

January 1 – December 31, 2021

Evidence of Coverage Snapshot

Williamson County Government

H4513 – 815

For Retirees of **Williamson County Government**

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Cigna Preferred Medicare (HMO)

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](https://www.CignaMedicare.com/group/MAresources).

Please note: This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1, 2021 – December 31, 2021. 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 Preferred Medicare (HMO), 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 Preferred Medicare (HMO).

To get information from us in a way that works for you, please call Member 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, member 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. Member service also has free language interpreter services available for non-English speakers.

[CignaMedicare.com/group/MAresources](https://www.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 2021 Evidence of Coverage.

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<p>Gives the details about which types of medical care are covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.</p>	
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<p>Tells about the three stages of drug coverage. (<i>Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage</i>) and how these stages affect what you pay for your drugs. Explains the 4 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.</p>	

Our service area for Cigna Preferred Medicare (HMO) includes these counties in **Tennessee** : Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Cheatham, Chester, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Fayette, Fentress, Gibson, Giles, Grainger, Grundy, Hamblen, Hamilton, Hardeman, Hardin, Haywood, Henderson, Hickman, Houston, Humphreys, Jackson, Jefferson, Knox, Lauderdale, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Montgomery, Moore, Morgan, Overton, Perry, Pickett, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sumner, Tipton, Trousdale, Union, Van Buren, Warren, Wayne, White, Williamson, Wilson.

If you plan to move out of the service area, please contact Member 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 Preferred Medicare (HMO)
<i>Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services</i>	
How much is the monthly premium?	Please contact your Plan Sponsor. In addition, you must keep paying your Medicare Part B premium.
How much is the medical deductible?	This plan does not have a deductible
How much is the prescription drugs 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. Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart below). This limit is called the maximum out-of-pocket amount for medical services.</p> <p>As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021 is \$3,000. The amounts you pay for copays and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked in <i>italics</i> in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of \$3,000. You will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).</p> <p>Your yearly limit(s) in this plan:</p> <p style="padding-left: 40px;">\$3,000 for services you receive from in-network providers for Medicare-covered benefits.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>

The table below provides you with your medical benefits and cost as a member 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**COVID-19 Coverage and Information**

As Cigna continues to respond to the global spread of COVID-19 your safety and well-being are priorities to us. Visit our **COVID-19 Resource Center at [Cigna.com/Coronavirus](https://www.cigna.com/coronavirus)** for the most up-to-date information on care and coverage (testing, diagnosis, and treatment). Click on the 'Medicare and Medicaid Members' button for Medicare coverage information.

 **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.

There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.

Acupuncture for chronic low back pain

Covered service include:

Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

For the purpose of this benefit, chronic low back pain is defined as:

- Lasting 12 weeks or longer
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease)
- Not associated with surgery; and
- Not associated with pregnancy

An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.

Treatment must be discontinued if the patient is not improving or is regressing.

Authorization rules may apply





\$20 copayment for each Medicare-covered acupuncture visit.




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 member 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 member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

Authorization rules may apply to non-emergency ambulance services.

\$50 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
<p> Annual wellness visit</p> <p>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.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>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.</p>
<p> Bone mass measurement</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members 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.</p> <p>Cigna offers a variety of Disease Management (DM) programs, including respiratory disease, for members who qualify. Limitations will apply.</p>	<p>Authorization rules may apply.</p> <p>\$10 copayment for each Medicare-covered cardiac rehabilitative and intensive cardiac rehabilitative therapy visit</p> <p>You will have one copayment when multiple therapies are provided on the same date and at the same place of service.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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 (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. 	<p>Authorization rules may apply.</p> <p>\$20 copayment for each Medicare-covered chiropractic visit</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years. Certain DNA screenings have criteria to qualify for testing. Please discuss screening options with your physician.</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare.</p>	<p>An authorization is required for non-emergency Medicare-covered services.</p> <p>\$20 copayment for Medicare-covered dental services</p>
<p> Depression screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>
<p>Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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. <p>Note: Syringes and needles are covered under our Part D benefit. Please refer to Chapter 6 of the <i>Evidence of Coverage</i> for cost-sharing information.</p>	<p>Authorization rules may apply</p> <p>\$0 copayment for preferred brand Medicare-covered diabetic monitoring supplies. Non-preferred brand diabetic test strips, monitors and continuous glucose monitoring devices may be covered in medically necessary situations.</p> <p>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.</p> <p>\$0 copayment for Medicare-covered therapeutic shoes and inserts</p> <p>\$0 copayment for Medicare-covered diabetes self-management training</p>
<p>Durable medical equipment and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p>	<p>Authorization rules may apply.</p> <p>20% coinsurance for Medicare-covered items</p>

Medical Services that are covered for you

What you must pay when you get these medical services

Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use

Durable medical equipment and related supplies (cont'd)

in the home, IV infusion pumps, speech generating devices, 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.

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.

\$120 copayment for Medicare-covered emergency room visits

\$120 copayment for worldwide emergency room visits 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 emergency room visit.

If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital.


 **Health and wellness education programs**

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 Cigna's 24-Hour Health Information Line, call 1-866-576-8773 (TTY 711).

\$0 copayment for these health and wellness programs:

- 24 Hour Health Information Line
- HealthWise

Medical Services that are covered for you	What you must pay when you get these medical services
<p>* 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.</p> <p>HealthWise</p> <p>You will have access to video and written content on a variety of health and wellness topics through the Cigna Medicare website.</p>	
<p>Hearing services</p> <p>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.</p>	<p>\$20 copayment for Medicare-covered Hearing Exams.</p> <p>A separate PCP/Specialist cost - share will apply if additional services requiring cost-sharing are rendered.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p>
<p>Home-delivered meals</p> <p>When released from an inpatient hospital stay or skilled nursing facility, you can get 14 healthy frozen meals delivered to your home. You will receive a call from the plan's meal provider to schedule delivery. This benefit is available up to 3 times each year. Releases from an emergency department, observation stay or outpatient visit are not eligible.</p> <p>For more information on your home-delivered meals benefit, please refer to Cigna's Member Handbook or call Member Service (phone numbers are listed on the back cover of this booklet).</p>	<p><i>\$0 copayment for the home-delivered meals benefit.</i></p>
<p>Home health agency care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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) 	<p>Authorization rules may apply.</p> <p>\$0 copayment for Medicare-covered home health visits</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<ul style="list-style-type: none"> • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	
<p>Home Infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. 	<p>You pay the applicable cost sharing for each service obtained. Please refer to the <i>Durable medical equipment and related supplies and Medicare Part B Prescription drugs</i> benefit listings for related cost share benefits.</p>
<p>Hospice care</p> <p>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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> 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.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> 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:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services 	<p>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.</p> <p>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.</p> <p><u>Hospice Consultation</u></p> <p>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 <i>Evidence of Coverage</i>.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<ul style="list-style-type: none"> If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) <p>Hospice care (cont'd)</p> <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> 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.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p> <p>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.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> Pneumonia vaccine Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary 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 <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>
<p>Inpatient hospital care</p> <p>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.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> 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) 	<p>Authorization rules may apply.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>For each Medicare-covered hospital stay, your copayment is:</p> <p>\$200 per admission</p> <p>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-</p>

Medical Services that are covered for you

- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies

Inpatient hospital care (cont'd)

- 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 outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community 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.
- 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/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.

What you must pay when you get these medical services

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 an inpatient hospital stay.

If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a network hospital.



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

Authorization rules may apply.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Medical Services that are covered for you	What you must pay when you get these medical services
<p>psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p>	<p>For each Medicare-covered hospital stay, your copayment is:</p>
Inpatient mental health care (cont'd)	<p>\$200 per admission</p> <p>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.</p> <p>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.</p>
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p>	<p>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 <i>Evidence of Coverage</i>.</p>
<p>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 hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p>	
<ul style="list-style-type: none"> • 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 Services that are covered for you	What you must pay when you get these medical services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>Medical nutrition therapy (cont'd)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs that may be subject to step therapy include:</p> <ul style="list-style-type: none"> • 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 Aranesp®) 	<p>Authorization rules may apply.</p> <p>20% coinsurance for Medicare-covered Part B Chemotherapy drugs and other Part B drugs</p> <p>Medicare Part B drugs may be subject to step therapy requirements.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<ul style="list-style-type: none"> Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>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.</p> <p>Medicare Part B prescription drugs (cont'd)</p> <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>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.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services</p> <p>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:</p> <ul style="list-style-type: none"> 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 	<p>Authorization rules may apply</p> <p>\$20 copayment for Medicare-covered opioid treatment services.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> 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 	<p>Authorization rules may apply.</p> <p>Authorization not required for COVID-19 related testing</p> <p>A facility fee may also apply.</p> <p>0% or 20% coinsurance for Medicare-covered diagnostic procedures and tests. 0% coinsurance for EKG and diagnostic colorectal screenings. 20% coinsurance for all other diagnostic procedures and tests.</p> <p>\$0 copayment for Medicare-covered lab services</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p>Outpatient diagnostic tests and therapeutic services and supplies (cont'd)</p>	<p>\$0 copayment for Medicare-covered blood services</p> <p>0% or 20% coinsurance for Medicare-covered diagnostic radiology services (not including X-rays). \$0 copayment for mammography and ultrasounds. 20% coinsurance for all other diagnostic and nuclear medicine radiological services.</p> <p>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.</p> <p>20% coinsurance for Medicare-covered therapeutic radiology services.</p> <p>20% coinsurance for Medicare-covered X-rays. Authorization not required.</p> <p>\$20 copayment for Medicare-covered X-rays at a specialist office. 20% coinsurance for X-rays performed at all other locations. Authorization not required.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>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.</p>	<p>Authorization rules may apply</p> <p>\$100 copayment for Medicare-covered outpatient hospital observation.</p>

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 <http://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 Member 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 telepsych services. To find these providers you can visit

Authorization rules may apply.


\$0 copayment for each Medicare-covered individual or group therapy visit



\$0 copayment for each Medicare-covered individual or group therapy visit with a psychiatrist


\$0 copayment for each Medicare-covered Telehealth-Behavioral health visit


<p>Medical Services that are covered for you</p>	<p>What you must pay when you get these medical services</p>
<p>https://providersearch.hsconnectonline.com/OnlineDirectory online or call Member Service (phone numbers are printed on the back cover of this booklet). Catasys OnTrak™ is a personalized wellness program for members diagnosed with anxiety, depression, or substance use disorder. The program includes nurse care coaching, counseling, and medical treatment, if recommended.</p>	<p>\$0 copayment for Catasys On Trak™ program.</p>
<p>Outpatient rehabilitation services Covered services include: physical therapy (in-person or virtual), 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).</p>	<p>Authorization rules may apply. \$20 copayment for Medicare-covered Occupational Therapy visits \$20 copayment for Medicare-covered Physical Therapy (in-person or virtual) visits \$20 copayment for Medicare-covered 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.</p>
<p>Outpatient substance abuse services Covered services include: Substance abuse services including Partial Hospitalization Program, Opioid Treatment Programs (OTP), outpatient evaluation, outpatient therapy and medication 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.</p>	<p>Authorization rules may apply. \$10 copayment for Medicare-covered group substance abuse outpatient treatment visits \$20 copayment for Medicare-covered individual substance abuse outpatient treatment visits</p>
<p>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.”</p>	<p>Authorization rules may apply. \$0 to \$100 copayment for each Medicare-covered outpatient hospital facility visit. \$0 copayment for any surgical procedures (i.e. polyp removal) during a colorectal screening. \$20 copayment for non-surgical visits. \$100 copayment for all other Outpatient Services not provided in an Ambulatory Surgical Center. \$0 or \$100 copayment for each Medicare-covered ambulatory surgical center visit. \$0 copayment for any</p>


Medical Services that are covered for you	What you must pay when you get these medical services
	surgical procedures (i.e. polyp removal) during a colorectal screening. \$100 copayment for all other Ambulatory Surgical Center (ASC) services.
<p>Partial hospitalization services</p> <p>“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.</p>	<p>Authorization rules may apply.</p> <p>\$20 copayment for Medicare-covered partial hospitalization program services</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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: allergies, Cough, Headache, Nausea, and other low-risk illnesses. <ul style="list-style-type: none"> ○ You have the option of receiving these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who offers the service by telehealth. ○ The telehealth benefit is applicable to providers who partner with MDLive 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. Please contact MDLive at 1-866-918-7836 (TTY711) or visit the MDLive website at www.MDLive.com/CignaMedicare for more information on this benefit. Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include video. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • Telehealth services for monthly end-stage renal disease-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. 	<p>\$10 copayment for each Medicare-covered primary care doctor visit and each Medicare-covered MD Live telehealth doctor visit.</p> <p>\$20 copayment for each Medicare-covered specialist visit</p> <p>\$10 copayment in a PCP office or \$20 copayment for each Medicare-covered Other Health Care Professional Service.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<ul style="list-style-type: none"> • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other doctors by telephone, internet, or electronic health record 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 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— <ul style="list-style-type: none"> - 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. 	
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medically necessary treatment of injuries and diseases of the feet (such as hammer toe, bunion deformities or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>\$20 copayment for each Medicare-covered podiatry visit</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p>Prosthetic devices and related supplies</p> <p>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.</p>	<p>Authorization rules may apply.</p> <p>20% coinsurance for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members 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.</p> <p>Cigna offers a variety of Disease Management (DM) programs, including respiratory disease, for members who qualify. Limitations will apply.</p>	<p>Authorization rules may apply.</p> <p>\$10 copayment for each Medicare-covered pulmonary rehabilitative therapy visit</p> <p>You will have one copayment when multiple therapies are provided on the same date and at the same place of service.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>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.</p> <p>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</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p>subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members 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) <p>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."</p>	<p>Authorization rules may apply for Medicare-covered renal dialysis.</p> <p>\$0 copayment for Medicare-covered kidney disease education services</p> <p>\$20 copayment for Medicare-covered renal dialysis</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")</p> <p>Plan covers up to 100 days each benefit period. No prior hospital stay is required. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets 	<p>Authorization rules may apply.</p> <p>For Medicare-covered SNF stays, the copayment is:</p> <ul style="list-style-type: none"> – Days 1-20: \$0 copayment per day – Days 21-100: \$50 copayment per day <p>For each Medicare-covered SNF stay, you are required to pay the applicable</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<ul style="list-style-type: none"> • 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 <p>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.</p> <ul style="list-style-type: none"> • 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. 	<p>cost-sharing, starting with Day 1 each time you are admitted. Cost-sharing applies to day of discharge.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> 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.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Special supplemental benefits fro the chronically ill</p> <p>Meals for ESRD Members</p> <p>Plan offers meal delivery to members diagnoses with End-Stage Renal Disease (ESRD) and enrolled in an ESRD-related case management program. Members are eligible for this benefit once each year.</p>	<p>Authorization is required.</p> <p><i>\$0 copayment for 56 meals over 28 days, once each year.</i></p>
<p>Supervised Exercise Therapy (SET)</p>	<p>Authorization rules may apply.</p>

Medical Services that are covered for you	What you must pay when you get these medical services
<p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and are recommended for treatment by the responsible physician. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>\$10 copayment for each Medicare covered Supervised Exercise Therapy visit</p> <p>You will have one copayment when multiple therapies are provided by the same provider on the same date and at the same place of service.</p>
<p>Urgently needed services</p> <p>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.</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p><i>Urgently needed services are covered worldwide.</i></p>	<p>\$20 copayment for Medicare-covered urgently needed service visit</p> <p><i>\$120 copayment for worldwide emergency/urgent coverage and worldwide emergency transportation.</i></p> <p><i>\$50,000 (U.S. currency) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories</i></p> <p>Emergency transportation must be medically necessary.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the urgently needed services visit.</p>
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. 	<p>\$0 or \$20 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</p>

Medical Services that are covered for you

- 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
- 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 Medicare-covered vision benefits, please call Member Service (phone numbers are printed on the back cover of this booklet).

What you must pay when you get these medical services

exam. \$20 copayment for all other Medicare-covered vision services.

A separate PCP/Specialist cost-share will apply if additional services requiring cost-sharing are rendered. (e.g., but not limited to, if a medical eye condition is discovered during a preventive routine eye exam).

For surgical procedures performed in an outpatient surgical center, a separate physician cost share or facility fee may apply

\$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 1. What you pay for your Part D prescription drugs

Your Costs	Cigna Preferred Medicare (HMO)
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. As shown in the table below, there are “drug payment stages” for your prescription drug coverage under our plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>Because there is no deductible for the plan, this payment stage does not apply to you.</p> <p>(Details are in Section 4 of Chapter 6 in your Evidence of Coverage booklet.)</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$4,130.</p> <p>(Details are in Section 5 of Chapter 6 in your Evidence of Coverage booklet.)</p>	<p>You will continue to pay the same copays/coinsurance as the initial level stage.</p> <p>You stay in this stage until your year-to-date “out of pocket costs” (your payments) reach a total of \$6,550. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of Chapter 6 in your Evidence of Coverage booklet.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2021).</p> <p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.70 copay for generic (including brand name drugs treated as generic) and a \$9.20 copayment for all other drugs. <p>(Details are in Section 7 of Chapter 6 in your Evidence of Coverage booklet.)</p>

Your Medicare Prescription Drug Coverage as a member of Cigna Preferred Medicare (HMO).

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	\$10	\$10	\$10	\$10
Tier 2: Preferred Brand Drugs	\$25	\$25	\$25	\$25
Tier 3: Non-Preferred Generic and Brand Drugs	\$50	\$50	\$50	\$50
Tier 4: Specialty Generic and Brand Drugs	\$50	\$50	\$50	\$50

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	\$20 / \$20	\$20 / \$20
Tier 2: Preferred Brand Drugs	\$50 / \$50	\$50 / \$50
Tier 3: Non-Preferred Generic and Brand Drugs	\$100 / \$100	\$100 / \$100
Tier 4:** Specialty Generic and Brand Drugs	N/A / N/A	N/A / N/A

**Specialty drugs are limited to a 30-day supply

Your plan includes the following clinical management edits. Refer to your 2021 Formulary for more information.

Prior Authorization

Quantity Limits

Step Therapy



Method	Member Service – Contact Information
CALL	<p>1-888-281-7867</p> <p>Calls to this number are free. Member 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.</p> <p>Member Service also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Member 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.</p>
FAX	1-888-766-6403
WRITE	<p>Cigna, Attn: Member Service, P.O. Box 20002, Nashville, TN 37202</p> <p>LetUsHelpYou@healthspring.com</p>
WEBSITE	CignaMedicare.com/group/MAresources

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