SUMMARY OF BENEFITS

January 1, 2018 – December 31, 2018

Cigna-HealthSpring® Premier (HMO-POS) H5410-018

Our service area includes the following counties in Florida:

Bay, Escambia, Okaloosa, Santa Rosa and Walton

Cigna-HealthSpring Premier (HMO-POS) H5410-018

Cigna HealthSpring®

H5410_18_55373 Accepted

INTRODUCTION TO SUMMARY OF BENEFITS

This Summary of Benefits gives you a summary of what **Cigna-HealthSpring Premier (HMO-POS)** 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* online at **www.cignahealthspring.com**, or call us to request a copy.

Tips for comparing your Medicare choices

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

What's Inside

Cigna-HealthSpring Premier (HMO-POS)
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 – February 14, 8 a.m. – 8 p.m. local time, 7 days a week. From February 15 – September 30, Monday – Friday 8 a.m. – 8 p.m. local time, Saturday 8 a.m. – 6 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 at **1-888-767-1879 (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 PREMIER (HMO-POS)

Who can join?

To join **Cigna-HealthSpring Premier (HMO-POS)**, 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 in Florida: Bay, Escambia, Okaloosa, Santa Rosa and Walton.

Which doctors, hospitals, and pharmacies can I use?

Cigna-HealthSpring Premier (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services, you can use providers that are not in our network.

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 complete plan 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 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 *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 Premier (HMO-POS)
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	$100 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers for Medicare-covered benefits. There is no maximum out-of-pocket cost for out-of-network benefits. If you reach the in-network 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.
Is there a limit on how much the plan will pay?	Yes. Our plan has a coverage limit of $25,000 every year for out-of-network benefits.

3 COVERED MEDICAL & HOSPITAL BENEFITS

Benefit	What you pay		What you should know
	In-Network	Out-of-Network	
Covered Medical and Hospital Benefits Note: Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.			
Inpatient Hospital Coverage[1,2]			
Our plan covers 90 days for an inpatient hospital stay. 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.	$280 copay for days 1 through 6 $0 copay for days 7 through 90	30% of the cost per stay	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[1,2]			
Ambulatory Surgical Center (ASC)	$0 copay for surgical procedures (i.e. polyp removal) during a colorectal screening $195 copay for all other ASC services	30% of the cost	
Outpatient Services & Observation	$0 copay for surgical procedures (i.e. polyp removal) during a colorectal screening $250 copay for all other Outpatient Services including observation and outpatient surgical services not	30% of the cost	

Benefit	What you pay		What you should know
	In-Network	Out-of-Network	
Outpatient Surgery[1,2] cont.			
	provided in an ASC		
Doctors Visits[1,2]			
Primary Care Physician (PCP)	$0 copay	30% of the cost	
Specialists	$40 copay	30% of the cost	
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	$0 copay	30% of the cost	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		What you should know
	In-Network	Out-of-Network	
Preventive Care cont.			
• 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			
Emergency Care			
Emergency care services	$80 copay	$80 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	$80 copay	$80 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	$50 copay	$50 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
	In-Network	Out-of-Network	
Diagnostic Services, Labs & Imaging[1,2] *(Costs for these services may vary based on place of service)*			
Diagnostic procedures and tests	$0 copay for EKG and diagnostic colorectal screenings $200 copay for all other diagnostic procedures and tests	30% of the cost	
Lab services	$15 copay	30% of the cost	
Therapeutic radiological services	$60 copay	30% of the cost	
X-ray services	$15 copay	30% of the cost	
Diagnostic radiological services (such as MRIs, CT scans)	$0 copay for mammography and ultrasounds $200 copay for all other diagnostic and nuclear medical radiological services	30% of the cost	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[2]			
Hearing exams (Medicare-covered)	$0 copay in a Primary Care Physician office $40 copay in a Specialist office	30% of the cost	
Routine hearing exams (one every year)	$0 copay	Not covered	
Hearing aid evaluation/fitting (one every three years)	$0 copay	Not covered	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 coverage maximum	Not covered	The plan has a maximum coverage amount for hearing aids of $700 per ear per device every three years.

Benefit	What you pay		What you should know
	In-Network	Out-of-Network	
Dental Services[1]			
Dental Services (Medicare-covered)	$40 copay	30% of the cost	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) • Cleanings (one every six months) • Bitewing X-ray (one every year) • Full mouth & panoramic X-ray (one every 36 months) *This plan offers additional dental benefits as an Optional Supplemental Benefit. See section 5 – "Optional Supplemental Benefits" for details.*	$0 copay	Not covered	Frequency limits vary depending on the type of covered service.
Vision Services			
Eye exams (Medicare-covered)	$0 copay glaucoma screening and diabetic retinal exams $40 copay for all other Medicare-covered vision services	30% of the cost	
Routine eye exam (one every year)	$0 copay	Not covered	
Eyewear (Medicare-covered)	$0 copay	30% of the cost	
Routine eyewear • Eyeglasses–lenses and frames (one every year) • Eyeglass lenses (one every year) • Eyeglass frames (one every year)	$0 copay up to plan coverage maximum of $100 every year	Not covered	The plan specified allowance may be applied to one set of the customer's choice of eyewear, 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
	In-Network	Out-of-Network	
Vision Services cont.			
• Contact lenses • Upgrades			
Mental Health Services[1]			
Inpatient: 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.	$270 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	30% of the cost	
Outpatient: Individual or group therapy visit	$40 copay	30% of the cost	
Skilled Nursing Facility *(SNF)*[1]			
Our plan covers up to 100 days in the SNF.	$0 copay per day for days 1 through 20 $167 copay per day for days 21 through 100	30% of the cost	
Rehabilitation Services[1,2]			
Cardiac (heart) rehab services	$30 copay	30% of the cost	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.
Pulmonary rehab services	$30 copay	30% of the cost	
Occupational therapy services	$40 copay	30% of the cost	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	$40 copay	30% of the cost	

Benefit	What you pay		What you should know
	In-Network	Out-of-Network	
Ambulance[1]			
Ground service (one-way trip)	$225 copay	$225 copay	
Air service (one-way trip)	20% of the cost	20% of the cost	
Transportation			
	Not covered	Not covered	
Prescription Drugs[1]			
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% of the cost	For Part B drugs such as chemotherapy drugs: 30% of the cost	This plan has Part D prescription drug coverage. See Section 4.
Foot Care *(Podiatry Services)* [2]			
Podiatry services (Medicare-covered)	$40 copay	30% of the cost	
Medical Equipment & Supplies[1,2]			
Durable Medical Equipment (wheelchairs, oxygen, etc.)	20% of the cost	30% of the cost	
Prosthetic Devices (braces, artificial limbs, etc.) and related medical supplies	20% of the cost	30% of the cost	
Diabetes Supplies & Services	$0 copay for diabetes self-management training 20% of the cost for therapeutic shoes or inserts 0% or 20% of the cost, depending on the supply, for diabetes monitoring supplies	30% of the cost	Preferred brands diabetic test strips and monitors covered at $0 cost-share. Non- preferred brands not covered. 20% of the cost 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.

Benefit	What you pay		What you should know
	In-Network	Out-of-Network	
Fitness & Wellness Programs			
Fitness Program	$0 copay	Not covered	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 Nurse Line			
	$0 copay	Not covered	Registered nurses provide telephonic access for customers who request health and medical information and guidance.
Chiropractic Care[2]			
Chiropractic services (Medicare-covered)	$20 copay	30% of the cost	
Home Health Care[1]			
	$0 copay	30% of the cost	
Hospice			
Hospice care must be provided by a Medicare-certified hospice program.	$0 copay	30% of the cost	You may have to pay part of the cost for drugs and respite care. Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. Please contact us for more details.
Outpatient Substance Abuse[1]			
Individual or group therapy visit	$40 copay	30% of the cost	
Over-the-Counter (OTC) Items			
	Not covered	Not covered	

4 PRESCRIPTION DRUG BENEFITS

<table>
<tr><th>Benefit</th><th>Cigna-HealthSpring Premier (HMO-POS)</th></tr>
<tr><td colspan="2">Prescription Drug Benefits</td></tr>
<tr><td>Medicare Part D Drugs
Initial Coverage</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 $3,750. 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>$1 / $2 / $1</td><td>$6 / $12 / $6</td><td>$6 / $12 / $6</td></tr>
<tr><td>Tier 2: Generic Drugs</td><td>$9 / $18 / $9</td><td>$15 / $30 / $15</td><td>$15 / $30 / $15</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 Tier</td><td>31% for 30 day supply only</td><td>31% for 30 day supply only</td><td>31% 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 formulary (drug list) on our website www.cignahealthspring.com. Or, call us and we will send you a copy of the formulary.
</td></tr>
</table>

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<tr><td>Coverage Gap</td><td>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s 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 $3,750. Not everyone will enter the coverage gap.

After you enter the coverage gap, you pay 35% of the plan’s cost for covered brand name drugs and 44% of the plan’s cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap.

This plan offers some additional prescription drug coverage for Tier 1 preferred generic drugs in the coverage gap. See the table that follows to find out how much you will pay.
<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>$1 / $2 / $1</td><td>$6 / $12 / $6</td><td>$6 / $12 / $6</td></tr>
</table>
</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 $5,000, 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
$3.35 copay for generic drugs (including brand drugs treated as generic) and $8.35 copay for all other drugs.</td></tr>
</table>

5 OPTIONAL SUPPLEMENTAL BENEFITS

Benefit	Cigna-HealthSpring Premier (HMO-POS)
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 $22.80 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 $1,500 every year for comprehensive dental services. Unused amounts of the annual allowance do not carry forward to future benefit years.