



Cigna-HealthSpring Advantage (HMO) offered by Cigna

ANNUAL NOTICE OF CHANGES FOR 2018

You are currently enrolled as a member of Cigna-HealthSpring Advantage (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Sections 1.1 and 1.4 for information about benefit and cost changes for our plan.
- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 1.3 for information about our *Provider and Pharmacy Directory*.
- Think about your overall health care costs.
 - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
 - How much will you spend on your premium and deductibles?
 - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area.
 - Use the personalized search feature on the Medicare Plan Finder at <https://www.medicare.gov> website. Click "Find health & drug plans."
 - Review the list in the back of your Medicare & You handbook.
 - Look in Section 3.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Cigna-HealthSpring Advantage (HMO), you don't need to do anything. You will stay in Cigna-HealthSpring Advantage (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Cigna-HealthSpring Advantage (HMO).
- If you join by December 7, 2017, your new coverage will start on January 1, 2018.

Additional Resources

- To get information from us in a way that works for you, please call Customer Service (phone numbers are in Section 7.1 of this booklet). We can give you information in Braille, in large print, and other alternate formats if you need it.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About Cigna-HealthSpring Advantage (HMO)

- Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select State Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal.
 - When this booklet says "we," "us," or "our," it means Cigna. When it says "plan" or "our plan," it means Cigna-HealthSpring Advantage (HMO).
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Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Cigna-HealthSpring Advantage (HMO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes* and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.**

Cost	2017 (this year)	2018 (next year)
Monthly plan premium	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	\$6,500	\$6,500
Doctor office visits	Primary care visits: \$0 copayment per visit Specialist visits: \$40 copayment per visit	Primary care visits: \$0 copayment per visit Specialist visits: \$45 copayment per visit
Inpatient hospital stays 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.	Days 1-5: \$360 copayment per day Days 6-90: \$0 copayment per day	Days 1-5: \$355 copayment per day Days 6-90: \$0 copayment per day

Annual Notice of Changes for 2018
Table of Contents

Summary of Important Costs for 2018		3
SECTION 1	Changes to Benefits and Costs for Next Year	5
Section 1.1	Changes to the Monthly Premium	5
Section 1.2	Changes to Your Maximum Out-of-Pocket Amount	5
Section 1.3	Changes to the Provider Network	5
Section 1.4	Changes to Benefits and Costs for Medical Services	5
SECTION 2	Administrative Changes	7
SECTION 3	Deciding Which Plan to Choose	8
Section 3.1	If you want to stay in our plan	8
Section 3.2	If you want to change plans	8
SECTION 4	Deadline for Changing Plans	8
SECTION 5	Programs That Offer Free Counseling about Medicare	8
SECTION 6	Programs That Help Pay for Prescription Drugs	9
SECTION 7	Questions?	9
Section 7.1	Getting Help from our plan	9
Section 7.2	Getting Help from Medicare	10

SECTION 1 Changes to Benefits and Costs for Next Year**Section 1.1 Changes to the Monthly Premium**

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	\$6,500	\$6,500 Once you have paid \$6,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2018 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*.

Cost	2017 (this year)	2018 (next year)
Ambulance services	You pay a copayment of \$200 for each one-way Medicare-covered ground ambulance trip.	You pay a copayment of \$220 for each one-way Medicare-covered ground ambulance trip.
Cardiac rehabilitation services	Referral from your Primary Care Physician (PCP) is not required.	Referral from your Primary Care Physician (PCP) is required.
Chiropractic services	You pay a copayment of \$20 for each Medicare-covered chiropractic visit.	You pay a copayment of \$15 for each Medicare-covered chiropractic visit.
Dental services	You pay a copayment of \$40 for Medicare-covered dental services	You pay a copayment of \$45 for Medicare-covered dental services
Emergency care	You pay a copayment of: \$75 for Medicare-covered emergency room visits. \$75 for worldwide emergency room visits and worldwide emergency transportation.	You pay a copayment of: \$80 for Medicare-covered emergency room visits. \$80 for worldwide emergency room visits and worldwide emergency transportation.
Inpatient hospital care	You pay a copayment of: – Days 1-5: \$360 per day – Days 6-90: \$0 per day For each Medicare-covered hospital stay.	You pay a copayment of: – Days 1-5: \$355 per day – Days 6-90: \$0 per day For each Medicare-covered hospital stay.
Inpatient mental health care	You pay a copayment of: – Days 1-5: \$300 per day – Days 6-90: \$0 per day For each Medicare-covered Inpatient mental hospital stay.	You pay a copayment of: – Days 1-4: \$355 per day – Days 5-90: \$0 per day For each Medicare-covered Inpatient mental hospital stay.
Medicare Diabetes Prevention Program (MDPP)	Not offered by Medicare in 2017.	There is no coinsurance, copayment, or deductible for the MDPP benefit. 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 longterm dietary change, increased physical activity, and problem solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.
Outpatient diagnostic tests and therapeutic services and supplies	You pay a copayment of: \$0 or \$150 for Medicare-covered diagnostic procedures and tests. \$0 for EKG and diagnostic colorectal screenings. \$150 for all other diagnostic procedures and tests. \$0 or \$150 for Medicare-covered diagnostic radiology services (not including X-rays). \$0 for mammography and ultrasounds. \$150 for all other diagnostic radiological services.	You pay a copayment of: \$0 or \$200 for Medicare-covered diagnostic procedures and tests. \$0 for EKG and diagnostic colorectal screenings. \$200 for all other diagnostic procedures and tests. \$0 or \$200 or 20% coinsurance for Medicare-covered diagnostic radiology services. \$0 copayment for mammography and ultrasounds. 20% coinsurance for nuclear medicine radiological services. \$200 copayment for all other diagnostic radiological services.

Cost	2017 (this year)	2018 (next year)
Physician/Practitioner/Other Health Care Professional services	You pay a copayment of: \$40 for each Medicare-covered specialist visit. \$0 in a Primary Care Physician office or \$40 in a Specialist office for Other Health Care Professional Service.	You pay a copayment of: \$45 for each Medicare-covered specialist visit. \$0 in a Primary Care Physician office or \$45 in a Specialist office for Other Health Care Professional Service.
Podiatry services	You pay a copayment of \$30 for each Medicare-covered podiatry visit.	You pay a copayment of \$45 for each Medicare-covered podiatry visit.
Pulmonary rehabilitation services	Referral from your Primary Care Physician (PCP) is not required.	Referral from your Primary Care Physician (PCP) is required.
Skilled nursing facility (SNF) care	You pay a copayment of: – Days 1-20: \$0 per day – Days 21-100: \$164 per day For each Medicare-covered SNF stay.	You pay a copayment of: – Days 1-20: \$0 per day – Days 21-100: \$167 per day For each Medicare-covered SNF stay.
Urgently needed services	You pay a copayment of: \$40 for Medicare-covered urgently needed services. \$75 for worldwide emergency/urgent care and worldwide emergency transportation.	You pay a copayment of: \$45 for Medicare-covered urgently needed services. \$80 for worldwide emergency/urgent care and worldwide emergency transportation.
Vision services	You pay a copayment of \$0 or \$40 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. \$0 copayment for glaucoma screenings and diabetic retinal exams. \$0 or \$40 copayment for all other Medicare-covered vision services.	You pay a copayment of \$0 or \$45 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. \$0 copayment for glaucoma screenings and diabetic retinal exams. \$45 copayment for all other Medicare-covered vision services.

SECTION 2 Administrative Changes

Please see the table below for other important changes to your plan.

Process	2017 (this year)	2018 (next year)
Mailing Address Change: Customer Service	Cigna-HealthSpring Attn: Customer Service P.O. Box 20002 Nashville, TN 37202	Cigna-HealthSpring Attn: Member Services P.O. Box 2888 Houston, TX 77252

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in our plan

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

Section 3.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- — *OR* — You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click "Review and Compare Your Coverage Options." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Cigna offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from our plan.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To change to Original Medicare without a prescription drug plan, you must either:
 - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
 - — *OR* — Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2018.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK)
- In Missouri, the SHIP is called CLAIM - State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They

can help you understand your Medicare plan choices and answer questions about switching plans. You can call Kansas's SHIP, Senior Health Insurance Counseling for Kansas (SHICK), at 1-800-860-5260 or Missouri's SHIP, CLAIM - State Health Insurance Assistance Program, at 1-800-390-3330.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
 - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. In Kansas, the ADAP is the Kansas AIDS Drug Assistance Program. In Missouri, the ADAP is the Missouri AIDS Drug Assistance Program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. To contact the Kansas AIDS Drug Assistance Program, please call 1-785-296-6174. To contact the Missouri AIDS Drug Assistance Program, please call 1-573-751-6113 or 1-866-628-9891.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Kansas's ADAP, the Kansas AIDS Drug Assistance Program, at 1-785-296-6174, or Missouri's ADAP, the Missouri AIDS Drug Assistance Program, at 1-573-751-6113 or 1-866-628-9891.

SECTION 7 Questions?

Section 7.1 Getting Help from our plan

Questions? We're here to help. Please call Customer Service at 1-800-668-3813. (TTY only, call 711.) We are available for phone calls October 1 – February 14, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From February 15 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 6:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.

Read your 2018 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Cigna-HealthSpring Advantage (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.cignahealthspring.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*).

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on “Find health & drug plans.”)

Read *Medicare & You 2018*

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<https://www.medicare.gov>) or 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.