Cigna-HealthSpring PreventiveCare (HMO) offered by Cigna-HealthSpring

ANNUAL NOTICE OF CHANGES FOR 2017

You are currently enrolled as a member of Cigna-HealthSpring PreventiveCare (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- To get information from us in a way that works for you, please call Customer Service (phone numbers are in Section 7.1 of this booklet). We can give you information in Braille, in large print, and other alternate formats if you need it.
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) 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 on the individual requirement for MEC.

About Cigna-HealthSpring PreventiveCare (HMO)

- Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select State Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Cigna-HealthSpring. When it says "plan" or "our plan," it means Cigna-HealthSpring PreventiveCare (HMO).

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Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our *Provider and Pharmacy Directory*.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Cigna-HealthSpring PreventiveCare (HMO):

If you want to stay with us next year, it's easy — you don't need to do anything.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Cigna-HealthSpring PreventiveCare (HMO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$147	$166
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $5 copayment per visit Specialist visits: $50 copayment per visit	Primary care visits: $10 copayment per visit Specialist visits: $50 copayment per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$1,220 copayment per stay	$1,400 copayment per stay

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $280 Copayments or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard cost-sharing:* $4 copayment • Drug Tier 2: *Standard cost-sharing:* $10 copayment • Drug Tier 3: *Standard cost-sharing:* $47 copayment • Drug Tier 4: *Standard cost-sharing:* $95 copayment • Drug Tier 5: *Standard cost-sharing:* 26% coinsurance	Deductible: $280 Copayments or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Preferred cost-sharing:* $4 copayment *Standard cost-sharing:* $9 copayment • Drug Tier 2: *Preferred cost-sharing:* $10 copayment *Standard cost-sharing:* $15 copayment • Drug Tier 3: *Preferred cost-sharing:* $42 copayment *Standard cost-sharing:* $47 copayment • Drug Tier 4: *Preferred cost-sharing:* $90 copayment *Standard cost-sharing:* $95 copayment • Drug Tier 5: *Preferred cost-sharing:* 27% coinsurance *Standard cost-sharing:* 27% coinsurance

Annual Notice of Changes for 2017
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Optional Supplemental Benefits Monthly Premium	$12.60	$12.60

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2017 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2017 *Provider and Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2017 Evidence of Coverage*.

Cost	2016 (this year)	2017 (next year)
Ambulance services	You pay a copayment of $175 for each one-way Medicare-covered ground ambulance trip.	You pay a copayment of $195 for each one-way Medicare-covered ground ambulance trip.
Cardiac rehabilitation services	You pay a copayment of: $15 for each Medicare-covered cardiac rehabilitative therapy visit. $15 for each Medicare-covered intensive cardiac rehabilitative therapy visit.	You pay a copayment of: $0 for each Medicare-covered cardiac rehabilitative therapy visit. $0 for each Medicare-covered intensive cardiac rehabilitative therapy visit.
Hearing services	You pay a copayment of $50 for Medicare-covered diagnostic hearing exams. $500 allowance per hearing aid device per ear every three years.	You pay a copayment of $10 in a Primary Care Physician office or $20 in all other office settings for Medicare-covered diagnostic hearing exams $700 allowance per hearing aid device per ear every three years.
Inpatient hospital care	You pay a copayment of $1,220 for each Medicare-covered hospital stay.	You pay a copayment of $1,400 for each Medicare-covered hospital stay.
Inpatient mental health care	You pay a copayment of $1,220 for each Medicare-covered inpatient mental hospital stay.	You pay a copayment of $1,400 for each Medicare-covered inpatient mental hospital stay.

Cost	2016 (this year)	2017 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	You pay a copayment/coinsurance of: 0% or 30% for Medicare-covered diagnostic procedures and tests. 0% coinsurance for EKG. 30% for all other diagnostic procedures and tests. $0 for Medicare-covered lab services. $0 for Medicare-covered blood services. 20% for Medicare-covered diagnostic radiology services. 20% for Medicare-covered therapeutic radiology services. 20% for Medicare-covered X-rays.	You pay a copayment/coinsurance of: 0% or 30% for Medicare-covered diagnostic procedures and tests. 0% coinsurance for EKG and diagnostic colorectal screenings. 30% for all other diagnostic procedures and tests. $0 for Medicare-covered lab services. $0 for Medicare-covered blood services. 0% or 20% for Medicare-covered diagnostic radiology services. 0% for mammography. 20% for all other diagnostic radiology services. 20% for Medicare-covered therapeutic radiology services. 20% for Medicare-covered X-rays.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a coinsurance of 30% for each Medicare-covered outpatient hospital facility visit. You pay a copayment of $50 for each Medicare-covered ambulatory surgical center visit.	You pay a coinsurance of 0% or 30% for each Medicare-covered outpatient hospital facility visit. 0% for any surgical procedures (i.e. polyp removal) during a colorectal screening. 30% for all other Outpatient Services including observation and outpatient surgical services not provided in an Ambulatory Surgical Center. You pay a $0 or $50 copayment for each Medicare-covered ambulatory surgical center visit. $0 for any surgical procedures (i.e. polyp removal) during a colorectal screening. $50 for all other Ambulatory Surgical Center (ASC) services.
Physician/Practitioner/Other Health Care Professional services	You pay a copayment of: $5 for each Medicare-covered Primary Care Physician office visit. $50 for each Medicare-covered specialist visit. $5 in a Primary Care Physician office or $50 in a Specialist office for Other Health Care Professional Service.	You pay a copayment of: $10 for each Medicare-covered Primary Care Physician office visit. $50 for each Medicare-covered specialist visit. $10 in a Primary Care Physician office or $50 in a Specialist office for Other Health Care Professional Service.
Podiatry services	You pay a copayment of $50 for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically necessary foot care.	You pay a copayment of $40 for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically necessary foot care.
Pulmonary rehabilitation services	You pay a copayment of $15 for each Medicare-covered pulmonary rehabilitative therapy visit.	You pay a copayment of $0 for each Medicare-covered pulmonary rehabilitative therapy visit.

Cost	2016 (this year)	2017 (next year)
Skilled nursing facility (SNF) care	You pay a copayment of: • Days 1-20: $0 per day • Days 21-100: $160 per day For each Medicare-covered SNF stay.	You pay a copayment of: • Days 1-20: $0 per day • Days 21-100: $164 per day For each Medicare-covered SNF stay.
Vision services	You pay a copayment of $0 or $50 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. $0 copayment for glaucoma screenings. $50 copayment for all other Medicare-covered vision services. Contacts: unlimited $0 copayment for up to 1 pair of eyeglasses (lenses and frames) every two years. $100 plan coverage limit for supplemental eyewear every two years. Supplemental annual eyewear allowance applies to the retail value only. Applicable taxes are not covered.	You pay a copayment of $0 or $50 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. $0 copayment for glaucoma screenings and diabetic retinal exams. $50 copayment for all other Medicare-covered vision services. Contacts: unlimited $0 copayment for up to 1 pair of eyeglasses (lenses and frames) every year. $100 plan coverage limit for supplemental eyewear every year. Supplemental annual eyewear allowance applies to the retail value only. Applicable taxes are not covered.

Section 1.6 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 in this envelope. The Drug List we included in this envelope 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.cignahealthspring.com).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have received a formulary exception to a medication this year the formulary exception request is approved through the date indicated in the approval letter. A new formulary exception request is only needed if the date indicated on the letter has passed.

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 get "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred), and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible.	The deductible is $280. During this stage, you pay Stage 2: Initial Coverage Stage cost-sharing (see table below) for drugs on Tier 1 (Preferred Generic) and Tier 2 (Generic) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	The deductible is $280. During this stage, you pay Stage 2: Initial Coverage Stage cost-sharing (see table below) for drugs on Tier 1 (Preferred Generic) and Tier 2 (Generic) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. 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 *Evidence of Coverage*. 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.	Your cost for a one-month supply at a network pharmacy: **Preferred Generic:** *Standard cost-sharing:* You pay $4 per prescription. **Generic:** *Standard cost-sharing:* You pay $10 per prescription. **Preferred Brand:** *Standard cost-sharing:* You pay $47 per prescription. **Non-Preferred Brand:** *Standard cost-sharing:* You pay $95 per prescription. **Specialty Tier:** *Standard cost-sharing:* You pay 26% of the total cost. ——————— Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Preferred Generic:** *Preferred cost-sharing:* You pay $4 per prescription. *Standard cost-sharing:* You pay $9 per prescription. **Generic:** *Preferred cost-sharing:* You pay $10 per prescription. *Standard cost-sharing:* You pay $15 per prescription. **Preferred Brand:** *Preferred cost-sharing:* You pay $42 per prescription. *Standard cost-sharing:* You pay $47 per prescription. **Non-Preferred:** *Preferred cost-sharing:* You pay $90 per prescription. *Standard cost-sharing:* You pay $95 per prescription. **Specialty Tier:** *Preferred cost-sharing:* You pay 27% of the total cost. *Standard cost-sharing:* You pay 27% of the total cost. ——————— Once your total drug costs have reached $3,700, 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.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Other Changes

Process	2016 (this year)	2017 (next year)
Phone Number Change: Appeals for Medical Care	For information about your medical appeals call: 1-800-668-3813	For information about your medical appeals call: 1-800-511-6943
Retail Network Pharmacies with Preferred Cost-share	Your plan has retail network pharmacies with standard cost-sharing.	Your plan has retail network pharmacies with either preferred or standard cost-sharing. Your cost-sharing at preferred network pharmacies may be lower than the cost-sharing at standard network pharmacies. For the most up-to-date pharmacy network information, you can visit our website at www.cignahealthspring.com. You can also call Customer Service to get information about changes in the pharmacy network (phone numbers are located in Section 7.1 of this booklet).

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in Cigna-HealthSpring PreventiveCare (HMO)

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 stay enrolled as a member of our plan for 2017.

Section 3.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - — *or* — Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2017.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE 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. APPRISE 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 APPRISE at 1-800-783-7067.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has programs called Chronic Renal Disease Program (CRDP), PACE Needs Enhancement Tier (PACENET), Pharmaceutical Assistance Contract for the Elderly (PACE), and Special Pharmaceutical Benefits Program (SPBP) that help people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **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 Special Pharmaceutical Benefits Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Special Pharmaceutical Benefits Program at 1-800-922-9384.

SECTION 7 Questions?

Section 7.1 Getting Help from Cigna-HealthSpring PreventiveCare (HMO)

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 – February 14, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From February 15 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 6:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.

Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for Cigna-HealthSpring PreventiveCare (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.cignahealthspring.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

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2017*

You can read the *Medicare & You 2017* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.