January 1 – December 31, 2022

EVIDENCE OF COVERAGE

Cigna Preferred Medicare HMO

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Customer of Cigna Preferred Medicare (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1, 2022 – December 31, 2022. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Cigna Preferred Medicare (HMO), is offered by Cigna. (When this Evidence of Coverage says "we," "us," or "our," it means Cigna. When it says "plan" or "our plan," it means Cigna Preferred Medicare (HMO).

Cigna is contracted with Medicare for HMO, PPO and PDP plans and with select State Medicaid programs. Enrollment in Cigna depends on contract renewal.

This document is available for free in Spanish.

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet). We can give you information in Braille, in large print, and other alternate formats if you need it.

Benefits, deductible, and/or copayments/coinsurance may change on January 1, 2023.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Please contact our Customer Service number at 1-800-627-7534 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. (a voicemail system is available on weekends and holidays).

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2022 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a customer

SECTION 1. Introduction

Section 1.1 You are enrolled in Cigna Preferred Medicare (HMO), which is a Medicare HMO Plan

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Cigna Preferred Medicare (HMO).

There are different types of Medicare health plans. Cigna Preferred Medicare (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

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: https://www.irs.gov/Affordable-Care_Act/Individuals-and-Families for more information.

Section 1.2 What is the Evidence of Coverage booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a customer of the plan.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a customer of Cigna Preferred Medicare (HMO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in our plan between January 1, 2022 and December 31, 2022.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a customer of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2. What makes you eligible to be a plan customer?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* – you live in our geographic service area (Section 2.3 below describes our service area)

- -- *and* -- you are eligible based on your Plan Sponsor's enrollment requirements
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already am member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for your plan

Although Medicare is a Federal program, your plan is available only to individuals who live in our plan service area. To remain a customer of our plan, you must keep living in this service area. The service area is described below:

Our service area includes these counties in Arizona: Maricopa. Our service area includes these parts of counties in Arizona: Pinal, the following zip codes only: 85117, 85118, 85119, 85120, 85140, 85143, and 85178, 85220.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location. If you move outside of the service area, you cannot remain a customer of our plan. Please contact your Plan Sponsor for other options available to you.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

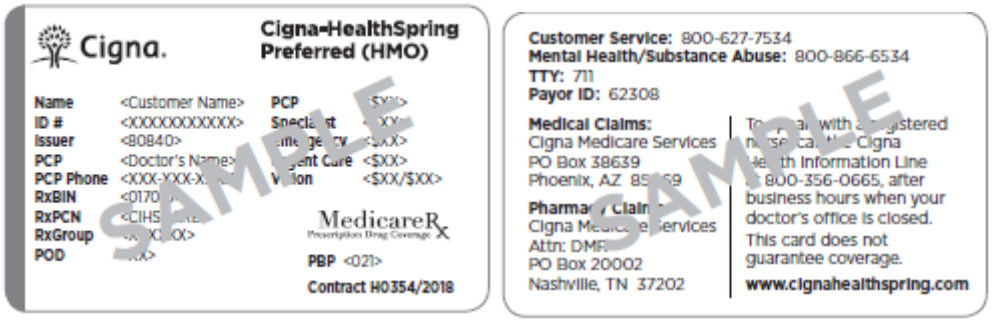
Section 2.4 U.S. Citizen or Lawful Presence

A customer of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna if you are not eligible to remain a customer on this basis. Cigna must disenroll you if you do not meet this requirement.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a customer of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Here's a sample membership card to show you what yours will look like:



As long as you are a customer of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Cigna membership card while you are a plan customer, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider and Pharmacy Directory*: Your guide to all providers in the plan's network

The *Provider and Pharmacy Directory* lists our network providers and durable medical equipment suppliers.

What are "network providers"?
Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to customers in our plan. The most recent list of suppliers is available on our website at www.CignaMedicareg.com

Why do you need to know which providers are part of our network?
It is important to know which providers are a part of our network because, with limited exceptions, while you are a customer of our plan you must use network providers to get your medical care and services. When you select a Primary Care Provider (PCP), you are also selecting an entire network (a specific group of Plan providers) of specialists and hospitals to which your PCP will refer you. If there are specific specialists or hospitals you want to use, you must find out whether your PCP sends his/her patients to those providers. Each plan PCP has certain plan specialists and hospitals they use for referrals. This means the PCP you select will determine the specialists and hospitals you may use. Please call Customer Service for details regarding the specialists and hospitals you may use. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 *(Using the plan's coverage for your medical services)* for more specific information about emergency, out-of-network, and out-of-area coverage.

If you do not have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also view the *Provider and Pharmacy Directory* on our website at CignaMedicare.com/group/MAresources or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 The *Provider and Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?
Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan customers.

Why do you need to know about network pharmacies?
You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at cignamedicare.com/group/MAresources 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 which pharmacies are in our network.

If you do not have the *Provider and Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also view the *Provider and Pharmacy Directory* on our website at CignaMedicare.com/group/MAresources or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.4 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Cigna-HealthSpring Preferred (HMO). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Cigna Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you included information for the covered drugs that are most commonly used by our customers. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit our website at CignaMedicare.com/group/MAresources or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.5 The Part D Explanation of Benefits (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs)* gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 4. Your monthly premium for your plan

Section 4.1 How much is your plan premium?

As a customer of our plan, you may pay a monthly premium. Your coverage is provided through contract with your current employer or former employer or union. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Please contact your plan sponsor for information about your plan premium.

In some situations, your plan premium could be <u>more</u>

In some situations, your plan premium could be more. This situation is described below.

- Some customers are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these customers, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 1, Section 5 explains the late enrollment penalty.
- If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

SECTION 5. Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to you Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over; there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in our plan, we let you know the amount of the penalty. Your Part D late enrollment penalty is considered part of your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2022, this average premium amount is $33.37.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $33.37, which equals $4.67. This rounds to $4.70. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you do not have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2022* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

SECTION 6. Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

"If your income is greater than $87,000 for an individual (or married individuals filing separately) or greater than $174,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare coverage."

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 6.2 How much is the extra Part D amount

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

Section 6.3 What can you do if you disagree about paying an extra Part D amount

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7. More information about your monthly premium

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A and most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a customer of the plan.**

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

• If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

• If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.

• For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit https://www.medicare.gov/ on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2022* gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2022* from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1‑800‑633‑4227), 24 hours a day, 7 days a week. TTY users call 1‑877‑486‑2048.

Section 7.1 If you pay a Part D late enrollment penalty, there are several ways you can pay.

Your coverage is provided through a contract with your current or former employer or union. Please contact your plan sponsor for information about your plan premium.

Section 7.2 Can we change your monthly plan premium during the year?

In some cases, the part of the premium that you pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a customer qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the customer's monthly plan premium. So a customer who becomes eligible for Extra Help during the year would begin to pay less towards their monthly premium. And a customer who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the Extra Help program in Chapter 2, Section 7.

SECTION 8. Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group/IPA. A Medical Group is an association of primary care providers (PCPs), specialists and/or ancillary providers, such as therapists and radiologists. An Independent Physician Association, or IPA, is a group of primary care and specialty care physicians who work together in coordinating your medical needs.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Call your Plan Sponsor to let them know about these changes:

- Changes to your name, your address, or your phone number

Call us to let us know about these changes:

- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you do not need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 9. We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 10. How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its

coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family customer's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family customer is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan customer ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1. Plan contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or customer card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-800-627-7534 Calls to this number are free. October 1 – March 31, 8:00 a.m. – 8:00 p.m. MST, 7 days a week. April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. MST, (A voicemail system is available on weekends, after hours, and on holidays.) Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people with difficulties with hearing or speaking. Calls to this number are free. October 1 – March 31, 8:00 a.m. – 8:00 p.m. MST, 7 days a week. April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. MST, (A voicemail system is available on weekends, after hours, and on holidays.)
WRITE	Cigna Medicare Services Attn: Medicare Customer Service P.O. Box 29030 Phoenix, AZ 85038
WEBSITE	mycigna.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-627-7534 Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).

TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
FAX	1-866-730-1896
WRITE	Cigna Medicare Services Attn: Prior Authorization Dept. P.O. Box 29030 Phoenix, AZ 85038

How to contact us when you are making an appeal about your medical care or Part D prescription drugs
An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or Part D prescription drug coverage, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Appeals for Medical Care or Part D Prescription Drugs – Contact Information
CALL	1-800-627-7534 Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
FAX	1-866-567-2474
WRITE	Cigna Medicare Services Attn: Medicare Appeal Dept. P.O. Box 29030 Phoenix, AZ 85038
WEBSITE	CignaMedicare.com/group/MAresources

How to contact us when you are making a complaint about your medical care or Part D prescription drugs
You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Complaints about Medical Care or Part D Prescription Drugs – Contact Information
CALL	1-800-627-7534 Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
FAX	1-866-567-2474
WRITE	Cigna Medicare Attn: Grievance Department P.O. Box 188080 Chattanooga, TN 37422
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-627-7534 Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).
FAX	1-866-845-7267
WRITE	Cigna Attn: Determinations & Exceptions P. O. Box 20002

	Nashville, TN 37202
WEBSITE	CignaMedicare.com/group/MAresources

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received
For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

Method	**Payment Requests – Contact Information**	
CALL	1-800-627-7534 Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).	
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and holidays).	
WRITE	**Part C (Medical):** Cigna Medicare Services Attn: Medicare Claims Dept. P.O. Box 29030 Phoenix, AZ 85038	**Part D (Pharmacy):** Cigna Medicare Services Attn: Direct Customer Reimbursement P.O. Box 20002 Nashville, TN 37202
WEBSITE	CignaMedicare.com/group/MAresources	

SECTION 2. Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	**Medicare – Contact Information**
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Cigna Preferred Medicare (HMO): • **Tell Medicare about your complaint:** You can submit a complaint about Cigna Preferred Medicare (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you do not have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Arizona, 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 rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. **SHIP** counselors can also help you understand your Medicare plan choices and answer questions about switching plans.