January 1 – December 31, 2020

EVIDENCE OF COVERAGE Snapshot

Williamson County Government

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Customer of Cigna-HealthSpring True Choice (PPO)

For detailed descriptions of the tables included in this document, please see Chapter 4 and Chapter 6 in your Evidence of Coverage booklet for a detailed description of the tables included in this document. You can view a copy of the Evidence of Coverage online at CignaMedicare.com/group/MAresources.

Please note: This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1, 2020 – December 31, 2020. 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-HealthSpring True Choice (PPO), is offered by Cigna. (When this Evidence of Coverage Snapshot says "we," "us," or "our," it means Cigna. When it says "plan" or "our plan," it means Cigna-HealthSpring True Choice (PPO).

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, 2021.

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

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 document provides you with cost share information for your Medical Benefits and your Part D prescription drugs. For more detailed information please refer to Chapters 4 and 6 of your 2020 Evidence of Coverage.

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

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back page of this document). 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.

SECTION 1. Medical Benefits Chart (what is covered and what you pay)

Benefit	Cigna-HealthSpring True Choice (PPO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
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?	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. Your yearly limit(s) in this plan: $1,500 for services you receive from providers for Medicare-covered benefits. If you reach the limit on out-of-pocket costs, you keep getting 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.

The table below provides you with your medical benefits and cost as a customer of the plan. Please refer to Chapter 4, Section 2 for detailed information on the medical benefits chart below.

 You will see this apple next to the preventive services in the benefits chart.

Medical Services that are covered for you	What you must pay when you get these medical services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a customer whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the customer's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is	Authorization required for non-emergency ambulance services. In-Network and Out-of-Network $0 copayment for each one-way Medicare-covered ambulance trip

Medical Services that are covered for you	What you must pay when you get these medical services
medically required.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you do not need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the annual wellness visit. A separate copay may apply if a non-preventive screening lab test or other non-preventive services are provided at the time of an annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for customers who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Cigna-HealthSpring offers a program for Congestive Heart Failure (CHF) for customers who qualify. Limitations will apply. Cigna-HealthSpring offers a variety of Disease Management (DM) programs, including respiratory disease, for customers who qualify. Limitations will apply.	In-Network and Out-of-Network $10 copayment for each Medicare-covered cardiac rehabilitative therapy visit $10 copayment for each Medicare-covered intensive cardiac rehabilitative therapy visit You will have one copayment when multiple therapies are provided on the same date and at the same place of service.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the intensive behavioral

Medical Services that are covered for you	What you must pay when you get these medical services
(if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position) if you get it from a chiropractor.	In-Network and Out-of-Network $20 copayment for each Medicare-covered chiropractic visit
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years. Certain DNA screenings have Criteria to qualify for testing. Please discuss screening options with your physician. For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy In addition to Medicare-covered colorectal cancer screening exams, we cover Medicare-covered diagnostic exams and any surgical procedures (i.e. polyp removal) during a colorectal screening for a $0 copayment.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Medical Services that are covered for you	What you must pay when you get these medical services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare.	An authorization is required for non-emergency Medicare-covered services. In-Network and Out-of-Network $25 copayment for Medicare-covered dental services
Depression screening We cover one screening for depression per year. The screening must be done a primary care setting that can provide follow-up treatment and referrals.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips • Lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. Note: Syringes and needles are covered under our Part D benefit. Please refer to Chapter 6 of the *Evidence of Coverage* for cost-sharing information.	In-Network and Out-of-Network $0 copayment for preferred brand Medicare-covered diabetes monitoring supplies. Non-preferred brand diabetic test strips, monitors and continuous glucose monitoring devices are not covered. You are eligible for one glucose monitor and one continuous glucose monitoring device every two years. You are also eligible for 200 glucose test strips or three sensors per 30-day period depending on your monitor. $0 copayment for Medicare-covered therapeutic shoes and inserts $0 copayment for Medicare-covered diabetes self-management training

Medical Services that are covered for you	What you must pay when you get these medical services
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital beds, IV infusion pumps, oxygen equipment, nebulizers, and walkers. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at CignaMedicare.com/group/MAresources.	Authorization rules may apply. In-Network and Out-of-Network 10% coinsurance for Medicare-covered items
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services out-of-network is the same as for such services furnished in-network. Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or discharged. Observation services may be given in the emergency department or another area of the hospital. For information about the observation services cost-sharing, please see the Outpatient hospital observation section of this Evidence of Coverage. *Emergency care is covered worldwide.*	In-Network and Out-of-Network $65 copayment for Medicare-covered emergency room visits *$65 copayment for worldwide emergency room visits* *$50,000 (U.S. currency) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories*. Emergency transportation must be medically necessary. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the emergency room visit.
Health and wellness education programs 24 Hour Health Information Line: Use Cigna's 24-Hour Health Information Line to talk one-on-one with a nurse advocate*. We're available every day of the year to provide health-related education, guidance, and support. To access the 24-Hour Health Information Line, call Cigna Customer Service (phone numbers are printed on the back cover of this booklet) and ask to be connected with the 24-Hour Health Information Line. After hours, select the Health Information Line option from the Customer Service phone menu. * These 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 copayment for these health and wellness programs:* *– 24 Hour Health Information Line* *– Membership in Health Club/Fitness Classes*

Medical Services that are covered for you	What you must pay when you get these medical services
The fitness benefit provides several options to help you stay active. You are eligible for a fitness facility membership at a participating fitness location where you can take advantage of exercise equipment location amenities and, where available, group exercise classes tailored to meet the needs of older adults. You will receive orientation to the facility and equipment. If you prefer to exercise in the privacy of your home, you can select from a variety of home fitness kits. You can select up to two home fitness kit options per calendar year. Members may have access to low-impact classes (where available) focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination; one-on-one Lifestyle coaching sessions by phone; online or DVD classes; virtual streaming exercise videos, a quarterly newsletter; web tools; and the mobile app. Non-standard services that call for an added fee are not part of the fitness program and will not be reimbursed.	
Hearing services 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.	In-Network and Out-of-Network $25 copayment for Medicare-covered Hearing Exams. A separate PCP/Specialist cost - share will apply if additional services requiring cost-sharing are rendered.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services	Authorization rules may apply. In-Network and Out-of-Network $0 copayment for Medicare-covered home health visits

Medical Services that are covered for you	What you must pay when you get these medical services
• Medical equipment and supplies	
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. Hospice Consultation You pay the applicable cost-sharing for the provider of the service (for example, physician services). Please refer to the applicable benefit in this section of this *Evidence of Coverage.*
Immunizations Covered Medicare Part B services include:	In-Network and Out-of-Network

Medical Services that are covered for you	What you must pay when you get these medical services
• Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care 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. Our plan covers an unlimited number of days for an inpatient hospital stay. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.	Authorization rules may apply. <u>In-Network and Out-of-Network</u> 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, your copayment is: $0 per admission For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing starting with Day 1 each time you are admitted. Cost-sharing does not apply on day of discharge. If readmitted within 24 hours for the same diagnosis the benefit will continue from original admission. You may not owe any additional copayments. In some instances, readmission within 30-days may result in continuation of benefits from the original admission, pending quality medical review by Cigna. Our plan covers an unlimited number of days for a Medicare-covered hospital stay.

Medical Services that are covered for you	What you must pay when you get these medical services
• Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. • You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 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.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	Authorization rules may apply. In-Network and Out-of-Network 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, your copayment is: $0 per admission For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with Day 1 each time you are admitted. 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. There is a $0 copayment per lifetime reserve day.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the	You pay the applicable cost-sharing for other services as though they were provided on an outpatient basis. Please refer to the applicable benefit in this section of this *Evidence of Coverage.*

Medical Services that are covered for you	What you must pay when you get these medical services
hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity and problem solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Customers of our plan receive coverage for these drugs through our plan. Covered drugs that may be subject to step therapy include:	Authorization rules may apply. In-Network and Out-of-Network

Medical Services that are covered for you	What you must pay when you get these medical services
• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit® and Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.cigna.com/medicare/part-d/drug-list-formulary. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	10% coinsurance for Medicare-covered Part B Chemotherapy drugs and other Part B drugs Medicare Part B drugs may be subject to step therapy requirements.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: ● 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	Authorization rules may apply In-Network and Out-of-Network $0 copayment for Medicare-covered opioid treatment services.
Outpatient diagnostic tests and therapeutic services and supplies	Authorization rules may apply.

Medical Services that are covered for you	What you must pay when you get these medical services
Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	In-Network and Out-of-Network A separate PCP/Specialist cost-share will apply if additional services requiring cost-sharing are rendered. $0 copayment for Medicare-covered diagnostic procedures and tests. $0 copayment for Medicare-covered lab services $0 copayment for Medicare-covered blood services $0 copayment for Medicare-covered diagnostic radiology services (not including X-rays). If multiple test types (such as CT and PET) are performed in the same day, multiple copayments will apply. If multiple tests of the same type (for example, CT scan of the head and CT scan of the chest) are performed in the same day one copayment will apply. $0 copayment for Medicare-covered therapeutic radiology services. $0 copayment for Medicare-covered X-rays. No prior authorization needed for X-rays.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.	Authorization rules may apply In-Network and Out-of-Network $0 copayment for Medicare-covered outpatient hospital observation.

Medical Services that are covered for you	What you must pay when you get these medical services
You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 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.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 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.	Authorization rules may apply. You pay the applicable cost-sharing for these services. Please refer to the applicable benefit in this section of this *Evidence of Coverage*. Self-administered drugs (medication you would normally take on your own) are not covered in an outpatient hospital setting. These drugs may be covered under your Part D benefit. Please contact Customer Service for more information.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Members will be able to access certain providers that offer telehealth services for behavioral health via phone/computer/tablet, etc. enabling easier access to tele-psych services. To find these providers you can visit	Authorization rules may apply. In-Network and Out-of-Network $0 copayment for each Medicare-covered group therapy visit $0 copayment for each Medicare-covered individual therapy visit $0 copayment for each Medicare-covered Telehealth-Behavioral health visit

Medical Services that are covered for you	What you must pay when you get these medical services
https://providersearch.hsconnectonline.com/OnlineDirectory online or call Customer Service (phone numbers are printed on the back cover of this booklet).	
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Authorization rules may apply. In-Network and Out-of-Network $10 copayment for Medicare-covered Occupational Therapy visits $10 copayment for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits You will have one copayment when multiple therapies (such as PT, OT, ST) are provided on the same date and at the same place of service.
Outpatient substance abuse services Covered services include: Substance abuse services, evaluation, and management provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified behavioral health care professional as allowed under applicable state laws.	Authorization rules may apply. In-Network and Out-of-Network $0 copayment for Medicare-covered group substance abuse outpatient treatment visits $0 copayment for Medicare-covered individual substance abuse outpatient treatment visits
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	Authorization rules may apply. In-Network and Out-of-Network $0 copayment for each Medicare-covered outpatient hospital facility visit. $0 copayment for each Medicare-covered ambulatory surgical center visit.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Authorization rules may apply. In-Network and Out-of-Network $25 copayment for Medicare-covered partial hospitalization program services

Medical Services that are covered for you	What you must pay when you get these medical services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including for: Allergies, Cough, Headache, Nausea, and other low-risk illnesses. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. The telehealth benefit is applicable to providers who partner with MD Live for telehealth services. Members will be required to complete registration and a brief medical history upon first use of telehealth and provide applicable copay at time of the telehealth visit. Ease contact MD Live at 1-866-918-7836 or visit the MD Live website at www.MDLive.com/CignaMedicare.com for more information on this benefit. Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can included video. • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor-if you are an established patient and the virtual check-in in not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours-if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment-if you are an established patient. • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of	In-Network and Out-of-Network $15 copayment for each Medicare-covered primary care doctor visit and each Medicare-covered MD Live telehealth doctor visit. $25 copayment for each Medicare-covered specialist visit $15 copayment in a Primary Care Physician office or $25 copayment in a Specialist office for Medicare-covered Other Health Care Professional Service.

Medical Services that are covered for you	What you must pay when you get these medical services
teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Medicare covers services provided by other health providers, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Health professional means— - a physician who is a doctor of medicine or osteopathy; or - a physician assistant, nurse practitioner, or clinical nurse specialist; or - a medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for customers with certain medical conditions affecting the lower limbs	In-Network and Out-of-Network $0 copayment for each Medicare-covered podiatry visit
Post-hospital meals After you are discharged from a hospital stay (for surgery or for a chronic condition), you are eligible to receive 14 nutritional meals delivered to your home, with the goal of making your transition to home more comfortable and safe. Upon discharge from the hospital for a qualified stay, the meal vendor will contact you to determine if you want to access the benefit and set up delivery. The one-time delivery will be packaged in Styrofoam coolers with dry ice and will be delivered free of charge to you .In some cases, the meals will be personally delivered to you by the meal company employee who will be happy to put the meals away for you with your permission. Members are eligible to receive this benefit for up to 3 qualified hospital stays per year. Benefit only applies to discharge during an acute inpatient stay and does not apply to a behavioral health discharge.	*$0 copayment for the post-hospital meal benefit.*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies	Authorization rules may apply. In-Network and Out-of-Network

Medical Services that are covered for you	What you must pay when you get these medical services
Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	10% coinsurance for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for customers who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Cigna-HealthSpring offers a program for Congestive Heart Failure (CHF) for customers who qualify. Limitations will apply. Cigna-HealthSpring offers a variety of Disease Management (DM) programs, including respiratory disease, for customers who qualify. Limitations will apply.	In-Network and Out-of-Network $10 copayment for each Medicare-covered pulmonary rehabilitative therapy visit You will have one copayment when multiple therapies are provided on the same date and at the same place of service.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Medical Services that are covered for you	What you must pay when you get these medical services
subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
🍎 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help customers make informed decisions about their care. For customers with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	Authorization rules may apply for Medicare-covered renal dialysis. In-Network and Out-of-Network $0 copayment for Medicare-covered kidney disease education services $0 copayment for Medicare-covered renal dialysis
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Plan covers up to 100 days each benefit period. No prior hospital stay is required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets	Authorization rules may apply. In-Network and Out-of-Network For Medicare-covered SNF stays, the copayment is: – Days 1-100: $0 copayment per day For each Medicare-covered SNF stay, you are required to pay the applicable

Medical Services that are covered for you	What you must pay when you get these medical services
• Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	cost-sharing, starting with Day 1 each time you are admitted. Cost-sharing applies to day of discharge.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	In-Network and Out-of-Network There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	Authorization rules may apply. In-Network and Out-of-Network $10 copayment for each Medicare covered Supervised Exercise Therapy visit You will have one copayment when multiple therapies are provided by the

Medical Services that are covered for you	What you must pay when you get these medical services
• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	same provider on the same date and at the same place of service.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. *Urgently needed services are covered worldwide.*	In-Network and Out-of-Network $25 copayment for Medicare-covered urgently needed service visit $65 *copayment for worldwide emergency/urgent coverage and worldwide emergency transportation.* *$50,000 (U.S. currency) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories* Emergency transportation must be medically necessary. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the urgently needed services visit.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare does not cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • For people with diabetes, screening for diabetic retinopathy is covered once per year	In-Network and Out-of-Network $0 or $25 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screening and diabetic retinal exam. $25 copayment for all other Medicare-covered vision services.

Medical Services that are covered for you	What you must pay when you get these medical services
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. For more information on your vision benefit, please refer to the Cigna's Customer Handbook or contact Cigna's vision vendor, Superior Vision, at 1-888-886-1995.	A separate PCP/Specialist cost-share will apply if additional services requiring cost-sharing are rendered. $0 copayment for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens)
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

SECTION 2. What you pay for your Part D prescription drugs

Your Costs	Cigna-HealthSpring Rx (PDP)
Monthly Premium	Contact your plan sponsor.
Annual Deductible	$0 / year You need to pay this amount before your Initial Coverage begins.

What you pay for a drug depends on which drug payment state you are in when you get the drug.

Please see Chapter 6, Section 2.1 in your Evidence of Coverage booklet for a detailed description of the table shown below.

Stage 1 *Yearly Deductible Stage*	Stage 2 *Initial Coverage Stage*	Stage 3 *Coverage Gap Stage*	Stage 4 *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you. (Details are in Section 4 of Chapter 6 in your Evidence of Coverage booklet.)	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,020. (Details are in Section 5 of Chapter 6 in your Evidence of Coverage booklet.)	You will continue to pay the same copays/coinsurance as the initial level stage. You stay in this stage until your year-to-date "out of pocket costs" (your payments) reach a total of $6,350. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of Chapter 6 in your Evidence of Coverage booklet.)	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2020). You pay the greater of: • 5% of the cost, or • $3.60 copay for generic (including brand name drugs treated as generic) and an $8.95 copayment for all other drugs. (Details are in Section 7 of Chapter 6 in your Evidence of Coverage booklet.)

Your Medicare Prescription Drug Coverage as a customer of Cigna-HealthSpring True Choice Rx (PPO).

Please see Chapter 6, section 5.2 in your Evidence of Coverage booklet for a detailed description of the table shown below.

Your share of the cost when you get a *one-month* (up to a 30-day or 31-day supply in a network long-term care pharmacy) supply of a covered Part D prescription drug from:

Cost Share Tier	Network pharmacy	The plan's mail-order service	Network long-term care pharmacy	Out-of-network pharmacy*
Tier 1: Preferred Generic Drugs	$15	$15	$15	40%
Tier 2: Preferred Brand Drugs	25% ($25 min, $100 max)	25% ($25 min, $100 max)	25% ($25 min, $100 max)	40%
Tier 3: Non-Preferred Generic and Brand Drugs	40% ($40 min, $100 max)	40% ($40 min, $100 max)	40% ($40 min, $100 max)	40%
Tier 4: Specialty Generic and Brand Drugs	40% ($40 min, $100 max)	40% ($40 min, $100 max)	40% ($40 min, $100 max)	40%

*Coverage is limited to certain situations; see Chapter 5 of the Evidence of Coverage booklet for details.

Please see Chapter 6, Section 5.4 in your Evidence of Coverage booklet for a detailed description of the table shown below.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

Cost Share Tier	Network pharmacy (60-day / 90-day supply)	The plan's mail-order service (60-day / 90-day supply)
Tier 1: Preferred Generic Drugs	$30 / $15	$30 / $15
Tier 2: Preferred Brand Drugs	25% ($50 min, $200 max) / $45	25% ($50 min, $200 max) / $45
Tier 3: Non-Preferred Generic and Brand Drugs	40% ($80 min, $200 max) / $80	40% ($80 min, $200 max) / $80
Tier 4: Specialty Generic and Brand Drugs*	N/A / N/A	N/A / N/A

*Specialty drugs are limited to a 30-day supply

Additional Benefits offered

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 2020 Formulary document for details. The cost share you pay on these drugs do not count toward your annual TrOOP.

Your plan includes the following clinical management edits. Refer to your 2020 Formulary for more information.

Prior Authorization
Quantity Limits
Step Therapy

Method	Customer Service – Contact Information
CALL	1-888-281-7867 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 8:00 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.
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. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-888-766-6403
WRITE	Cigna, Attn: Customer Service, P.O. Box 20002, Nashville, TN 37202 LetUsHelpYou@healthspring.com
WEBSITE	CignaMedicare.com/group/MAresources