Cigna Fundamental Medicare (HMO) offered by Cigna

ANNUAL NOTICE OF CHANGES FOR 2022

You are currently enrolled as a member of Cigna Fundamental Medicare (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 1.1 and 1.4 for information about benefit and cost changes for our plan.

☐ 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 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.

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 2022* 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.

H4407_22_98467_011_M
OMB Approval 0938-1051 (Expires: February 29, 2024)
22_A_H4407_011

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2021, you will be enrolled in Cigna Fundamental 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, 2021**
   - If you don't join another plan by **December 7, 2021**, you will be enrolled in Cigna Fundamental Medicare (HMO).
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

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 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 Fundamental Medicare (HMO)

- Cigna contracts 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 Cigna 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 Fundamental Medicare (HMO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Cigna Fundamental 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	2021 (this year)	2022 (next year)
Monthly plan premium	$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 1.2 for details.)	$5,900	$5,900
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 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: $295 copayment per day Days 7-90: $0 copayment per day	Days 1-6: $295 copayment per day Days 7-90: $0 copayment per day

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium **(You must also continue to pay your Medicare Part B premium.)**	$0	$0
Part B Premium Reduction	We will reduce your monthly Medicare Part B Premium by up to $50	We will reduce your monthly Medicare Part B Premium by up to $50

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	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$5,900	$5,900 Once you have paid $5,900 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.cignamedicare.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 2022 *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, we must 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 to manage your care.

Section 1.4 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 *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Additional telehealth services: Physical therapy and Speech and Language Pathology	In-Network You pay a copayment of $35 for Medicare-covered Physical therapy virtual visits. Medicare-covered Speech and Language Pathology virtual visits are not covered.	In-Network You pay a copayment of $0 for Medicare-covered Physical therapy virtual visits. You pay a copayment of $0 for Medicare-covered Speech and Language Pathology virtual visits.
Ambulance services	In-Network You pay a copayment of $275 for each one way Medicare-covered ground ambulance trip.	In-Network You pay a copayment of $265 for each one way Medicare-covered ground ambulance trip.
Annual physical exam	In-Network Not covered.	In-Network You pay a copayment of $0 for an annual physical exam.
Catasys Program	In-Network You pay a copayment of $0 for Catasys OnTrak™ program.	In-Network Catasys OnTrak™ program not covered.
Dental Services	In-Network: There is $1000 allowance Every Year for supplemental preventive and comprehensive dental services.	In-Network: There is $1500 allowance Every Year for supplemental preventive and comprehensive dental services.

Cost	2021 (this year)	2022 (next year)
Hearing services	In-Network You pay a copayment of $0 for hearing aid fitting evaluation every three years. $700 allowance per hearing aid device per ear Every Three Years. Members are responsible for all costs over and above the allowance amount.	In-Network You pay a copayment of $0 for hearing aid fitting evaluation every two years. $1500 allowance per hearing aid device per ear Every Two Years. Members are responsible for all costs over and above the allowance amount.
Over-the-Counter Items and Services	Limited to $30 Every Three Months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.	Limited to $50 Every Three Months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.
Skilled nursing facility (SNF) care	In-Network You pay a copayment of: – Days 1-20: $0 per day – Days 21-100: $184 per day for each Medicare-covered SNF stay.	In-Network You pay a copayment of: – Days 1-20: $0 per day – Days 21-100: $188 per day for each Medicare-covered SNF stay.
Vision services	In-Network There is $150 allowance Every Year for supplemental eyewear.	In-Network There is $250 allowance Every Year for supplemental eyewear.

SECTION 2 Administrative Changes

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

Description	2021 (this year)	2022 (next year)
Cigna Vision Vendor Change	Cigna has a vision vendor that you can contact for information on your vision benefits.	Cigna will have a new vision vendor for 2022. For information on your vision benefits, please call 1-888-886-1995.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in our plan

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 Fundamental Medicare (HMO).

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 2022 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, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (SHIP) (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 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 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

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, 2022.

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 8, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage.*

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. In Mississippi, the SHIP is called State Health Insurance Assistance Program (SHIP).

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 (SHIP) 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 State Health Insurance Assistance Program (SHIP) at 1-601-359-4500.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance. In Mississippi, the ADAP is the Mississippi AIDS Drug Assistance Program. Note: 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.

  If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. To contact the Mississippi AIDS Drug Assistance Program, please call 1-601-576-7400 or 1-866-458-4948.

  For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Mississippi AIDS Drug Assistance Program at 1-601-576-7400 or 1-866-458-4948.

SECTION 7 Questions?

Section 7.1 Getting Help from our plan

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 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Cigna Fundamental 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*).

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 (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 2022*

You can read the *Medicare & You 2022* 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.