



Cigna True Choice Medicare (PPO) offered by Cigna Healthcare

ANNUAL NOTICE OF CHANGES FOR 2024

You are currently enrolled as a member of Cigna True Choice Medicare (PPO). 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*, located on our website at www.cignamedicare.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

☐ **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.
 - ☐ Review the changes to Medical care costs (doctor, hospital).
 - ☐ Review the changes to our drug coverage, including authorization requirements and costs.
 - ☐ Think about how much you will spend on premiums, deductibles, and cost sharing.
- ☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.
- ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.
- ☐ 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 www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.
- ☐ 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, 2023, you will stay in Cigna True Choice Medicare (PPO).
- ☐ To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on January 1, 2024. This will end your enrollment with Cigna True Choice Medicare (PPO).
- ☐ If you recently moved into, currently live in, or just moved out of 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.

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 True Choice Medicare (PPO)

- ☐ 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 HealthcareSM product depends on contract renewal.
 - ☐ When this booklet says “we,” “us,” or “our,” it means Cigna Healthcare. When it says “plan” or “our plan,” it means Cigna True Choice Medicare (PPO).
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Annual Notice of Changes for 2024

Table of Contents

Summary of Important Costs for 2024.....	4
SECTION 1 Changes to Benefits and Costs for Next Year.....	7
Section 1.1 Changes to the Monthly Premium.....	7
Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts.....	7
Section 1.3 Changes to the Provider and Pharmacy Networks.....	7
Section 1.4 Changes to Benefits and Costs for Medical Services.....	8
Section 1.5 Changes to Part D Prescription Drug Coverage.....	14
SECTION 2 Administrative Changes.....	16
SECTION 3 Deciding Which Plan to Choose.....	16
Section 3.1 If you want to stay in Cigna True Choice Medicare (PPO).....	16
Section 3.2 If you want to change plans.....	16
SECTION 4 Deadline for Changing Plans.....	17
SECTION 5 Programs That Offer Free Counseling about Medicare.....	17
SECTION 6 Programs That Help Pay for Prescription Drugs.....	17
SECTION 7 Questions?.....	17
Section 7.1 Getting Help from Cigna True Choice Medicare (PPO).....	17
Section 7.2 Getting Help from Medicare.....	18

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Cigna True Choice Medicare (PPO) in several important areas.
Please note this is only a summary of costs.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: \$5,600 From in-network and out-of-network providers combined: \$8,950	From network providers: \$5,600 From in-network and out-of-network providers combined: \$8,950
Doctor office visits	<u>In-Network</u> Primary care visits: \$0 copayment per visit Specialist visits: \$30 copayment per visit <u>Out-of-Network</u> Primary care visits: \$40 copayment per visit Specialist visits: \$55 copayment per visit	<u>In-Network</u> Primary care visits: \$0 copayment per visit Specialist visits: \$40 copayment per visit <u>Out-of-Network</u> Primary care visits: \$40 copayment per visit Specialist visits: \$55 copayment per visit
Inpatient hospital stays	<u>In-Network</u> \$295 per day for days 1-5; \$0 per day for days 6-90 <u>Out-of-Network</u> 30% per stay	<u>In-Network</u> \$295 per day for days 1-5; \$0 per day for days 6-90 <u>Out-of-Network</u> 40% per stay

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	<p>Deductible: \$0</p> <p>Copayments or Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 1: Standard cost sharing: \$5 copayment Preferred cost sharing: \$0 copayment <input type="checkbox"/> Drug Tier 2: Standard cost sharing: \$9 copayment Preferred cost sharing: \$4 copayment <input type="checkbox"/> Drug Tier 3: Standard cost sharing: \$45 copayment Preferred cost sharing: \$40 copayment <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 4: Standard cost sharing: \$85 copayment Preferred cost sharing: \$80 copayment <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 5: Standard cost sharing: 33% coinsurance Preferred cost sharing: 33% coinsurance <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> During this payment stage, the plan pays most of the cost for your covered drugs. 	<p>Deductible: \$0</p> <p>Copayments or Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 1: Standard cost sharing: \$10 copayment Preferred cost sharing: \$0 copayment <input type="checkbox"/> Drug Tier 2: Standard cost sharing: \$20 copayment Preferred cost sharing: \$10 copayment <input type="checkbox"/> Drug Tier 3: Standard cost sharing: \$47 copayment Preferred cost sharing: \$47 copayment <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 4: Standard cost sharing: \$100 copayment Preferred cost sharing: \$99 copayment <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug Tier 5: Standard cost sharing: 33% coinsurance Preferred cost sharing: 33% coinsurance <p>You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> During this payment stage, the plan pays the full cost for your covered Part D drugs.

Cost	2023 (this year)	2024 (next year)
	For each prescription you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.)	<input type="checkbox"/> You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year**Section 1.1 Changes to the Monthly Premium**

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

- 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 have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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

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

Cost	2023 (this year)	2024 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$5,600	\$5,600 Once you have paid \$5,600 combined out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	\$8,950	\$8,950 Once you have paid \$8,950 combined out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider and Pharmacy Networks

An updated *Provider and Pharmacy Directory* is located on our website at www.cignamedicare.com. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider and Pharmacy Directory* 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 2024 *Provider and Pharmacy Directory* 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

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

Cost	2023 (this year)	2024 (next year)
Prior authorization	<p>Prior authorization may be required for the following services:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Additional telehealth services <input type="checkbox"/> Outpatient rehabilitation services: <ul style="list-style-type: none"> ○ Physical Therapy ○ Speech Therapy 	<p>Prior authorization is not required for the following services:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Additional telehealth services <input type="checkbox"/> Outpatient rehabilitation services: <ul style="list-style-type: none"> ○ Physical Therapy ○ Speech Therapy
Ambulance services	<p><u>In-Network and Out-of-Network</u></p> <p>You pay a copayment of \$275 for each one-way Medicare-covered ground ambulance trip.</p>	<p><u>In-Network and Out-of-Network</u></p> <p>You pay a copayment of \$270 for each one-way Medicare-covered ground ambulance trip.</p>
Cardiac rehabilitation services	<p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 30% for each Medicare-covered cardiac rehabilitative therapy visit.</p> <p>You pay a coinsurance of 30% for each Medicare-covered intensive cardiac rehabilitative therapy visit.</p>	<p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 40% for each Medicare-covered cardiac rehabilitative therapy visit.</p> <p>You pay a coinsurance of 40% for each Medicare-covered intensive cardiac rehabilitative therapy visit.</p>
Chiropractic services	<p><u>In-Network</u></p> <p>You pay a copayment of \$15 for each Medicare-covered chiropractic visit.</p>	<p><u>In-Network</u></p> <p>You pay a copayment of \$20 for each Medicare-covered chiropractic visit.</p>
Dental services (Medicare-covered)	<p><u>In-Network</u></p> <p>You pay a copayment of \$30 for Medicare-covered dental services.</p>	<p><u>In-Network</u></p> <p>You pay a copayment of \$40 for Medicare-covered dental services.</p>
Dental services (Routine)	<p><u>In-Network and Out-of-Network</u></p> <p>We provide a dental allowance of \$1,500 combined preventive and comprehensive allowance every year combined for routine preventive and comprehensive dental services every year.</p>	<p><u>In-Network and Out-of-Network</u></p> <p>We provide a dental allowance of \$1,700 combined preventive and comprehensive allowance every year combined for routine preventive and comprehensive dental services every year.</p>
Diabetes self-management training, diabetic services and supplies	<p><u>Out-of-Network</u></p> <p>You pay a copayment of \$30 for Medicare-covered diabetic monitoring supplies.</p>	<p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 40% for Medicare-covered diabetic monitoring supplies.</p>

Cost	2023 (this year)	2024 (next year)
	You pay a coinsurance of 30% for Medicare-covered therapeutic shoes and inserts.	You pay a coinsurance of 40% for Medicare-covered therapeutic shoes and inserts.
Durable medical equipment and related supplies	<u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered items.	<u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered items.
Emergency care	<u>In-Network and Out-of-Network</u> You pay a copayment of \$110 for Medicare-covered emergency room visits. You pay a copayment of \$110 for Medicare-covered Worldwide emergency room visits. You pay a copayment of \$110 for Medicare-covered Worldwide emergency transportation.	<u>In-Network and Out-of-Network</u> You pay a copayment of \$120 for Medicare-covered emergency room visits. You pay a copayment of \$120 for Medicare-covered Worldwide emergency room visits. You pay a copayment of \$120 for Medicare-covered Worldwide emergency transportation.
Hearing services (Medicare-covered)	<u>In-Network</u> You pay a copayment of \$30 for Medicare-covered hearing exams. <u>Out-of-Network</u> You pay a coinsurance of 50% for Medicare-covered hearing exams.	<u>In-Network</u> You pay a copayment of \$20 for Medicare-covered hearing exams. <u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered hearing exams.
Hearing services (Routine)	<u>In-Network</u> You pay a copayment of \$0 for one fitting evaluation for hearing aids every three years. <u>Out-of-Network</u> You pay a coinsurance of 30% for one routine exam every year. You pay a coinsurance of 30% for one fitting evaluation for hearing aid every three years. <u>In-Network and Out-of-Network</u> Hearing aid allowance of \$2,500 for both ears combined every three years. Unlimited hearing aids up to allowance amount.	<u>In-Network</u> You pay a copayment of \$0 for one fitting evaluation for hearing aids every year. You pay a copayment of \$399 - \$1,800 per device for hearing aids. Actual cost will depend on hearing aid selected. Limited to two devices every year. <u>Out-of-Network</u> You pay a coinsurance of 50% for one routine exam every year. You pay a coinsurance of 50% for one fitting evaluation for hearing aid every year. Customers are required to contact Cigna Healthcare's hearing vendor to access hearing aid benefits.
Home health agency care	<u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered home health visits.	<u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered home health visits.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital care	<u>Out-of-Network</u> For each Medicare-covered hospital stay you pay a coinsurance of: 30%	<u>Out-of-Network</u> For each Medicare-covered hospital stay you pay a coinsurance of: 40%
Inpatient services in a psychiatric hospital	<u>Out-of-Network</u> For each Medicare-covered psychiatric hospital stay you pay a coinsurance of: 30%	<u>Out-of-Network</u> For each Medicare-covered psychiatric hospital stay you pay a coinsurance of: 40%
Medicare-covered Preventive services	<u>Out-of-Network</u> You pay a copayment of \$0 for Medicare-covered Preventive services.	<u>Out-of-Network</u> You pay a copayment of \$40 for Medicare-covered Preventive services.
Medicare Part B prescription drugs	<u>In-Network</u> You pay a coinsurance of 20% for Medicare Part B insulin drugs. You pay a coinsurance of 20% for Medicare Part B Chemotherapy/Radiation drugs. You pay a coinsurance of 20% for Other Medicare Part B drugs.	<u>In-Network</u> You pay a coinsurance of 0 - 20%; up to \$35 for Medicare Part B insulin drugs. You pay a coinsurance of 0 - 20% for Medicare Part B Chemotherapy/Radiation drugs. You pay a coinsurance of 0 - 20% for Other Medicare Part B drugs.
Opioid treatment services	<u>In-Network</u> You pay a copayment of \$35 for Medicare-covered opioid treatment services.	<u>In-Network</u> You pay a copayment of \$40 for Medicare-covered opioid treatment services.
Outpatient diagnostic tests and therapeutic services and supplies test	<u>In-Network</u> You pay a copayment of \$0 for Medicare-covered genetic tests. You pay a copayment of \$0 or \$100 for Medicare-covered diagnostic procedures and tests. \$0 copayment for EKG and diagnostic colorectal screenings. \$100 for all other diagnostic procedures and tests. You pay a copayment of \$0 or \$125 for Medicare-covered diagnostic radiology services (not including X-rays). \$0 for mammography and ultrasounds. \$125 for all other diagnostic and nuclear medicine radiological services. You pay a copayment of \$20 for Medicare-covered X-rays.	<u>In-Network</u> You pay a coinsurance of 20% for Medicare-covered genetic tests. You pay a copayment of \$0 or \$150 for Medicare-covered diagnostic procedures and tests. \$0 copayment for EKG and diagnostic colorectal screenings. \$150 for all other diagnostic procedures and tests. You pay a copayment of \$0 or \$150 for Medicare-covered diagnostic radiology services (not including X-rays). \$0 for mammography and ultrasounds. \$150 for all other diagnostic and nuclear medicine radiological services. You pay a copayment of \$30 for Medicare-covered X-rays.

Cost	2023 (this year)	2024 (next year)
	<p><u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered diagnostic procedures and tests. You pay a coinsurance of 30% for Medicare-covered lab services and genetic tests. You pay a coinsurance of 30% for Medicare-covered blood services. You pay a coinsurance of 30% for Medicare-covered diagnostic and nuclear medicine radiological services. You pay a coinsurance of 30% for Medicare-covered therapeutic radiology services. You pay a coinsurance of 30% for Medicare-covered X-rays.</p>	<p><u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered diagnostic procedures and tests. You pay a coinsurance of 40% for Medicare-covered lab services and genetic tests. You pay a coinsurance of 40% for Medicare-covered blood services. You pay a coinsurance of 40% for Medicare-covered diagnostic and nuclear medicine radiological services. You pay a coinsurance of 40% for Medicare-covered therapeutic radiology services. You pay a coinsurance of 40% for Medicare-covered X-rays.</p>
Outpatient hospital observation	<p><u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered outpatient hospital observation.</p>	<p><u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered outpatient hospital observation.</p>
Outpatient mental health care	<p><u>Out-of-Network</u> You pay a copayment of \$55 for Medicare-covered individual or group therapy visit. You pay a copayment of \$55 for Medicare-covered individual or group therapy visit with a psychiatrist.</p>	<p><u>Out-of-Network</u> You pay a copayment of \$40 for Medicare-covered individual or group therapy visit. You pay a copayment of \$40 for Medicare-covered individual or group therapy visit with a psychiatrist.</p>

Cost	2023 (this year)	2024 (next year)
Outpatient rehabilitation services	<u>In-Network</u> You pay a copayment of \$20 for Medicare-covered Occupational Therapy visits. You pay a copayment of \$20 for Medicare-covered Physical Therapy in-person visits. You pay a copayment of \$20 for Medicare-covered Speech and Language Pathology in-person visits. <u>Out-of-Network</u> You pay a copayment of \$50 for Medicare-covered Occupational Therapy visits. You pay a copayment of \$50 for Medicare-covered Physical Therapy in-person visits. You pay a copayment of \$50 for Medicare-covered Speech and Language Pathology in-person visits.	<u>In-Network</u> You pay a copayment of \$40 for Medicare-covered Occupational Therapy visits. You pay a copayment of \$40 for Medicare-covered Physical Therapy in-person visits. You pay a copayment of \$40 for Medicare-covered Speech and Language Pathology in-person visits. <u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered Occupational Therapy visits. You pay a coinsurance of 40% for Medicare-covered Physical Therapy in-person visits. You pay a coinsurance of 40% for Medicare-covered Speech and Language Pathology in-person visits.
Outpatient substance abuse services	<u>In-Network</u> You pay a copayment of \$35 for Medicare-covered individual or group substance abuse outpatient treatment visits.	<u>In-Network</u> You pay a copayment of \$40 for Medicare-covered individual or group substance abuse outpatient treatment visits.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	<u>Out-of-Network</u> You pay a coinsurance of 30% for each Medicare-covered outpatient hospital facility visit. You pay a coinsurance of 30% for each Medicare-covered ambulatory surgical center visit.	<u>Out-of-Network</u> You pay a coinsurance of 40% for each Medicare-covered outpatient hospital facility visit. You pay a coinsurance of 40% for each Medicare-covered ambulatory surgical center visit.
Partial hospitalization services and Intensive outpatient services	<u>In-Network</u> You pay a copayment of \$70 for Medicare-covered partial hospitalization services. <u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered partial hospitalization services.	<u>In-Network</u> You pay a copayment of \$85 for Medicare-covered partial hospitalization and intensive outpatient services. <u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered partial hospitalization and intensive outpatient services.
Physician/Practitioner/Other Health Care Professional services	<u>In-Network</u> You pay a copayment of \$30 for each Medicare covered Specialist visit.	<u>In-Network</u> You pay a copayment of \$40 for each Medicare-covered Specialist visit.

Cost	2023 (this year)	2024 (next year)
Podiatry services	<u>In-Network</u> You pay a copayment of \$25 for each Medicare-covered podiatry visit. <u>Out-of-Network</u> You pay a coinsurance of 50% for each Medicare-covered podiatry visit.	<u>In-Network</u> You pay a copayment of \$40 for each Medicare-covered podiatry visit. <u>Out-of-Network</u> You pay a coinsurance of 40% for each Medicare-covered podiatry visit.
Prosthetic devices and related supplies	<u>Out-of-Network</u> You pay a coinsurance of 30% for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices.	<u>Out-of-Network</u> You pay a coinsurance of 40% for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices.
Pulmonary rehabilitation services	<u>Out-of-Network</u> You pay a coinsurance of 30% for each Medicare-covered pulmonary rehabilitative therapy visit.	<u>Out-of-Network</u> You pay a coinsurance of 40% for each Medicare-covered pulmonary rehabilitative therapy visit.
Skilled nursing facility (SNF) care	<u>In-Network</u> For each Medicare-covered SNF stay you pay a copayment of: \$10 per day for days 1-20; \$196 per day for days 21-61 \$0 per day for days 62-100 <u>Out-of-Network</u> For each Medicare-covered SNF stay you pay a coinsurance of: 30%	<u>In-Network</u> For each Medicare-covered SNF stay you pay a copayment of: \$0 per day for days 1-20; \$203 per day for days 21-100 <u>Out-of-Network</u> For each Medicare-covered SNF stay you pay a coinsurance of: 40%
Supervised exercise therapy (SET)	<u>Out-of-Network</u> You pay a coinsurance of 30% for each Medicare-covered supervised exercise therapy visit.	<u>Out-of-Network</u> You pay a coinsurance of 40% for each Medicare-covered supervised exercise therapy visit.
Urgently needed services	<u>In-Network and Out-of-Network</u> You pay a copayment of \$110 for Medicare-covered Worldwide urgently needed services.	<u>In-Network and Out-of-Network</u> You pay a copayment of \$120 for Medicare-covered Worldwide urgently needed services.
Vision services (Medicare-covered)	<u>In-Network</u> You pay a copayment of \$0 or \$30 for Medicare-covered exams to diagnose and	<u>In-Network</u> You pay a copayment of \$0 or \$40 for Medicare-covered exams to diagnose and

Cost	2023 (this year)	2024 (next year)
	<p>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. \$30 for all other Medicare-covered vision services.</p> <p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 0% or 50% for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. 0% coinsurance for glaucoma screenings and diabetic retinal exams. 50% for all other Medicare-covered vision services.</p> <p>You pay a coinsurance of 30% for one pair of Medicare-covered eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens.</p>	<p>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. \$40 for all other Medicare-covered vision services.</p> <p><u>Out-of-Network</u></p> <p>You pay a copayment of \$0 or \$50 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. \$50 for all other Medicare-covered vision services.</p> <p>You pay a coinsurance of 40% for one pair of Medicare-covered eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens.</p>
Vision services (Routine)	<p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 30% for one routine exam every year</p>	<p><u>Out-of-Network</u></p> <p>You pay a coinsurance of 50% for one routine exam every year</p>

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 or moving them to a different cost-sharing tier. **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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs. 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.

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**.

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (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

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p> <p>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 <i>Evidence of Coverage</i>.</p> <p>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.”</p>	<p>Your cost for a one-month supply at a network pharmacy.</p> <p>Tier 1 (Preferred Generic Drugs): <i>Standard cost-sharing:</i> You pay \$5 per prescription. <i>Preferred cost-sharing:</i> You pay \$0 per prescription.</p> <p>Tier 2 (Generic Drugs): <i>Standard cost-sharing:</i> You pay \$9 per prescription. <i>Preferred cost-sharing:</i> You pay \$4 per prescription.</p> <p>Tier 3 (Preferred Brand Drugs): <i>Standard cost-sharing:</i> You pay \$45 per prescription. <i>Preferred cost-sharing:</i> You pay \$40 per prescription. You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4 (Non-Preferred Drugs): <i>Standard cost-sharing:</i> You pay \$85 per prescription. <i>Preferred cost-sharing:</i> You pay \$80 per prescription. You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5 (Specialty Drugs): <i>Standard cost-sharing:</i> You pay 33% of the total cost. <i>Preferred cost-sharing:</i> You pay 33% of the total cost. You will pay no more than \$35 per</p>	<p>Your cost for a one-month supply at a network pharmacy.</p> <p>Tier 1 (Preferred Generic Drugs): <i>Standard cost-sharing:</i> You pay \$10 per prescription. <i>Preferred cost-sharing:</i> You pay \$0 per prescription.</p> <p>Tier 2 (Generic Drugs): <i>Standard cost-sharing:</i> You pay \$20 per prescription. <i>Preferred cost-sharing:</i> You pay \$10 per prescription.</p> <p>Tier 3 (Preferred Brand Drugs): <i>Standard cost-sharing:</i> You pay \$47 per prescription. <i>Preferred cost-sharing:</i> You pay \$47 per prescription. You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4 (Non-Preferred Drugs): <i>Standard cost-sharing:</i> You pay \$100 per prescription. <i>Preferred cost-sharing:</i> You pay \$99 per prescription. You will pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5 (Specialty Drugs): <i>Standard cost-sharing:</i> You pay 33% of the total cost. <i>Preferred cost-sharing:</i> You pay 33% of the total cost. You will pay no more than \$35 per</p>

	month supply of each covered insulin product on this tier.	month supply of each covered insulin product on this tier.
	Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached \$5,030, 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.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific 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.

Description	2023 (this year)	2024 (next year)
Admission for Inpatient Hospital, Inpatient Psychiatric Hospital, and Skilled Nursing Facility	A new benefit period starts when you have been out of an inpatient hospital, inpatient psychiatric hospital, or skilled nursing facility for 60 days. After 60 days you will be required to pay the applicable cost-share upon readmission.	You may be required to pay the applicable cost-share each time you are admitted to an inpatient hospital, inpatient psychiatric hospital, or skilled nursing facility.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in Cigna True Choice Medicare (PPO)

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 True Choice Medicare (PPO).

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 2024 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

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 2024* 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.

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, 2024.

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. If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Tennessee, the SHIP is called Tennessee State Health Insurance Assistance Program (SHIP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Tennessee 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 Tennessee State Health Insurance Assistance Program (SHIP) at 1-877-801-0044.

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. 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 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 (applications).
- **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 Tennessee HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Tennessee HIV Drug Assistance Program (HDAP) at 1-615-532-2392.

SECTION 7 Questions?

Section 7.1 Getting Help from Cigna True Choice Medicare (PPO)

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 2024 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 2024. For details, look in the 2024 *Evidence of Coverage* for Cigna True Choice Medicare (PPO). 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 2024

Read the *Medicare & You 2024* 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.

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