MedicareRx
Prescription Drug Coverage

July 1, 2021 – June 30, 2022

Evidence Of Coverage Snapshot

LACERA

H0354 – 805

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Customer 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 **www.CignaMedicare.com**.

This booklet gives you the details about your Medicare health care and prescription drug coverage from July 1, 2021 – June 30, 2022. 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 says "we," "us," or "our," it means Cigna. When it says "plan" or "our plan," it means Cigna Preferred Medicare (HMO).

Cigna is contracted with Medicare for HMO, PPO and PDP plans and with select State Medicaid programs. Enrollment in Cigna depends on contract renewal.

This document is available for free in Spanish.

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 July 1, 2022.

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

Please call our customer service number at 1-800-627-7534 (TTY 711), 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.

Cigna

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.

Our service area for Cigna Preferred Medicare (HMO) includes these counties in Arizona: Pinal, the following zip codes only: 85117, 85118, 85119, 85120, 85140, 85143, and 85178, 85220.

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 Preferred Medicare (HMO)
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?	$0 per year for Part D prescription drugs
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: $5,500 for services you receive from in-network 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.

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

Services that are covered for you	**What you must pay** when you get these 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.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening. A separate copay may apply for provider visit or any other non-preventative services.
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	**Authorization rules may apply to non-emergency ambulance services.** $0 copayment for each one-way Medicare-covered ambulance trip

Services that are covered for you	**What you must pay** when you get these services
transportation could endanger the person's health and that transportation by ambulance is 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.	There is no coinsurance, copayment, or deductible for the annual wellness visit. A separate copay may apply if 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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement A separate copay may apply for provider visit or any other non-preventative service.
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	There is no coinsurance, copayment, or deductible for covered screening mammograms. A separate copay may apply for provider visit or any other non-preventative service.
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.	**Referral form your Primary Care Physician (PCP) is required.** $10 copayment for each Medicare-covered cardiac rehabilitation therapy visit. $10 copayment for each Medicare-covered intensive cardiac rehabilitation therapy visit. 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.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	There is no coinsurance, copayment, or deductible for the intensive behavioral

Services that are covered for you	**What you must pay** when you get these services
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 well.	therapy cardiovascular disease preventive benefit. A separate copay may apply for provider visit or any other non-preventative service.
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).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. A separate copay may apply for provider visit or any other non-preventative service.
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	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. A separate copay may apply for provider visit or any other non-preventative service.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation. • In addition, you are also covered for twelve (12) routine chiropractic visits per year. • The routine visits must be medically needed as determined by Cigna's contracted chiropractic administrator, American Specialty Health Network (ASHN). • All Medicare-covered chiropractic services as well as routine chiropractic services are provided by Arizona-licensed chiropractic providers.	**A referral from your PCP is not required for the first routine chiropractic visit. However, your chiropractor must receive authorization from ASHN for your subsequent plan of care.** $12 copayment for each Medicare-covered chiropractic visit *$12 copayment for each routine chiropractic visit, up to 12 visits ever year.*
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)	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. A separate copay may apply for provider visit or any other non-preventative service.

Services that are covered for you	**What you must pay** when you get these services
• 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.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. • Medicare-covered dental services and procedures.	**Authorization is required for non-emergency Medicare-covered services.** **Referral from your Primary Care Physician (PCP) is required for Medicare-covered dental services.** $12 copayment for each Medicare-covered visit.
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.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. A separate copay may apply for provider visit or any other non-preventative service.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. A separate copay may apply for provider visit or any other non-preventative service.

Services that are covered for you	**What you must pay** when you get these services
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 this *Evidence of Coverage* for cost-sharing information.	**Referral from your Primary Care Physician (PCP) is required for diabetes self-management training** $0 copayment for Medicare-covered preferred brand diabetic test strips, monitors and continuous glucose monitoring devices. Non-preferred brand diabetic test strips, monitors and continuous glucose monitoring devices may be covered in medically necessary situations. 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
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, powered mattress systems, diabetic supplies, and hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME 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 www.CignaMedicare.com.	**Authorization rules may apply.** $0 copayment 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.	$90 copayment for Medicare covered emergency room visits. $90 copayment *for worldwide emergency room visits and worldwide emergency transportation*

Services that are covered for you	**What you must pay** when you get these services
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.	*$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 cost–sharing you would pay at a network hospital.
Health and wellness education programs The Cigna Health Information Line is always open. Call any hour of the day or night, any day of the year, for helpful answers and reliable information on a wide variety of topics. Or call to listen to recorded audio tapes from our Health Information Library. The toll-free number is 1-800-356-0665. 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 exercise 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	*$0 copayment for these health and wellness programs:* *-Cigna Health Information Line* *- Membership in Health Club/Fitness Classes*
Hearing services	**Referral from your Primary Care Physician (PDP) is required for Medicare-covered hearing exams.**

Services that are covered for you	**What you must pay** when you get these 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. Supplemental benefits cover: • up to one routine hearing exam every year • fitting evaluation for a hearing aid(s) • hearing aid(s) Hearing aid evaluations are part of the routine hearing exam. Multiple fittings are allowed if necessary to ensure hearing aids are accurately fitted.	$12 copayment for each Medicare-covered hearing exam. *$0 copayment for each routine hearing exam* $0 copayment for hearing aids fitting and evaluation visits. You are also eligible to receive a $200 allowance per hearing aid. *Out of pocket costs for hearing aids do not count toward your annual maximum out-of-pocket amount.*
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	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening. A separate copay may apply for provider visit or any other non-preventative service.
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 • Medical equipment and supplies	**Authorization rules may apply.** **Referral from your Primary Care Physician (PDP) is required.** $0 copayment for Medicare-covered home health services
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	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

Services that are covered for you	**What you must pay** when you get these services
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 <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. <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: • 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) <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. <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 *(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. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	paid for by Original Medicare, not our plan. You must get care from a Medicare-certified hospice. <u>Hospice Consultation</u> 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: • 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, such as the shingles vaccine.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. A separate office visit copay may apply.

Services that are covered for you	**What you must pay** when you get these services
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. Please contact your transplant case manager to determine what expenses (including travel and lodging expenses) Cigna will cover. For more information (including limitations, restrictions and exclusions) you can visit the Cigna LifeSOURCE website at www.cignalifesource.com or call 1-800-668-9682 (TTY: 711), Monday through Friday, 8:00 am to 6:00 pm, Eastern Standard Time. • 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	**Authorization rules may apply.** Except in 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 copayment 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 72 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 inpatient hospital days per benefit period. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
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 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	**Authorization rules may apply.** 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 copayment 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.
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 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	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.*

Services that are covered for you	**What you must pay** when you get these services
• 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.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services. A separate copay may apply for provider visit or any other non-preventative service.
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit. A separate copay may apply for provider visit or any other non-preventative service.
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 include: • 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	**Authorization rules may apply.** 20% coinsurance for oral Medicare-covered Part B drugs including oral chemotherapy. $0 copayment for all other Medicare-covered Part B drugs including non-oral chemotherapy.

Services that are covered for you	**What you must pay** when you get these services
• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 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.	
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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. A separate copay may apply for provider visit or any other non-preventative service.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Customers under 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.** $12 copayment for Medicare-covered opioid treatment services.
Outpatient diagnostic tests and therapeutic services and supplies 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	**Authorization rules may apply. Referral from your physician is required.** A separate PCP/Specialist cost share may apply if certain additional services requiring cost-sharing are rendered during the visit. $0 copayment for Medicare-covered diagnostic procedures and tests. $0 copayment for Medicare-covered lab services. $0 copayment for Medicare-covered blood services.

Services that are covered for you	**What you must pay** when you get these services
Please note: Not all high-tech radiological procedures are available at the CMG. In the event CMG does not perform a specific procedure requested, you will be referred to a contracted high-tech radiological facility.	$0 to $125 copayment for Medicare-covered diagnostic radiology services (not including X-rays). $0 copayment for mammograms, ultrasounds and non-cardiac nuclear studies. $12 copayment or each cardiac nuclear studies and routine stress tests. $125 copayment for all other diagnostic radiological services. 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. $12 copayment for Medicare-covered therapeutic radiology services. $0 copayment for Medicare-covered X-rays. Authorization not required.
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 by state licensure law and hospital staff bylaws to admit patients to be 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. You can 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-	**Authorization rules may apply.** **Referral from your Primary Care Physician (PCP) may be required** $12 copayment for Medicare-covered outpatient hospital observation.

Services that are covered for you	**What you must pay** when you get these services
MEDICARE (1-800-633-4227). TYY 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 • Chemotherapy treatment **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/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.	**Authorization rules may apply.** **Referral from your Primary Care Physician (PCP) may be required.** 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. Customers 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, call Customer Service (phone numbers are printed on the back cover of this booklet).	**Authorization rules may apply**. $12 copayment for each Medicare-covered individual or group therapy visit. $12 copayment for each Medicare covered Telehealth Behavioral health visit.
Outpatient rehabilitation services	**Authorization rules may apply.** **Referral from your Primary Care**

Services that are covered for you	**What you must pay** when you get these 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).	**Physician (PCP) is required.** $12 copayment for Medicare covered Occupational Therapy visits $12 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, addictionologists or other Medicare-qualified behavioral health care professional as allowed under applicable state laws.	**Authorization rules may apply** $12 copayment for each Medicare-covered individual or group 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. Referral from your Primary Care Physician (PCP)/Specialist is required for Outpatient surgical services and non-surgical visits.** $0 or $12 copayment for each Medicare-covered outpatient hospital facility visit. $0 for any surgical procedures (i.e., polyp removal) during a colorectal screening. $12 copayment for all other outpatient surgical services not provided in an Ambulatory Surgical Center. $0-$12 copayment for each Medicare-covered ambulatory surgical center visit. $0 copayment for any surgical procedures (i.e., polyp removal) during a colorectal screening. $12 copayment for all other Ambulatory Surgical Center (ASC) services.

Services that are covered for you	**What you must pay** when you get these services
	Please note surgical procedures performed at the CMG are limited. In the event the CMG cannot perform a specific procedure, you will be referred to a contracted surgical center.
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. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	**Authorization rules may apply.** $12 copayment for each Medicare covered partial hospitalization visit.
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 MDLive for telehealth services. Customers 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 1-866-301-8658 or visit the MDLive website at www.MDLive.com/CignaMedicareAZ for more information on this benefit. Electronic exchange can be by smartphone, regular telephone, computer, or tablet and can include 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 is	**Authorization rules may apply for Medicare-covered specialist visits.** $0 copayment for each Medicare-covered primary care doctor visit and each Medicare-covered MDLive telehealth doctor visit. $12 copayment for Medicare-covered specialist visit. $0 copayment in a Primary Care Physicians office or $12 copayment in a Specialist office for Medicare-covered Other Health Care Professional Service.

Services that are covered for you	**What you must pay** when you get these services
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 with 24 hour-if you are an established patient and the remote evaluation is not related to an office visit within the 7 previous 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 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	**Authorization rules may apply.** **Referral from your Primary Care Physician (PCP) is required for certain podiatry services.** $12 copayment for each Medicare-covered podiatry visit. $12 copayment for each supplemental routine 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	*$0 copayment for the post-hospital meal benefit*

Services that are covered for you	**What you must pay** when you get these services
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.	
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	There is no coinsurance, copayment, or deductible for an annual PSA test. A separate copay may apply for provider visit or any other non-preventative service.
Prosthetic devices and related supplies 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. Please see Section 3.1 for a list of exclusions.	**Authorization rules may apply.** $0 copayment for Medicare-covered prosthetics and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for customers who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**Referral from your Primary Care Physician (PCP) is required.** $10 copayment for each Medicare-covered pulmonary rehabilitative therapy visit. 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.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. A separate copay may apply for provider visit or any other non-preventative service.

Services that are covered for you	**What you must pay** when you get these services
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 customers 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. A separate copay may apply for provider visit or any other non-preventative service.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit. A separate copay may apply for provider visit or any other non-preventative service.
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)	**Authorization rules may apply for Medicare-covered renal dialysis. Referral from your Primary Care Physician (PCP) is required.** $0 copayment for Medicare-covered kidney disease education services. $12 copayment for Medicare-covered renal dialysis

Services that are covered for you	**What you must pay** when you get these services
• 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."	
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.") You are covered for 100 days in a skilled nursing facility each benefit period. You do not have to stay in a hospital first in order for your SNF stay to be covered. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • 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. • 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.	**Authorization rules may apply.** 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 cost-sharing, starting with day 1 each time you are admitted. Cost-sharing does not apply on day of discharge.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	There is no coinsurance, copayment, or deductible for the Medicare-covered

Services that are covered for you	**What you must pay** when you get these services
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.	smoking and tobacco use cessation preventive benefits. A separate copay may apply for provider visit or any other non-preventative service.
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: ●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.	**Authorization rules may apply. Referral from your Primary Care Physician (PCP) is required.** $10 copayment for each Medicare covered Supervised Exercise Therapy visit 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.
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.	$25 copayment for Medicare-covered urgently needed service visit *$90 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.

Services that are covered for you	**What you must pay** when you get these services
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. However, this plan covers one (1) supplemental routine eye exam (including eye refraction) per year. Eye refractions outside of the annual supplemental routine eye exams are not covered • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • 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.) • Eyeglasses and frames or contact lenses up to the plan allowance amount. Supplemental annual eyewear allowance applied to the retail value only. Applicable taxes are not covered. Unused balance of the allowance amount does not carry forward to future benefit years. Medically needed eyewear must be obtained from a Cigna Medical Group Vision Center. Medically needed eyewear obtained from a non-contracted provider is not covered. Routine eye exams must be obtained from the Cigna Medical Group. Routine eye exams obtained from other than a Cigna Medical Group vision center are not covered.	**Authorized rules may apply for medically necessary eyewear. Referral is required for medically needed eye exam and is required to see an Ophthalmologist. Referral is not required to see an Optometrist** $0 or $12 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 screenings and diabetic retinal exams. $12 copayment for all other Medicare-covered vision services A separate office visit copayment may 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). *$0 copayment for one routine eye exam every year* *$0 copayment up to the eyewear allowance for* • *Up to one pair of eyeglasses (lenses and frames) every year* • *Contact lenses (one every year)* • *Upgrades* $50 allowance every year from a Cigna Medical Group Vision Center. Members are responsible for all costs over and above the allowance amount.
"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.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit

Services that are covered for you	**What you must pay** when you get these services
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.	A separate copay may apply for provider visit or any other non-preventative service.

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

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. Please see Chapter 6, Section 2.1 in your *Evidence of Coverage* booklet for a detailed description of the table 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 this chapter.)	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 $4,130. (Details are in Section 5 of this chapter.)	You will pay the same cost share for Tiers 1 - 4 as you paid during the initial coverage stage and you will pay 25% for Tier 5. 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. (Details are in Section 6 of this chapter.)	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). (Details are in Section 7 of this chapter.)

Your share of the cost when you get a *one-month* (30-day) supply (or less) of a covered Part D prescription drug from:

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.

Cost-Sharing	Network pharmacy	The plan's mail-order service	Network long-term care pharmacy	Out-of-network pharmacy
Tier 1 (Preferred Generic Drugs)	$0	$0	$0	$0
Tier 2 (Generic Drugs)	$10	$10	$10	$10
Tier 3 (Preferred Brand Drugs)	$45	$45	$45	$45
Tier 4 (Non-Preferred Drugs)	$95	$95	$95	$95
Tier 5 (Specialty Generic & Brand Drugs)	33%	33%	33%	33%

Your share of the cost when you get a *long-term* (up to a 90-day) supply of a covered Part D prescription drug from:

Cost-Sharing	Network pharmacy (60-day / 90-day supply)	The plan's mail-order service (60-day / 90-day supply)
Tier 1 (Preferred Generic Drugs)	$0 / $0	$0 / $0
Tier 2 (Generic Drugs)	$20 / $30	$20 / $30
Tier 3 (Preferred Brand Drugs)	$90 / $135	$90 / 135
Tier 4 (Non-Preferred Drugs)	$190 / $285	$190 / $185
Tier 5 (Specialty Generic & Brand Drugs)	N/A	N/A

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

Prior Authorization
Quantity Limits
Step Therapy

Cigna-HealthSpring Customer Service

Method	Customer Service – Contact Information
CALL	1-800-627-7534 Calls to this number are free. Customer Service is available October 1 – March 31, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (a voicemail system is available on weekends and 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, seven days a week, 8 a.m. – 8 p.m. local time. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time (voicemail system is available on weekends and holidays).
WRITE	Cigna Medicare Services Attn: Medicare Customer Service PO Box 29030 Phoenix, AZ 85038
WEBSITE	www.cignahealthspring.com

State Health Insurance Assistance Program (Arizona SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-432-4040
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	State Health Insurance Assistance Program Department of Economic Security, Division of Aging and Adult Services (DAAS) 1789 W. Jefferson, Site Code 950A Phoenix, AZ 85007
WEBSITE	https://des.az.gov/services/aging-and-adult/statehealth-insurance-assistanceprogram-ship

SUMMARY OF BENEFITS

2021-2022
July 1, 2021 to
June 30, 2022

Cigna Preferred Medicare (HMO)
Lacera
H0354 / 805

No referrals required

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

Our service area includes the following counties:
Arizona: Maricopa county, AZ (Full county) Pinal county, AZ (select zip codes – 85117, 85118, 85119, 85120, 85140, 85143, 85178, 85220)

Introduction

What's Inside

This Summary of Benefits gives you a summary of what **Cigna Preferred Medicare (HMO)** covers and what you pay. This information is not a complete description of benefits. Call 1-800-627-7534 (TTY 711) for more information. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage (EOC) Snapshot* online at myCigna.com or call us to request a copy.

Comparing coverage
If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or, use the Medicare Plan Finder on www.medicare.gov.

More about Original Medicare
If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Need help?
Call toll-free **1-800-627-7534 (TTY 711).** Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call during weekends, after hours, and on federal holidays.

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

1 About this plan

Which doctors, hospitals and pharmacies can I use?
Cigna Preferred Medicare (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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

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

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

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

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

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

❷ Monthly Premium, Deductible & Limits

Benefit	Cigna Preferred Medicare (HMO)
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?	**$0** per year for medical services.
How much is the Prescription Drugs Deductible?	**$0** per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Original Medicare does not have annual limits on out-of-pocket costs. Your yearly limit(s) in this plan: **$5,500** for services you receive from in-network providers for Medicare-covered benefits. This limit is the most you pay for copays, coinsurance and other costs for Medicare services for the year. If you reach the limit on out-of-pocket costs, you keep getting in-network covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

❸ Covered Medical & Hospital Benefits

Benefit	What you Pay
Note: Services with a [1] may require prior authorization.	
Inpatient Hospital Coverage[1]	
Our plan covers an unlimited number of days for an inpatient hospital stay.	**$0** per admission
Outpatient Hospital Coverage	
Ambulatory Surgical Center (ASC)[1]	**$ 0 or $12** copay
Outpatient Services[1]	**$ 0 or $12** copay
Outpatient Observation[1]	**$12** copay
Doctors Visits[1]	
Primary Care Physician	**$0** copay
Specialists	**$12** copay
Preventive Care	
Our plan covers many Medicare-covered preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Lung cancer screening with low dose computed tomography (LDCT). • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit	**$0** copay Any additional preventive services approved by Medicare During the contract year will be covered. Please see your *Evidence of Coverage* (EOC) for frequency of covered services.

Benefit	What you Pay
Emergency Care	
Emergency Care Services	**$90** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$90** copay Maximum worldwide coverage amount **$50,000**
Urgently Needed Services	
Urgent Care Services	**$25** copay
Diagnostic services, Labs & Imaging *(Costs for these services may vary based on place of service or type of service)*	
Diagnostic Procedures and Tests[1]	**$0** copay
Lab Services[1] For COVID-19 testing a prior authorization is not required.	**$0** copay
Therapeutic Radiological Services[1]	**$12** copay
X-ray Services[1]	**$0** copay
Diagnostic Radiological Services (such as MRIs, CT Scans)[1]	**$0 – $125** copay
Hearing Services	
Hearing Exams (Medicare-covered)	**$12** copay in a Primary Care Physician Office **$12** copay in a Specialist office
Routine Hearing Exams	**$0** copay for one routine exam every year
Hearing Aid Evaluation/Fitting	**$0** copay
Hearing Aids	**$0** copay up to plan maximum coverage amount for hearing aids of $200 per ear per device every three years.
Dental Services	
Dental Services (Medicare-Covered)[1]	**$12** copay Limited dental services (this does not included services in connection with care, treatment, filling, removal, or replacement of teeth).
Vision Services	
Eye Exams (Medicare-covered)	**$12** copay
Routine Eye Exam	**$0** copay for one routine exam every year
Glaucoma Screening (Medicare-covered)	**$0** copay
Eyewear (Medicare-covered)	**$0** copay
Routine Eyewear Eyeglasses-lenses and frames (one every year) Eyeglass lenses (one every year) Eyeglass frames (one every year) Contact Lenses (unlimited) Upgrades	**$0** copay up to plan maximum coverage amount $50 every year

Benefit	What you Pay
Mental Health Services	
Inpatient[1] Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Our plan also covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.	**$0** per admission
Outpatient[1] Individual or Group Therapy Visit	**$12** copay
Skilled Nursing Facility *(SNF)*[1]	
Our plan covers up to 100 days in the SNF.	**$0** per day for days 1–100
Rehabilitation Services	
Cardiac (heart) Rehab Services[1]	**$10** copay
Pulmonary Rehab Services[1]	**$10** copay
Occupational Therapy Services[1]	**$12** copay
Physical Therapy and Speech and Language Therapy Services[1]	**$12** copay
Ambulance[1]	
Ground Service (one-way trip)	**$0** copay
Air Service (one-way trip)	**$0** copay
Transportation[1]	
Members are required to coordinate with Cigna vendors for transportation to plan-approved locations at least 48 hours in advance. Mileage restrictions may apply. See *Evidence of Coverage Snapshot* for full details and restrictions related to benefit.	Not Covered
Prescription Drugs	
Medicare Part B Drugs[1] Medicare-covered Part B Drugs may be subject to step therapy requirements.	**20%** coinsurance for oral Part B including oral chemotherapy drugs $0 for all other Part B drugs. This plan has Part D prescription drug coverage. See Section 4 in this *Summary of Benefits*.
Foot Care *(Podiatry Services)*	
Medicare-covered Podiatry Services	**$12** copay
Routine Podiatry Services	$12 copay
Medical Equipment & Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc)[1]	**$0** copay
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**$0** copay
Diabetes Supplies & Services Brand limitations apply to certain supplies.	**$0** copay for Diabetes self-management training **$0** copay of the cost for therapeutic shoes or inserts **$0** copay for diabetic monitoring supplies

Benefit	What you Pay
Fitness & Wellness Programs	
Fitness Program Program offers a fitness center membership and home fitness program in addition to enhanced technology options and senior lifestyle coaching.	**$0** copay
Health Information Line	
Talk one-on-one with a Nurse Advocate to get timely answers to your health-related questions at no additional cost, anytime day or night.	**$0** copay
Chiropractic Care	
Chiropractic Services (Medicare-covered)	**$12** copay
Chiropractic Services (Routine)	$12 copay up to 12 visits per year
Home Health Care[1]	
	$0 copay
Hospice	
Hospice care must be provided by a Medicare-certified hospice program Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.	$0
Outpatient Substance Abuse[1]	
Individual or Group Therapy Visit	**$12** copay
Opioid Treatment Services[1]	
FDA-approved treatment medications in addition to testing, counseling and therapy.	**$12** copay
Home Delivered Meals	
	$0 copay for home delivered meals Limited to 14 meals per discharge from qualified hospital stay or skilled nursing facility (up to three stays per year)
Telehealth Services *(Medicare-Covered)*	
For nonemergency care, you can talk with an MDLIVE doctor via phone or video for certain telehealth services, including: allergies, cough, headache, sore throat and other low-risk illnesses.	$0 copay
Acupuncture	
Acupuncture Services (Medicare-covered)[1] Services for chronic lower back pain.	**$12** copay
Supplemental Acupuncture Services	Not Covered

❹ Prescription Drug Benefits

Benefit	Cigna Preferred Medicare (HMO)
Prescription Drug Benefits	
Medicare Part D Drugs Initial Coverage (after you pay your deductible, if applicable) **Tier 1:** Preferred Generic Drugs **Tier 2:** Generic Drugs **Tier 3:** Preferred Brand Drugs **Tier 4:** Non Preferred Drugs **Tier 5**: Specialty Drugs	The following chart shows the cost-sharing amounts for covered drugs under this plan. After you pay your yearly deductible (if applicable), you pay the following until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and our plan.

Tier	Standard Retail Cost-Sharing 30 / 60 / 90 Days	Standard Mail Order Cost-Sharing 30 / 60 / 90 Days
1	$0 / $0 / $0	$0 / $0 / $0
2	$10 / $20 / $30	$10 / $20 / $30
3	$45 / $90 / $135	$45 / $90 / $135
4	$95 / $190 / $285	$95 / $190 / $285
5*	33% / N/A / N/A	33% / N/A / N/A

*Specialty drugs are limited to a 30-day supply

Your costs may be different if you qualify for Extra Help. Your copay or coinsurance is based on the drug tier for your medication, which you can find in the Plan Prescription drug List (Formulary) included in this mailing or on our website myCigna.com. Or, call us and we will send you a copy of the formulary.

<table>
<tr><th>Benefit</th><th>Cigna Preferred Medicare (HMO)</th></tr>
<tr><td>Coverage Gap

Tier 1: Preferred Generic Drugs
Tier 2: Generic Drugs
Tier 3: Preferred Brand Drugs
Tier 4: Non Preferred Drugs
Tier 5: Specialty Drugs</td><td>Most Medicare drug plans have a coverage gap (also called the “Donut Hole”). This means that there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay the amounts in the table below for covered drugs until your costs total $6,550, which is the end of the Coverage Gap.
<table>
<tr><th>Tier</th><th>Standard Retail Cost-Sharing 30 / 60 / 90 Days</th><th>Standard Mail Order Cost-Sharing 30 / 60 / 90 Days</th></tr>
<tr><td>1</td><td>$0 / $0 / $0</td><td>$0 / $0 / $0</td></tr>
<tr><td>2</td><td>$10 / $20 / $30</td><td>$10 / $20 / $30</td></tr>
<tr><td>3</td><td>$45 / $90 / $135</td><td>$45 / $90 / $135</td></tr>
<tr><td>4</td><td>$95 / $190 / $285</td><td>$95 / $190 / $285</td></tr>
<tr><td>5*</td><td>25% / N/A / N/A</td><td>25% / N/A / N/A</td></tr>
</table>
*Specialty drugs are limited to a 30-day supply</td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) have reached $6,550, the plan will pay most of the cost for your drugs. Your share of the cost of covered drugs will be the greater of:

5% of the cost

- or -

$3.70 copay for generic (including brand drugs treated as generic) and
$9.20 copayment for all other drugs.</td></tr>
<tr><td>Out-of-Network</td><td>If you get your drug at an out-of-network pharmacy, you will pay the same cost-share you would pay for a 30-day supply at an in-network retail pharmacy. If you reside in a long-term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.</td></tr>
</table>

Benefit	Cigna Preferred Medicare (HMO)
Your plan includes the following clinical management edits. Refer to your 2022 Formulary for more information.	
Prior Authorization	
Quantity Limits	
Step Therapy	
*	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a month supply.
+	Quantity limitations, prior authorization, and step therapy always apply for drugs with this symbol.
HRM PA	This high risk medication requires prior authorization
D/E PA	This prescription drug requires prior authorization. This drug may be covered under Medicare Part D depending on conditions.
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on conditions.
LA	Limited Availability drug. This drug may be available only at certain pharmacies.