care** | You pay a coinsurance of:<br>20% for each Medicare-covered individual or group therapy visit.<br>20% for each Medicare-covered individual or group therapy visit with a psychiatrist. | You pay a coinsurance of:<br>15% for each Medicare-covered individual or group therapy visit.<br>15% for each Medicare-covered individual or group therapy visit with a psychiatrist. |
| **Outpatient substance abuse services** | You pay a coinsurance of 20% for Medicare-covered individual or group substance abuse outpatient treatment visits. | You pay a coinsurance of 15% for Medicare-covered individual or group substance abuse outpatient treatment visits. |
| **Physician/Practitioner/Other Health Care Professional services** | You pay a copayment/coinsurance of:<br>20% for each Medicare-covered Specialist visit.<br>$0 in a Primary Care Physician office or 20% in a Specialist office for Medicare-covered Other Health Care Professional Service. | You pay a copayment/coinsurance of:<br>15% for each Medicare-covered Specialist visit.<br>$0 in a Primary Care Physician office or 15% in a Specialist office for Medicare-covered Other Health Care Professional Service. |
| **Skilled nursing facility (SNF) care** | You pay a copayment of:<br>– Days 1-20: $0 per day<br>– Days 21-100: $164 per day<br>For each Medicare-covered SNF stay. | You pay a copayment of:<br>– Days 1-20: $0 per day<br>– Days 21-100: $167 per day<br>For each Medicare-covered SNF stay. |
| **Transportation** | You pay a copayment of $0 for up to 42 one-way trips to plan-approved location every year | You pay a copayment of $0 for up to 50 one-way trips to plan-approved location every year |
| **Urgently needed services** | You pay a copayment of $75 for worldwide emergency/urgent care and worldwide emergency transportation. | You pay a copayment of $80 for worldwide emergency/urgent care and worldwide emergency transportation. |

| Cost | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Vision services** | You pay coinsurance of 0% or 20% for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. 0% for glaucoma screenings and diabetic retinal exams. 20% coinsurance for all other Medicare-covered vision services.<br>You pay a copayment of $0 up to the plan coverage limit for:<br>– up to 1 pair of eyeglasses (lenses and frames) every two years<br>– unlimited contact lenses up to plan coverage limit | You pay coinsurance of 0% or 15% for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. 0% for glaucoma screenings and diabetic retinal exams. 15% coinsurance for all other Medicare-covered vision services.<br>You pay a copayment of $0 up to the plan coverage limit for:<br>– up to 1 pair of eyeglasses (lenses and frames) every two years<br>– unlimited contact lenses up to plan coverage limit<br>– up to 1 pair of eyeglass lenses every two years<br>– up to 1 pair eyeglass frames every two years<br>– upgrades |

## Section 1.6 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 in this envelope. The Drug List we included in this envelope 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.cignahealthspring.com).

We made changes to our Drug List, including changes to the drugs we cover and changes to 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.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have received a formulary exception to a medication this year the formulary exception request is approved through the date indicated in the approval letter. A new formulary exception request is only needed if the date indicated on the letter has passed.

## Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages — the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages — the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

### Changes to the Deductible Stage

| Stage | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage**<br>During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. | The deductible is $400. | The deductible is $405. |

### Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

| Stage | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>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.**<br>The costs in this row 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, 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:<br>**All Formulary Drugs:**<br>You pay 25% of the total cost or a $0/$1.20/$3.30/15%* copayment for generics or a $0/$3.70/$8.25/15%* copayment for all other drugs.<br>*Cost-sharing is based on your level of "Extra Help."<br>———————<br>Once your total drug costs have reached $3,700, 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:<br>**All Formulary Drugs:**<br>You pay 25% of the total cost or a $0/$1.25/$3.35/15%* copayment for generics or a $0/$3.70/$8.35/15%* copayment for all other drugs.<br>*Cost-sharing is based on your level of "Extra Help."<br>———————<br>Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage). |

### Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages — the Coverage Gap Stage and the Catastrophic Coverage Stage — are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

## SECTION 2 Administrative Changes

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

| Process | 2017 (this year) | 2018 (next year) |
|---|---|---|
| **Mailing Address Change: Customer Service** | Cigna-HealthSpring<br>Attn: Customer Service<br>P.O. Box 20002<br>Nashville, TN 37202 | Cigna-HealthSpring<br>Attn: Member Services<br>P.O. Box 2888<br>Houston, TX 77252 |

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 If you want to stay in Cigna-HealthSpring Traditions (HMO 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 stay enrolled as a member of our plan for 2018.

### 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 for 2018 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, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Cigna-HealthSpring 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 this (phone numbers are in Section 7.1 of this booklet).
  - — *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.

## SECTION 4 Deadline for Changing Plans

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.

## SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Delaware, the SHIP is called Delaware Medicare Assistance Bureau (DMAB)
- In District of Columbia, the SHIP is called Health Insurance Counseling Project (HICP)

- In Maryland, the SHIP is called Senior Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program 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 Delaware's SHIP, Delaware Medicare Assistance Bureau (DMAB), at 1-302-674-7364 or 1-800-336-9500, the District of Columbia's SHIP, Health Insurance Counseling Project (HICP), at 1-202-994-6272 or 1-202-724-5622 or Maryland's SHIP, Senior Health Insurance Assistance Program, at 1-410-767-1100 or 1-800-243-3425.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

**Help from your state's pharmaceutical assistance program.** Delaware and Maryland have a program called the State Pharmaceutical Assistance Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- In Delaware, the SPAP is called the Chronic Renal Disease Program (CRDP)
- In Maryland, the SPAPs are called Primary Adult Care Program (PAC), Maryland - SPDAP and Maryland Kidney Disease Program
- There is no SPAP for the District of Columbia

To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **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. 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 Delaware AIDS Drug Assistance Program in Delaware, the DC AIDS Drug Assistance Program in District of Columbia, or the Maryland AIDS Drug Assistance Program in Maryland. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Delaware's ADAP, the Delaware AIDS Drug Assistance Program, at 1-302-744-1050; District of Columbia's ADAP, the DC AIDS Drug Assistance Program, at 1-202-671-4900; or Maryland's ADAP, the Maryland AIDS Drug Assistance Program, at 1-410-767-6535 or 1-800-205-6308.

## SECTION 7 Questions?

### Section 7.1 Getting Help from Cigna-HealthSpring Traditions (HMO 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 – February 14, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From February 15 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 6:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.

**Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for Cigna-HealthSpring Traditions (HMO 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 included in this envelope.

**Visit our Website**

You can also visit our website at www.cignahealthspring.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**

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

**Read *Medicare & You 2018***

You can read the *Medicare & You 2018* Handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (https://www.medicare.gov) 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.

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