SUMMARY OF BENEFITS

2022
January 1, 2022 to
December 31, 2022

Cigna True Choice Medicare (PPO)
Vermont State Colleges System – Non-Faculty
H7849 – 817

No referrals required

Ver A3

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

Our service area for Cigna True Choice Medicare (PPO) includes the 50 United States, the District of Columbia and all U.S. Territories.

Introduction

What's Inside

This Summary of Benefits gives you a summary of what **Cigna True Choice Medicare (PPO)** covers and what you pay. This information is not a complete description of benefits. Call 1-888-281-7867 (TTY 711) for more information. It doesn't list every service that we cover or list 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 it online at **www.medicare.gov** or 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. Our automated phone system may answer your call during weekends, holidays, and after hours.

CignaMedicare.com/group/MAresources
You can also visit us online to find a provider or pharmacy, view plan information, and more.

❶ About this plan

Which doctors, hospitals and pharmacies can I use?
Cigna True Choice Medicare (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You may also choose to use providers that are out-of-network and there will not be a change to your copay or coinsurance.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider and Pharmacy Directory* at our website, CignaMedicare.com/group/MAresources.

What do we cover?
Like all Medicare health plans, we cover everything that Original Medicare covers-and more.

- Our customers get all of the benefits covered by Original Medicare.
- Our customers also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this *Summary of Benefits*.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the plan's complete *Comprehensive Prescription Drug List* which lists the Part D prescription drugs along with any restrictions on our website, myCigna.com.
- Or, call us and we will send you a copy of the plan's *Comprehensive Prescription Drug List*.

❷ 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?	**$250** per year for medical services.
How much is the Prescription Drugs Deductible?	**$0** per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Original Medicare does not have annual limits on out-of-pocket costs. Your yearly limit(s) in this plan: **$250** 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.

❸ Covered Medical & Hospital Benefits

Benefit	What you Pay
	In-Network and Out-of-Network
Covered Medical and Hospital Benefits **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** per admission
Outpatient Hospital Coverage	
Ambulatory Surgical Center (ASC)[1]	**$0** copay
Outpatient Services[1]	**$0** copay
Outpatient Observation[1]	**$0** copay
Doctors' Visits[1]	
Primary Care Physician	**$0** copay
Specialists	**$0** copay
Preventive Care	
Our plan covers many Medicare-covered preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma tests • Hepatitis B Virus (HBV) infection screening • Hepatitis C screening • HIV screening • Lung cancer screening with low dose computed tomography (LDCT) • Medical nutrition therapy services	**$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
• Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines; including COVID-19, Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit	
Emergency Care	
Emergency Care Services	**$0** copay
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$0** copay Maximum worldwide coverage amount $50,000
Urgently Needed Services	
Urgent Care Services	**$0** copay
Diagnostic services, Labs & Imaging *(Costs for these services may vary based on place of service)*	
Diagnostic Procedures and Tests[1]	**$0** copay
Lab Services[1] For COVID-19 testing a prior authorization is not required.	**$0** copay
Therapeutic Radiological Services[1]	**$0** copay
X-ray Services[1]	**$0** copay in a Primary Care Physician Office **$0** copay in a Specialist office **$0** copay or coinsurance in other outpatient locations
Diagnostic Radiological Services (MRIs, CT Scans, etc.)[1]	**$0** copay
Hearing Services	
Hearing Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	**$0** copay
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 three years
Hearing Aids	**$0** copay up to plan maximum coverage amount for hearing aids of **$700** per ear per device every three years.
Dental Services	
Dental Services (Medicare-Covered)[1] Limited dental services (this does not include services in connection with care, treatment, filling removal or replacement of teeth)	**$0** copay

Benefit	What you Pay
	In-Network and Out-of-Network
Vision Services	
Eye Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered. A facility cost-share may apply for procedures performed at an outpatient surgical center.	**$0** copay for diabetic retinal exams; **$0** copay for all other Medicare-covered vision services.
Routine Eye Exam	Not Covered
Glaucoma Screening (Medicare-covered)	**$0** copay
Eyewear (Medicare-covered)	**$0** copay
Routine Eyewear	Not covered
Mental Health Services	
Inpatient[1] Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Our plan also covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. 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** per admission
Outpatient[1] Individual or Group Therapy Visit	**$0** copay
Skilled Nursing Facility *(SNF)*[1]	
Our plan covers up to 100 days in the SNF.	**$0** copay
Rehabilitation Services	
Cardiac (heart) Rehab Services[1]	**$0** copay
Pulmonary Rehab Services[1]	**$0** copay
Occupational Therapy Services[1]	**$0** copay
Physical Therapy and Speech and Language Therapy Services[1]	**$0** copay
Physical Therapy, Speech and Language Therapy Telehealth Services[1]	**$0** copay
Ambulance[1]	
Ground Service (one-way trip)	**$0** copay
Air Service (one-way trip)	**$0** copay
Transportation[1]	
	Not covered
Prescription Drugs	
Medicare Part B Drugs[1] Medicare-covered Part B Drugs may be subject to step therapy requirements.	**$0** copay This plan has Part D prescription drug coverage. See Section 4 in this *Summary of Benefits*.

Benefit	What you Pay
	In-Network and Out-of-Network
Foot Care *(Podiatry Services)*	
Medicare-covered Podiatry Services	**$0** copay
Routine Podiatry Services	Not covered
Medical Equipment & Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**$0** copay
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**$0** copay
Diabetes Supplies & Services[1] Brand limitations apply to certain supplies	**$0** copay for diabetes self-management training **$0** for therapeutic shoes or inserts **$0** for diabetes monitoring supplies.
Fitness & Wellness Programs	
Fitness Program The program offers the flexibility of a fitness center memberships, digital fitness tools, and a home fitness kit.	**$0** copay
24-Hour Health Information Line	
Talk one-on-one with a Nurse Advocate* to get timely answers to your health-related questions at no additional cost, anytime day or night. *Nurse Advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.	**$0** copay
Chiropractic Care[1]	
Chiropractic Services (Medicare-covered)	**$0** copay
Chiropractic Services (Routine)	Not covered
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
Outpatient Substance Abuse[1]	
Individual or Group Therapy Visit	**$0** copay

Benefit	What you Pay
	In-Network and Out-of-Network
Opioid Treatment Services[1]	
FDA-approved treatment medications in addition to testing, counseling and therapy.	**$0** copay
Over-the-Counter Items *(OTC)*	
	Not Covered
Home Delivered Meals	
	$0 copay Limited to 14 meals per discharge from qualified hospital stay or skilled nursing facility (up to three stays per year), ESRD care management is limited to 56 meals per benefit period.* *Authorization applies to ESRD meals.
Telehealth Services *(Medicare-Covered)*	
For nonemergency care, talk with a telehealth doctor via phone or video for certain telehealth services, including: allergies, cough, headache, sore throat and other minor illnesses.	**$0** copay
Acupuncture	
Acupuncture Services (Medicare-covered)[1] Services for chronic lower back pain.	**$0** copay
Supplemental Acupuncture Services	Not Covered
Additional Benefits **Enjoy these extra benefits included in your plan.**	
Annual Physical Exam[1]	**$0** copay

❹ Prescription Drug Benefits

Benefit	Cigna True Choice Medicare (PPO)
Prescription Drug Benefits	
Medicare Part D Drugs Initial Coverage (after you pay your deductible, if applicable) **Tier 1:** Preferred Generic Drugs **Tier 2:** Generic Drugs **Tier 3:** Preferred Generic and Brand Drugs **Tier 4:** Specialty Generic and Brand Drugs	The following chart shows the cost-sharing 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 **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our plan.

Tier	Standard Retail Cost-Sharing 30 / 60 / 90 Days	Standard Mail Order Cost-Sharing 30 / 60 / 90 Days
1	$10 / $10 / $10	$10 / $10 / $10
2	$20 / $20 / $20	$20 / $20 / $20
3	$20 / $20 / $20	$20 / $20 / $20
4*	$20 / N/A / N/A	$20 / N/A / N/A

*Specialty drugs are limited to a 30-day supply

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 Plan Prescription drug List (Formulary) included in this mailing or on our website myCigna.com. Or, call us and we will send you a copy of the formulary.

<table>
<tr><th>Benefit</th><th>Cigna True Choice Medicare (PPO)</th></tr>
<tr><td>Coverage Gap

Tier 1: Preferred Generic Drugs
Tier 2: Generic Drugs
Tier 3: Preferred Generic and Brand Drugs
Tier 4: Specialty Generic and Brand Drugs</td><td>Most Medicare drug plans have a coverage gap (also called the “Donut Hole”). This means that there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay the amounts in the table below for covered drugs until your costs total $7,050, which is the end of the Coverage Gap.
<table>
<tr><th>Tier</th><th>Standard Retail Cost-Sharing 30 / 60 / 90 Days</th><th>Standard Mail Order Cost-Sharing 30 / 60 / 90 Days</th></tr>
<tr><td>1</td><td>$10 / $10 / $10</td><td>$10 / $10 / $10</td></tr>
<tr><td>2</td><td>$20 / $20 / $20</td><td>$20 / $20 / $20</td></tr>
<tr><td>3</td><td>$20 / $20 / $20</td><td>$20 / $20 / $20</td></tr>
<tr><td>4*</td><td>$20 / N/A / N/A</td><td>$20 / N/A / N/A</td></tr>
</table>
*Specialty drugs are limited to a 30-day supply</td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) have reached $7,050, the plan will pay most of the cost for your drugs. Your share of the cost of covered drugs will be the lesser of the Coverage Gap amount or the standard Catastrophic Coverage amount which is the greater of:

5% of the cost
- or -
$3.95 copayment for generic (including brand drugs treated as generic) and
$9.85 copayment for all other drugs.</td></tr>
<tr><td>Out-of-Network</td><td>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 would pay the standard retail cost-sharing at an in-network pharmacy.</td></tr>
<tr><td colspan="2">Additional Benefits Offered</td></tr>
<tr><td>Erectile Dysfunction Drugs
Cough and Cold Drugs
Prescription Vitamins</td><td>Your plan covers additional drugs not normally covered in a Medicare Prescription Drug Plan as indicated in the Formulary Drug List by the + symbol. Please see your 2022 Formulary document for details. The cost-share you pay on these drugs do not count toward your annual TrOOP.

^Sexual dysfunction medications are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories. Please review your 2022 formulary for more information.</td></tr>
</table>

Benefit	Cigna True Choice Medicare (PPO)
Your plan includes the following clinical management edits. Refer to your 2022 Formulary for more information.	
Prior Authorization	This drug requires prior authorization.
Quantity Limits	This drug has quantity limits.
Step Therapy	This drug has step therapy requirements.
*	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a month supply.
+	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
^	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
HRM PA	This high risk medication requires prior authorization.
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
LA	Limited Availability drug. This drug may be available only at certain pharmacies.