Summary of Benefits

2024
January 1, 2024 to
December 31, 2024

Cigna True Choice Medicare (PPO)
University of Vermont
H7787 – 801
Enhanced Drug List

Freedom to choose your own doctor with no referrals required
Out-of-network coverage available

A4

TO JOIN
You must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

The Cigna True Choice Medicare (PPO) service area includes all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Introduction

What's Inside

This Summary of Benefits gives you a summary of what Cigna True Choice Medicare (PPO) covers and what you pay. It doesn't list every service that we cover or every limitation or exclusion. To get a complete list of services we cover, refer to the plan's Evidence of Coverage (EOC) Snapshot online at myCigna.com or call us to request a copy.

Comparing coverage

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or, use the Medicare Plan Finder on www.medicare.gov.

More about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook.

View the handbook online at www.medicare.gov.

Get a copy 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.

Need help?

Call toll-free 1-888-281-7867 (TTY 711). Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.

You can also visit our website at: CignaMedicare.com/group/MAresources

„ Monthly Premium, Deductible & Limits

Benefit	Cigna True Choice Medicare (PPO)
How much is the monthly premium?	Please contact your Plan Sponsor. In addition, you must keep paying your Medicare Part B premium.
How much is the Medical Deductible?	$100 per year for medical services. Some services are not subject to the deductible. Refer to the Evidence of Coverage Snapshot for a list of those services.
Is there any limit on how much I will pay for my covered services?	Your yearly limit(s) in this plan: $500 for services you receive from in-network and out-of-network providers combined for Medicare-covered benefits. This limit is the most you pay for copays, coinsurance, and other costs for Medicare services for the year. If you reach the limit on out-of-pocket costs, you keep getting in-network and out-of-network covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
How much is the Prescription Drugs Deductible?	$0 per year for Part D prescription drugs.
Is there a limit on how much I pay for prescription drugs?	$750 per year for Part D prescription drugs.

… Covered Medical & Hospital Benefits

Benefit	What you Pay In-Network and Out-of-Network
Note : Services with a [1] may require prior authorization.	
Inpatient Hospital Coverage [1]	
Our plan covers an unlimited number of days for an inpatient hospital stay. For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with day 1 each time you are admitted.	$0 copay per admission
Outpatient Hospital Services	
Outpatient Hospital[1]	$0 copay
Outpatient Observation[1]	$0 copay
Ambulatory Surgical Ce nter (ASC) Services	
ASC Services (ASC)[1]	$0 copay
Doctors Visits [1]	
Primary Care Physician	$10 copay $0 copay for virtual visits
Specialists	$10 copay $0 copay for virtual visits
Preventive Care	
Our plan covers many Medicare-covered preventive services, including: ¾ Abdominal aortic aneurysm screening ¾ Alcohol misuse screening and counseling ¾ Bone mass measurement ¾ Breast cancer screening (mammogram) ¾ Cardiovascular disease (behavioral therapy) ¾ Cardiovascular screenings ¾ Cervical and vaginal cancer screening ¾ Colorectal cancer screenings (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy) ¾ Depression screening ¾ Diabetes screenings ¾ Diabetes self-management training ¾ Glaucoma tests ¾ Hepatitis B Virus (HBV) infection screening	$0 copay Any additional preventive services approved by Medicare during the contract year will be covered. Please see your Evidence of Coverage (EOC) for frequency of covered services.

Benefit	What you Pay
	In-Network and Out-of-Network
¾ Hepatitis C screening ¾ HIV screening ¾ Lung cancer screening with low dose computed tomography (LDCT) ¾ Medical nutrition therapy services ¾ Obesity screening and counseling ¾ Prostate cancer screenings (PSA) ¾ Sexually transmitted infections screening and counseling ¾ Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ¾ Vaccines; including COVID-19, Flu shots, Hepatitis B shots, Pneumococcal shots ¾ “Welcome to Medicare” preventive visit (one-time) ¾ Yearly “Wellness” visit	
Emergency Care	
Emergency Care Services	$0 copay
Worldwide Emergency/Urgent Coverage/Emergency Transportation	$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	
Routine Hearing Exams	$0 copay for one routine exam every year
Hearing Aid Evaluation/Fitting	$0 copay for one fitting evaluation per hearing aid every 2 years
Hearing Aids	$0 copay $3,000 maximum coverage amount for hearing aids every 2 years.
Dental Services (Medicare-covered) [1]	
Limited dental services (this does not include services in connection with care, treatment, filling removal or replacement of teeth)	$10 copay
Preventive and Comprehensive Dental Services	
	Not covered
Vision Services	
Eye Exams (Medicare-covered) A separate physician cost-share may apply if additional services requiring cost-sharing are rendered (e.g., but not limited to, if a medical eye condition is discovered during a preventive routine eye exam). A facility cost-share may apply for procedures performed at an outpatient surgical center.	$0 copay for diabetic retinopathy screening $10 copay for all other Medicare-covered vision services.
Routine Eye Exam One routine eye exam (including eye refraction) per year. Eye refractions outside of the annual non-Medicare-covered routine eye exam are not covered. For routine eye exams and eyewear services, customers are encouraged to select a provider within Cigna Healthcare's vision vendor network	$0 copay for one routine exam every year

Benefit	What you Pay In-Network and Out-of-Network
but are not required to do so. Customers have the option to select doctors and benefits both in and out of network with no referrals required, however, out-of-pocket costs may be higher for out-of-network services.	
Glaucoma Screening (Medicare-covered)	$0 copay
Eyewear (Medicare-covered)	$0 copay
Routine Eyewear ¾ Eyeglasses (lenses and frames) ¾ Eyeglass lenses ¾ Eyeglass frames ¾ Contact lenses (including contact lens fittings) ¾ Upgrades	$0 copay Plan maximum coverage amount of $250 . The plan-specified allowance may be applied to one set of the member's choice of eyewear once per year, to include the eyeglass frame/lenses/lens options combination or contact lenses (to include related professional fees) in lieu of eyeglasses.
Mental Health Services	
Inpatient[1] Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with Day 1 each time you are admitted.	$0 copay per admission
Outpatient[1] Individual or Group Therapy Visit	$0 copay
Skilled Nursing Facility (SNF) [1]	
Our plan covers unlimited days in the SNF.	$0 copay per day
Rehabilitation Services	
Cardiac (heart) Rehab Services[1]	$0 copay
Intensive Cardiac (heart) Rehab Services[1]	$0 copay
Pulmonary Rehab Services[1]	$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
calling 911. If you are experiencing a health care emergency, please call 911 or go to your nearest emergency room. *Nurse Advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing any medical advice.	
Home Delivered Meals	
	$0 copay Limited to 14 meals per discharge from qualified hospital stay or skilled nursing facility (up to 3 stays per year). ESRD care management is limited to 56 meals per benefit period.
Home Health Care [1]	
	$0 copay
Hospice	
Hospice care must be provided by a Medicare-certified hospice program. Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.	$0 copay
Medical Equipment and Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	20% coinsurance after deductible
Prosthetic Devices (braces, artificial limbs, etc.)	20% coinsurance after deductible
Related Medical Supplies[1]	20% coinsurance after deductible
Diabetes Supplies & Services[1] Brand limitations apply to certain supplies.	$0 copay for diabetes self-management training $0 copay for therapeutic shoes or inserts $0 copay for diabetes monitoring supplies
Opioid Treatment Services [1]	
FDA-approved treatment medications in addition to testing, counseling, and therapy.	$0 copay
Outpatient Substance Abuse [1]	
Individual or Group Therapy Visit	$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
Home Infusion Therapy includes enhanced home infusion therapy coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met	20% coinsurance after deductible

† Prescription Drug Benefits

Medicare Part D Drugs - Initial Coverage

The following chart shows the cost-share amounts for covered drugs under this plan. After you pay your yearly deductible (if applicable), you pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our plan.

If you get your drug at an out-of-network pharmacy, you will pay the same cost-share you would pay for a 30-day supply at an in-network retail pharmacy. If you reside in a long-term care facility, you will pay the standard retail cost-share at an in-network pharmacy.

Your costs may be different if you qualify for Extra Help. Your copay or coinsurance is based on the drug tier for your medication, which you can find in the Enhanced Drug List (Formulary) on our website CignaMedicare.com/group/MAresources. Or, call us and we will send you a copy of the formulary.

Tier	Supply	Retail Cost-Share	Mail-Order Cost-Share
Tier 1	30-day	$5	$5
	60-day	$10	$10
	90-day	$10	$10
Tier 2	30-day	$20	$20
	60-day	$40	$40
	90-day	$40	$40
Tier 3			

Your plan includes the following clinic al management edits. Refer to your 2024 Formulary for more information.

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