SUMMARY OF BENEFITS

January 1, 2019 - December 31, 2019

Cigna-HealthSpring Preferred Direct (HMO) H9725-001

Our service area include the following counties:

North Carolina: Alexander, Cabarrus, Catawba, Cleveland, Davidson, Davie, Forsyth, Gaston, Guilford, Iredell, Lincoln, Polk, Rowan, Stokes, Union and Yadkin counties, NC

Together, all the way.®

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INTRODUCTION TO SUMMARY OF BENEFITS

This *Summary of Benefits* gives you a summary of what **Cigna-HealthSpring Preferred Direct (HMO)** covers and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage* (EOC) online at **www.CignaHealthSpring.com**, or call us to request a copy.

What's Inside

1. About **Cigna-HealthSpring Preferred Direct (HMO)**
2. Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
3. Covered Medical & Hospital Benefits
4. Prescription Drug Benefits
5. Optional Supplemental Benefits (you must pay an additional premium for these benefits)

Tips for comparing your Medicare choices

- If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits*. Or, use the Medicare Plan Finder on **www.medicare.gov**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Cigna-HealthSpring Preferred Direct (HMO) Phone Numbers and Website

- If you are already a customer of this plan, call toll-free **1-800-668-3813 (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, Saturday 8 a.m. – 5 p.m. local time. Messaging service used weekends, after hours and on federal holidays.
- If you are not a customer of this plan, call toll-free **1-855-980-3049 (TTY 711)**, 7 days a week, 8 a.m. – 8 p.m. to speak with a licensed agent.
- Our website: **www.CignaHealthSpring.com**.

1 ABOUT CIGNA-HEALTHSPRING PREFERRED DIRECT (HMO)

Who can join?

To join **Cigna-HealthSpring Preferred Direct (HMO)**, 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:

North Carolina: Alexander, Cabarrus, Catawba, Cleveland, Davidson, Davie, Forsyth, Gaston, Guilford, Iredell, Lincoln, Polk, Rowan, Stokes, Union and Yadkin counties, NC

Which doctors, hospitals and pharmacies can I use?

Cigna-HealthSpring Preferred Direct (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, **www.CignaHealthSpring.com**.
- Or, call us and we will send you a copy of the *Provider and Pharmacy Directory*.

What do we cover?

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

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

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

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

How will I determine my drug costs?

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

2 MONTHLY PREMIUM, DEDUCTIBLE & LIMITS

Benefit	Cigna-HealthSpring Preferred Direct (HMO)
Monthly Premium, Deductible and Limits	
Monthly Premium	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**$300** per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2 and Tier 3 which are excluded from the deductible.
Referrals	This plan does not require referrals to see in-network specialist.
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: **$6,700** 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 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.

3 COVERED MEDICAL & HOSPITAL BENEFITS

Benefit	What You Pay	What You Should Know
Covered Medical and Hospital Benefits **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.	**$295** copay per day: Days 1 through 6 **$0** copay per day: Days 7 through 90	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-HealthSpring.
Outpatient Surgery		
Ambulatory Surgical Center (ASC)[1]	**$0** for any surgical procedures (i.e. polyp removal) during a colorectal screening. **$295** for all other Ambulatory Surgical Center (ASC) services.	
Outpatient Services & Observation[1]	**$0** for any surgical procedures (i.e. polyp removal) during a colorectal screening. **$295** for all other Outpatient Services including observation and outpatient surgical services not provided in an Ambulatory Surgical Center.	
Doctors' Visits		
Primary Care Physician (PCP)	**$0** copay	
Specialists[1]	**$40** copay	

Benefit	What You Pay	What You Should Know
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 screening (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 • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots and 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.
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.

Benefit	What You Pay	What You Should Know
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$90** copay	**$50,000** (U.S. currency) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.
Urgently Needed Services		
Urgent Care Services	**$55** copay	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.
Diagnostic Services, Labs & Imaging *(Costs for these services may vary based on place of service)*		
Diagnostic Procedures and Tests[1]	**$0** for EKG. **$275** for all other diagnostic procedures and tests.	
Lab Services[1]	**$0** copay	
Therapeutic Radiological Services[1]	**20%** coinsurance	
X-ray Services	**$20** copay	
Diagnostic Radiological Services (such as MRIs, CT Scans)[1]	**$0** copay for mammography and ultrasounds. **$275** copay for all other diagnostic and nuclear medicine radiological services.	If multiple test types (such as CT and PET) are performed on 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 on the same day, one copayment will apply.
Hearing Services		
Hearing Exams (Medicare-covered)	**$0** copay in a Primary Care Physician office; **$40** copay in a Specialist office	
Routine Hearing Exams (one every year)	**$0** copay	

Benefit	What You Pay	What You Should Know
Hearing Aid Evaluation/Fitting (one every three years)	**$0** copay	Hearing aid evaluations are part of the routine hearing exam once every three years. Multiple fittings are allowed if necessary to ensure hearing aids are accurately fitted.
Hearing Aids (one every three years)	**$0** copay up to plan maximum coverage amount of **$700** per ear per device every three years	
Dental Services		
Dental Services (Medicare-covered)[1] This plan offers additional dental benefits as an Optional Supplemental Benefit. See section 5 - ''Optional Supplemental Benefits'' for details.	**$40** copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)
Preventive Dental Services: • Oral exam (one every six months) • Cleaning (one every six months) • Bitewing x-ray (one every year) • Full mouth & panoramic x-ray (one every 36 months)	**$0** copay	Frequency limits vary depending on the type of covered service.
Vision Services		
Eye Exams (Medicare-covered)	**$0** copay for diabetic retinal exams. **$40** copay for all other Medicare-covered vision services.	
Routine Eye Exam (one every year)	**$0** copay	
Eyewear (Medicare-covered)	**$0** copay	
Routine Eyewear • Eye Glasses (Lenses and Frames) (one every year) • Eye Glass Lenses (one every year) • Eye Glass Frames (one every year) • Contact Lenses (unlimited) • Upgrades	**$0** copay up to plan maximum coverage amount of **$150** every year	The plan specified allowance may be applied to one set of choice eyewear for the member, to include the eyeglass frame/lenses/lens options combination or contact lenses (to include related professional fees) in lieu of eyeglasses.

Benefit	What You Pay	What You Should Know
Mental Health Services		
Inpatient[1]: Our plan covers 90 days for an inpatient psychiatric hospital stay. Our plan also covers 60 lifetime reserve days. The plan covers 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**$275** copay per day: Days 1 through 6 **$0** copay per day: Days 7 through 90	
Outpatient[1]: Individual or Group Therapy Visit	**$40** copay	
Skilled Nursing Facility *(SNF)*[1]		
Our plan covers up to 100 days in the SNF.	**$0** copay per day: Days 1 through 20 **$172** copay per day: Days 21 through 100	
Rehabilitation Services		
Cardiac (heart) Rehab Services	**$10** copay	
Pulmonary Rehab Services	**$10** copay	
Occupational Therapy Services[1]	**$40** copay	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.
Physical Therapy and Speech and Language Therapy Services[1]	**$40** copay	
Ambulance[1]		
Ground Service (one-way trip)	**$235** copay	
Air Service (one-way trip)	**20%** coinsurance	
Transportation[1]		
	$0 for 24 one-way trips to plan-approved locations per year.	

Benefit	What You Pay	What You Should Know
Prescription Drugs[1]		
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: **20%** coinsurance	This plan has Part D prescription drug coverage. See Section 4.
Foot Care *(Podiatry Services)*		
Medicare-Covered Podiatry Services	**$40** copay	
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**20%** coinsurance	
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**20%** coinsurance	
Diabetes Supplies & Services	**$0** copay for diabetes self-management training **20%** coinsurance for therapeutic shoes or inserts **0%** or **20%** of the cost, depending on the supply for diabetes monitoring supplies	Preferred brands diabetic test strips and monitors covered at **$0** cost share; Non-preferred brands not covered. **20%** coinsurance applies to other monitoring supplies (e.g.: Lancets). You are eligible for one glucose monitor every two years and 200 glucose test strips per 30-day period.
Fitness & Wellness Programs		
Fitness Program	**$0** copay	Basic gym membership at a participating fitness location including fitness classes. Provides home fitness kits as an alternative program option in lieu of facility membership.
24-Hour Health Information Line		
	$0 copay	24-Hour Health Information Line to talk one-on-one with a clinician. Available 24/7/365 where you'll get guidance and information.

Benefit	What You Pay	What You Should Know
Chiropractic Care		
Chiropractic Services (Medicare-covered)	**$15** copay	
Home Health Care[1]		
	$0 copay	
Hospice		
Hospice care must be provided by a Medicare-certified hospice program.	**$0** copay	Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. Hospice care must be provided by a Medicare-certified hospice program. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.
Outpatient Substance Abuse[1]		
Individual or Group Therapy Visit	**$40** copay	
Over-the-Counter Items *(OTC)*		
	$30 every three months	Some OTC items require a doctor's recommendation for a specific, diagnosable condition. Limited to one order per member per month. Members are eligible to use the full quarterly allowance anytime throughout the quarter. Unused balance can roll forward each quarter, but must be used by December 31st. Balance does not carry over year to year.
Meal Benefit		
	$0 copayment for post-hospital meals; limit 14 meals per discharge up to three qualified hospital stays per year	

4 PRESCRIPTION DRUG BENEFITS

<table>
<tr><th>Benefit</th><th>Cigna-HealthSpring Preferred Direct (HMO)</th></tr>
<tr><td colspan="2">Prescription Drug Benefits</td></tr>
<tr><td>Medicare Part D Drugs Initial Coverage (after you pay your deductible, if applicable)</td><td>The following chart shows the cost-sharing amounts for covered drugs under this plan. After you pay your yearly Part D deductible, you pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our plan.

<table>
<tr><th>Tier</th><th>Preferred Retail Cost-Sharing 30 / 60 / 90 Days</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>Tier 1: Preferred Generic Drugs</td><td>$2 / $4 / $4</td><td>$10 / $20 / $30</td><td>$10 / $20 / $30</td></tr>
<tr><td>Tier 2: Generic Drugs</td><td>$10 / $20 / $20</td><td>$20 / $40 / $60</td><td>$20 / $40 / $60</td></tr>
<tr><td>Tier 3: Preferred Brand Drugs</td><td>$42 / $84 / $126</td><td>$47 / $94 / $141</td><td>$47 / $94 / $141</td></tr>
<tr><td>Tier 4: Non-Preferred Drugs</td><td>50% / 50% / 50%</td><td>50% / 50% / 50%</td><td>50% / 50% / 50%</td></tr>
<tr><td>Tier 5: Specialty Drugs</td><td>27% for 30 day supply only</td><td>27% for 30 day supply only</td><td>27% for 30 day supply only</td></tr>
</table>

You may get your drugs at preferred or standard network retail pharmacies, or standard network mail order pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy because it has a preferred agreement with your plan.

You can get your prescription from an out-of-network pharmacy, but may pay more than you would pay at an in-network pharmacy. If you reside in a long term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.

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) on our website www.CignaHealthSpring.com. Or, call us and we will send you a copy of the formulary.</td></tr>
</table>

Benefit	Cigna-HealthSpring Preferred Direct (HMO)
Prescription Drug Benefits	
Coverage Gap	Most Medicare drug plans have a Coverage Gap (also called the "Donut Hole"). This means that there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after your total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,820**. Not everyone will enter the Coverage Gap. After you enter the Coverage Gap, you pay **25%** of the plan's cost for covered brand name drugs and **37%** of the plan's cost for covered generic drugs until your costs total **$5,100**, which is the end of the Coverage Gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) have reached **$5,100**, 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 of the drug or **$3.40** copay for generic drugs (including brand drugs treated as generic) and **$8.50** copay for all other drugs.

5 OPTIONAL SUPPLEMENTAL BENEFITS

Benefit	Cigna-HealthSpring Preferred Direct (HMO)
Optional Supplemental Benefits *You must pay an additional premium each month for these benefits*	
Package 1: Enhanced Dental – Comprehensive	Comprehensive Dental Services (**$10-$195**, depending on service): • Restorative Services • Periodontics • Extractions • Prosthodontics/Oral Surgery There are limitations on the number of covered services within a service category. Frequency limits and cost-sharing vary depending on the type of covered service.
How much is the monthly premium?	Additional **$46.20** per month. You must keep paying your Medicare Part B premium.
How much is the deductible?	This package does not have a deductible.
Is there a limit on how much the plan will pay?	The plan has a maximum coverage amount of **$1,000** every year for comprehensive dental services. Unused amounts of the annual allowance do not carry forward to future benefit years.

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