



SUMMARY OF BENEFITS

January 1, 2020 - December 31, 2020
Cigna-HealthSpring True Choice (PPO)
Williamson County Government

✚ No referral required

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

INTRODUCTION TO SUMMARY OF BENEFITS

This Summary of Benefits gives you a summary of what **Cigna-HealthSpring True Choice (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)* online at CignaMedicare.com/group/MAresources or call us to request a copy.

Tips for comparing your Medicare choices

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.

- 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.

Cigna-HealthSpring True Choice (PPO) Phone Numbers and Website

- Help is always here. If you have any questions, customer service is here to help. We go above and beyond to make sure you have everything you need to understand and get the most from your plan.
- **1-888-281-7867 (TTY 711)**
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. Customer service also has free language interpreter services available for non-English speakers.
- CignaMedicare.com/group/MAresources
You can also visit us online at to find a provider or pharmacy, view plan information, and more.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

What's Inside

- 1 About Cigna-HealthSpring True Choice (PPO)
- 2 Monthly Deductible, and Limits on How Much You Pay for Covered Services
- 3 Covered Medical & Hospital Benefits
- 4 Prescription Drug Benefits

1 ABOUT CIGNA-HEALTHSPRING TRUE CHOICE RX (PPO)

Who can join?

To join Cigna-HealthSpring True Choice (PPO), 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-HealthSpring True Choice (PPO) includes the 50 United States, the District of Columbia and all U.S. territories.

Which doctors, hospitals, and pharmacies can I use?

Cigna-HealthSpring True Choice (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.
- Or call us and we will send you a copy of the *Provider and Pharmacy Directory*.

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 complete plan Drug List (formulary) which lists the Part D prescription drugs along with any restrictions included in this mailing or once you join the plan, at myCigna.com.
- Or, call us and we will send you a copy of the plan's *Prescription Drug List* (formulary).

How will I determine my drug costs?

Our plan groups each medication into one of four "tiers." To locate the tier of your prescribed drug, please refer to the *Drug List* (formulary). The amount you pay depends on the tier of the drug you're taking and what stage of coverage you have reached. For information about the drug coverage stages that occur after you meet your deductible (if a deductible applies to you), see the prescription drug section within this Summary of Benefits.

2 MONTHLY PREMIUM, DEDUCTIBLE & LIMITS

Benefit	Cigna-HealthSpring True Choice (PPO)
Monthly Premium, Deductible, and Limits	
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 deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <p style="padding-left: 40px;">\$1,500 for services you receive from in-network providers for Medicare-covered benefits.</p> <p>This limit is the most you pay for copays, coinsurance and other costs for Medicare services for the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p> <p>Refer to the "Medicare & You" handbook for Medicare-covered services.</p>

3 COVERED MEDICAL & HOSPITAL BENEFITS

Benefit	What you Pay	
	In-Network	Out-of-Network
Covered Medical and Hospital Benefits Note: Services with a 1 may require prior authorization.		
Inpatient Hospital Coverage¹		
Our plan covers an unlimited number of days for an inpatient hospital stay.	\$0 per admission	\$0 per admission
Outpatient Hospital Coverage		
Ambulatory Surgical Center (ASC) ¹	\$0 copay	\$0 copay
Outpatient Services ¹	\$0 copay	\$0 copay
Outpatient Observation ¹	\$0 copay	\$0 copay
Doctors' Visits¹		
Primary Care Physician	\$15 copay	\$15 copay
Specialists	\$25 copay	\$25 copay
Preventive Care		
Our plan covers many Medicare-covered preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse 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, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Lung cancer screening with low dose computed tomography (LDCT). • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots 	\$0 copay Any additional preventive services approved by Medicare During the contract year will be covered. Please see your <i>Evidence of Coverage</i> (EOC) for frequency of covered services.	\$0 copay

Benefit	What you Pay	
	In-Network	Out-of-Network
<ul style="list-style-type: none"> • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit 		
Emergency Care		
Emergency Care Services	\$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	Same as in-network
Worldwide Emergency/Urgent Coverage/Emergency Transportation	\$65 copay Maximum worldwide coverage amount \$50,000	Same as in-network
Urgently Needed Services		
Urgent Care Services	\$25 copay	Same as in-network
Diagnostic services, Labs & Imaging (Costs for these services may vary based on place of service)		
Diagnostic Procedures and Tests ¹	\$0 copay	\$0 copay
Lab Services ¹	\$0 copay	\$0 copay
Therapeutic Radiological Services ¹	\$0 copay	\$0 copay
X-ray Services ¹	\$0 copay	\$0 copay
Diagnostic Radiological Services (such as MRIs, CT Scans) ¹	\$0 copay	\$0 copay
Hearing Services		
Hearing Exams (Medicare-covered)	\$25 copay	\$25 copay
Routine Hearing Exams	Not covered	Not covered
Hearing Aid Evaluation/Fitting	Not Covered	Not Covered
Hearing Aids	Not covered	Not covered
Dental Services		
Dental Services (Medicare-Covered) ¹	\$25 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	\$25 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
Vision Services		
Eye Exams (Medicare-covered)	\$0 or \$25 copay	\$0 or \$25 copay
Routine Eye Exam	Not Covered	Not Covered
Eyewear (Medicare-covered)	\$0 copay	\$0 copay

Benefit	What you Pay	
	In-Network	Out-of-Network
Routine Eyewear	Not covered	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.	\$0 per admission	\$0 per admission
Outpatient ¹ Individual or Group Therapy Visit	\$0 copay	\$0 copay
Skilled Nursing Facility (SNF)¹		
Our plan covers up to 100 days in the SNF.	\$0 per day for days 1–100	\$0 per day for days 1–100
Rehabilitation Services		
Cardiac (heart) Rehab Services ¹	\$10 copay	\$10 copay
Pulmonary Rehab Services ¹	\$10 copay	\$10 copay
Occupational Therapy Services ¹	\$10 copay	\$10 copay
Physical Therapy and Speech and Language Therapy Services ¹	\$10 copay	\$10 copay
Ambulance¹		
Ground Service (one-way trip)	\$0 copay	\$0 copay
Air Service (one-way trip)	\$0 copay	\$0 copay
Transportation¹		
Members may be required to use Cigna vendors for transportation to plan-approved locations. Mileage restrictions may apply. See <i>Evidence of Coverage Snapshot</i> for full details and restrictions related to benefit.	Not covered	Not covered
Prescription Drugs		
Medicare Part B Drugs ¹ Medicare-covered Part B Drugs may be subject to step therapy requirements.	10% coinsurance This plan has Part D prescription drug coverage. See Section 4.	10% coinsurance
Foot Care (Podiatry Services)		
Medicare-covered Podiatry Services	\$0 copay	\$0 copay
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	10% coinsurance	10% coinsurance
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies ¹	10% coinsurance	10% coinsurance
Diabetes Supplies & Services	\$0 copay for Diabetes self-management training	\$0 copay for Diabetes self-management training

Benefit	What you Pay	
	In-Network	Out-of-Network
	<p>\$0 copay for Therapeutic shoes or inserts</p> <p>\$0 copay for Diabetes monitoring supplies.</p>	<p>\$0 copay for Therapeutic shoes or inserts</p> <p>\$0 copay for Diabetes monitoring supplies.</p>
Fitness & Wellness Programs		
Fitness Program	<p>\$0 copay</p> <p>Basic gym membership at a participating fitness location including fitness classes. Provides home fitness kits as an alternative program option in lieu of facility membership.</p>	Combined with in-network
24-Hour Health Information Line		
Call 24-Hour Health Information Line to talk with a nurse advocate. 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 medical advice in any capacity as a health advocate.	\$0 copay	Combined with in-network
Chiropractic Care		
Chiropractic Services (Medicare-covered)	\$20 copay	\$20 copay
Home Health Care¹		
	\$0 copay	\$0 copay
Hospice		
Hospice care must be provided by a Medicare-certified hospice program	<p>\$0 copay</p> <p>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.</p>	
Outpatient Substance Abuse¹		
Individual or Group Therapy Visit	\$0 copay	\$0 copay

Benefit	What you Pay	
	In-Network	Out-of-Network
Opioid Treatment Services¹		
FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable Substance use counseling Individual and group therapy Toxicology testing	\$0 copay	\$0 copay
Over-the-Counter Items (OTC)		
	Not Covered	Not Covered
Meal Benefit		
	\$0 copay Limited to 14 meals per discharge from qualified hospital stay (up to three stays per year)	\$0 copay
MD Live Telehealth Services (Medicare-Covered)		
Covered services include certain telehealth services, including for: allergies, cough, headache, nausea and other low-risk illnesses. You must use a network provider that offers this service.	\$15 copay	\$15 copay
Supervised Exercise Therapy (SET)		
	\$10 copay SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.	\$10 copay
Acupuncture		
	Not covered	Not covered

4 PRESCRIPTION DRUG BENEFITS

Benefit	Cigna-HealthSpring True Choice (PPO)																
Prescription Drug Benefits																	
Medicare Part D Drugs Initial Coverage	<p>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 \$4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <table border="1" data-bbox="421 648 1478 1375"> <thead> <tr> <th data-bbox="421 648 740 814">Tier</th> <th data-bbox="740 648 1088 814">Standard Retail Cost-Sharing 30 / 60 / 90 Days</th> <th data-bbox="1088 648 1478 814">Standard Mail Order Cost-Sharing 30 / 60 / 90 Days</th> </tr> </thead> <tbody> <tr> <td data-bbox="421 814 740 907">Tier 1: Preferred Generic Drugs</td> <td data-bbox="740 814 1088 907">\$15 / \$30 / \$15</td> <td data-bbox="1088 814 1478 907">\$15 / \$30 / \$15</td> </tr> <tr> <td data-bbox="421 907 740 1086">Tier 2: Preferred Brand Drugs</td> <td data-bbox="740 907 1088 1086">25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45</td> <td data-bbox="1088 907 1478 1086">25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45</td> </tr> <tr> <td data-bbox="421 1086 740 1237">Tier 3: Non-Preferred Generic and Brand Drugs</td> <td data-bbox="740 1086 1088 1237">40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80</td> <td data-bbox="1088 1086 1478 1237">40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80</td> </tr> <tr> <td data-bbox="421 1237 740 1375">Tier 4: * Specialty Generic and Brand Drugs</td> <td data-bbox="740 1237 1088 1375">40% (\$40 min, \$100 max) / N/A / N/A</td> <td data-bbox="1088 1237 1478 1375">40% (\$40 min, \$100 max) / N/A / N/A</td> </tr> </tbody> </table> <p data-bbox="421 1397 1478 1511">You can get your prescription from an out-of-network pharmacy, but may pay more than you would pay at an in-network pharmacy. If you reside in a long-term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.</p> <p data-bbox="421 1526 1478 1677">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.</p> <p data-bbox="421 1692 964 1726">*Specialty drugs are limited to a 30-day supply</p>		Tier	Standard Retail Cost-Sharing 30 / 60 / 90 Days	Standard Mail Order Cost-Sharing 30 / 60 / 90 Days	Tier 1: Preferred Generic Drugs	\$15 / \$30 / \$15	\$15 / \$30 / \$15	Tier 2: Preferred Brand Drugs	25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45	25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45	Tier 3: Non-Preferred Generic and Brand Drugs	40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80	40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80	Tier 4: * Specialty Generic and Brand Drugs	40% (\$40 min, \$100 max) / N/A / N/A	40% (\$40 min, \$100 max) / N/A / N/A
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Benefit

Cigna-HealthSpring True Choice (PPO)

Coverage Gap

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 **\$4,020**. 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 **\$6,350**, which is the end of the Coverage Gap.

Tier	Standard Retail Cost-Sharing 30 / 60 / 90 Days	Standard Mail Order Cost-Sharing 30 / 60 / 90 Days
Tier 1: Preferred Generic Drugs	\$15 / \$30 / \$15	\$15 / \$30 / \$15
Tier 2: Preferred Brand Drugs	25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45	25% (\$25 min, \$100 max) / 25% (\$50 min, \$200 max) / \$45
Tier 3: Non-Preferred Generic and Brand Drugs	40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80	40% (\$40 min, \$100 max) / 40% (\$80 min, \$200 max) / \$80
Tier 4: * Specialty Generic and Brand Drugs	40% (\$40 min, \$100 max) / N/A / N/A	40% (\$40 min, \$100 max) / N/A / N/A

*Specialty drugs are limited to a 30-day supply

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) have reached **\$6,350**, the plan will pay most of the cost for your drugs. Your share of the cost of covered drugs will be the great of:

5% of the cost

- or -

\$3.60 copay for generic (including brand drugs treated as generic) and

\$8.95 copayment for all other drugs.

Out of Network

For drugs purchased at an out of network pharmacy, you will pay:

The 40% for a 30-day supply plus any amount that the out-of-network pharmacy billed that is higher than our typical standard retail pharmacy billed charges.

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