Cigna Preferred Medicare (HMO) offered by Cigna

ANNUAL NOTICE OF CHANGES FOR 2021

You are currently enrolled as a member of Cigna-HealthSpring Preferred (HMO). 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 2.1 and 2.5 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 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our *Provider and Pharmacy Directory.*

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☐ 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.

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 www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 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 don't join another plan by December 7, 2020, you will be enrolled in Cigna Preferred Medicare (HMO).
- 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, 2020**
- If you don't join another plan by **December 7, 2020**, you will be enrolled in Cigna Preferred Medicare (HMO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

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.
- 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 Preferred Medicare (HMO)
- 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. When it says "plan" or "our plan," it means Cigna Preferred Medicare (HMO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Cigna Preferred Medicare (HMO) in several important areas. **Please note this is only a summary of changes.** 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*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
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 2.2 for details.)	$6,700	$6,900
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $45 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $35 copayment per visit
Inpatient hospital stays 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 1-6: $325 copayment per day Days 7-90: $0 copayment per day	Days 1-6: $335 copayment per day Days 7-90: $0 copayment per day

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copayments or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost-sharing:* $9 copayment *Preferred cost-sharing:* $4 copayment • Drug Tier 2: *Standard cost-sharing:* $20 copayment *Preferred cost-sharing:* $15 copayment • Drug Tier 3: *Standard cost-sharing:* $47 copayment *Preferred cost-sharing:* $42 copayment • Drug Tier 4: *Standard cost-sharing:* $100 copayment *Preferred cost-sharing:* $95 copayment • Drug Tier 5: *Standard cost-sharing:* 33% coinsurance *Preferred cost-sharing:* 33% coinsurance	Deductible: $0 Copayments or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost-sharing:* $9 copayment *Preferred cost-sharing:* $0 copayment • Drug Tier 2: *Standard cost-sharing:* $20 copayment *Preferred cost-sharing:* $5 copayment • Drug Tier 3: *Standard cost-sharing:* $47 copayment *Preferred cost-sharing:* $42 copayment • Drug Tier 4: *Standard cost-sharing:* $100 copayment *Preferred cost-sharing:* $95 copayment • Drug Tier 5: *Standard cost-sharing:* 33% coinsurance *Preferred cost-sharing:* 33% coinsurance

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Cost	2020 (this year)	2021 (next year)
Inpatient hospital care	You pay a copayment of: – Days 1-6: $325 per day – Days 7-90: $0 per day For each Medicare-covered hospital stay.	You pay a copayment of: – Days 1-6: $335 per day – Days 7-90: $0 per day For each Medicare-covered hospital stay.
Inpatient mental health care	You pay a copayment of: – Days 1-5: $324 per day – Days 6-90: $0 per day For each Medicare-covered Inpatient mental hospital stay.	You pay a copayment of: – Days 1-6: $310 per day – Days 7-90: $0 per day For each Medicare-covered Inpatient mental hospital stay.
Opioid treatment services	You pay a copayment of $40 for Medicare-covered opioid treatment services.	You pay a copayment of $35 for Medicare-covered opioid treatment services.
Outpatient diagnostic tests and therapeutic services and supplies	**Authorization rules may apply.** You pay a copayment/coinsurance of: 20% for Medicare-covered therapeutic radiology services. $25 for Medicare-covered X-rays.	**Authorization rules may apply.** **Authorization not required for COVID-19 related testing.** You pay a copayment of: $60 for Medicare-covered therapeutic radiology services. $35 for Medicare-covered X-rays.
Outpatient hospital observation	You pay a copayment of $300 for Medicare-covered outpatient hospital observation.	You pay a copayment of $290 for Medicare-covered outpatient hospital observation.
Outpatient mental health care	You pay a copayment of: $40 for Medicare-covered individual or group therapy visit. $40 for Medicare-covered individual or group therapy visit with a psychiatrist. $40 for Medicare-covered Telehealth-Behavioral health visit. Catasys OnTrak™ program not covered.	You pay a copayment of: $0 for Medicare-covered individual or group therapy visit. $0 for Medicare-covered individual or group therapy visit with a psychiatrist. $0 for Medicare-covered Telehealth-Behavioral health visit. $0 for Catasys OnTrak™ program, based on the diagnosis of anxiety, depression, or substance use disorder.
Outpatient rehabilitation services	You pay a copayment of: $40 for Medicare-covered Occupational Therapy visits. $40 for Medicare-covered Physical Therapy visits. Virtual Physical Therapy visits not covered. $40 for Speech and Language Pathology visits.	You pay a copayment of: $35 for Medicare-covered Occupational Therapy visits. $35 for Medicare-covered in-person or virtual Physical Therapy visits. $35 for Speech and Language Pathology visits.
Outpatient substance abuse services	You pay a copayment of $40 for Medicare-covered individual or group substance abuse outpatient treatment visits.	You pay a copayment of $35 for Medicare-covered individual or group substance abuse outpatient treatment visits.

Cost	2020 (this year)	2021 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a copayment of $0 or $300 for each Medicare-covered outpatient hospital facility visit. $0 for any surgical procedures (i.e. polyp removal) during a colorectal screening. $300 for all other Outpatient Services not provided in an Ambulatory Surgical Center.	You pay a copayment of $0 or $290 for each Medicare-covered outpatient hospital facility visit. $0 for any surgical procedures (i.e. polyp removal) during a colorectal screening. $290 for all other Outpatient Services not provided in an Ambulatory Surgical Center.
Physician/Practitioner/Other Health Care Professional services	You pay a copayment of: $45 for each Medicare-covered Specialist visit. $0 in a Primary Care Physician office or $45 in a Specialist office for Medicare-covered Other Health Care Professional Service.	You pay a copayment of: $35 for each Medicare-covered Specialist visit. $0 in a Primary Care Physician office or $35 in a Specialist office for Medicare-covered Other Health Care Professional Service.
Podiatry services	You pay a copayment of $45 for each Medicare-covered podiatry visit.	You pay a copayment of $35 for each Medicare-covered podiatry visit.
Post-hospital meals	You pay a copayment of $0 for home-delivered meals after discharge from a qualified hospital stay.	The benefit name is changing to **Home-delivered meals**. You pay a copayment of $0 for home-delivered meals after discharge from a qualified hospital or skilled nursing facility stay.
Skilled nursing facility (SNF) care	You pay a copayment of: – Days 1-20: $0 per day – Days 21-100: $178 per day For each Medicare-covered SNF stay.	You pay a copayment of: – Days 1-20: $0 per day – Days 21-100: $184 per day For each Medicare-covered SNF stay.
Special supplemental benefits for the chronically ill – **Meals for ESRD members**	Not covered.	**Authorization is required.** You pay a copayment of $0 for 56 meals, over 28 days, once each year for End-Stage Renal Disease (ESRD) members enrolled in an ESRD-related case management program.
Vision services	You pay a copayment of $0 or $45 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screenings and diabetic retinal exams. $45 copayment for all other Medicare-covered vision services. $250 allowance for supplemental eyewear every year. Supplemental annual eyewear allowance applies to the retail value only.	You pay a copayment of $0 or $35 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screenings and diabetic retinal exams. $35 copayment for all other Medicare-covered vision services. $200 allowance for supplemental eyewear every year. Supplemental annual eyewear allowance applies to the retail value only.

Section 2.6 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 provided electronically. The Drug List provided electronically 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, 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.
  - 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 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.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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."

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 *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*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

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	2020 (this year)	2021 (next year)
Stage 2: 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 this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. 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*. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $4 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-Preferred Drugs):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $95 per prescription. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. ——————— Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-Preferred Drugs):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $95 per prescription. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. ——————— Once your total drug costs have reached $4,130, 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 the Coverage Gap Stage, for drugs on Tier 1, your cost-sharing is changing from a coinsurance to copayment. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

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

Description	2020 (this year)	2021 (next year)
Where to send a written complaint about your medical care or Part D prescription drugs	Cigna Attn: Member Grievances P.O. Box 2888 Houston, TX 77252-2888	Cigna Attn: Medicare Grievance Dept. P.O. Box 188080 Chattanooga, TN 37422

SECTION 4 Deciding Which Plan to Choose

Section 4.1 If you want to stay in Cigna Preferred Medicare (HMO)

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 Preferred Medicare (HMO).

Section 4.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- — *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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Cigna 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 8.1 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 5 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, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can 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, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 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)

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 or the District of Columbia's SHIP, Health Insurance Counseling Project (HICP), at 1-202-727-8370.

SECTION 7 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 has 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)
  - 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 6 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 or the DC AIDS Drug Assistance Program in District of Columbia. 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, or District of Columbia's ADAP, the DC AIDS Drug Assistance Program, at 1-202-671-4900.

SECTION 8 Questions?

Section 8.1 Getting Help from Cigna Preferred Medicare (HMO)

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 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Cigna Preferred Medicare (HMO). 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 8.2 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 (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 www.medicare.gov/plan-compare.)

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* 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 (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.