SUMMARY OF BENEFITS

January 1, 2019 - December 31, 2019

Cigna-HealthSpring TotalCare (HMO SNP)
H3949-009

Our service area include the following counties:

Pennsylvania: Bucks, Chester, Delaware, Lancaster, Montgomery and Philadelphia counties, PA

Together, all the way.®

Cigna HealthSpring®

INTRODUCTION TO SUMMARY OF BENEFITS

This *Summary of Benefits* gives you a summary of what **Cigna-HealthSpring TotalCare (HMO SNP)** 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

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 TotalCare (HMO SNP) 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 **1-800-856-7657 (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 TOTALCARE (HMO SNP)

Who can join?

To join **Cigna-HealthSpring TotalCare (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Pennsylvania Medicaid and live in our service area.

Our service area includes the following counties:

Pennsylvania: Bucks, Chester, Delaware, Lancaster, Montgomery and Philadelphia counties, PA

Which doctors, hospitals and pharmacies can I use?

Cigna-HealthSpring TotalCare (HMO SNP) 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 TotalCare (HMO SNP)
Monthly Premium, Deductible and Limits **Cost-sharing is based on your level of Medicaid eligibility*	
Monthly Premium	**$33.50** 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	Medicare Part D 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. This limit is the most you pay for copays, coinsurance and other costs for Medicare services for the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility. Refer to the “Medicare & You” handbook for Medicare-covered services. For Medicaid-covered services, refer to the Medicaid Coverage section in this document.

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.** **Services with a [2] may require a referral from your doctor.** **Cost-sharing is based on your level of Medicaid eligibility*		
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.	**$0** or **$280** copay* per day: Days 1 through 6 **$0** copay per day: Days 7 through 90	If readmitted within 72 hours for the same diagnosis the benefit will continue from original admission. You may not owe any additional copayments. Referral required for elective procedures only.
Outpatient Surgery		
Ambulatory Surgical Center (ASC)[1]	**0%** for any surgical procedures (i.e. polyp removal) during a colorectal screening. **0%** or **20%*** for all other Ambulatory Surgical Center (ASC) services.	
Outpatient Services & Observation[1, 2]	**0%** for any surgical procedures (i.e. polyp removal) during a colorectal screening. **0%** or **20%*** 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%** or **20%** coinsurance*	
Specialists[2]	**$0** or **$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	**$0** or **$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	**$0** or **$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	**0%** or **20%** of the cost* (up to **$65**)	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. **0%** or **20%** coinsurance* for all other diagnostic procedures and tests.	
Lab Services[1]	**$0** copay	
Therapeutic Radiological Services[1]	**0%** or **20%** coinsurance*	
X-ray Services	**0%** or **20%** coinsurance*	
Diagnostic Radiological Services (such as MRIs, CT Scans)[1]	**0%** coinsurance for mammography and ultrasounds. **0%** or **20%** coinsurance* for all other diagnostic and nuclear medicine radiological services.	
Hearing Services		
Hearing Exams (Medicare-covered)	**$0** or **$35** copay*	
Routine Hearing Exams (one every year)	**$0** copay	
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.

Benefit	What You Pay	What You Should Know
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]	**$0** or **$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.
Comprehensive Dental Services: • Restorative • Periodontics • Extractions • Prosthodontics/Oral surgery	**$0** copay up to a maximum coverage amount of **$3,000** every year	Unused amounts of the annual allowance do not carry forward to future benefit years. 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.
Vision Services		
Eye Exams (Medicare-covered)[1]	**$0** copay for diabetic retinal exams. **$0** or **$40** copay* for all other Medicare-covered vision services.	
Routine Eye Exam (one every year)	**$0** copay	
Eyewear (Medicare-covered)	**$0** copay	

Benefit	What You Pay	What You Should Know
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 **$500** 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.
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.	**$0** or **$324** copay* per day: Days 1 through 5 **$0** copay per day: Days 6 through 90	
Outpatient[1]: Individual or Group Therapy Visit	**0%** or **20%** coinsurance*	
Skilled Nursing Facility *(SNF)*[1]		
Our plan covers up to 100 days in the SNF.	**$0** copay per day: Days 1 through 20 **$0** or **$172** copay* per day: Days 21 through 100	
Rehabilitation Services		
Cardiac (heart) Rehab Services[1, 2]	**0%** or **20%** coinsurance*	
Pulmonary Rehab Services[1, 2]	**0%** or **20%** coinsurance*	
Occupational Therapy Services[1]	**0%** or **20%** coinsurance*	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]	**0%** or **20%** coinsurance*	
Ambulance[1]		
Ground Service (one-way trip)	**0%** or **20%** coinsurance*	

Benefit	What You Pay	What You Should Know
Air Service (one-way trip)	**0%** or **20%** coinsurance*	
Transportation[1]		
	$0 for unlimited trips to plan-approved locations per year.	
Prescription Drugs[1]		
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: **0%** or **20%** coinsurance*	This plan has Part D prescription drug coverage. See Section 4.
Foot Care *(Podiatry Services)*		
Medicare-Covered Podiatry Services[1]	**$0** or **$40** copay*	
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**0%** or **20%** coinsurance*	
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies[1]	**0%** or **20%** coinsurance*	
Diabetes Supplies & Services	**$0** copay for diabetes self-management training **0%** or **20%** coinsurance* for therapeutic shoes or inserts **0%** or **20%** coinsurance*, 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.

Benefit	What You Pay	What You Should Know
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.
Chiropractic Care		
Chiropractic Services (Medicare-covered)[2]	**0%** or **20%** coinsurance*	
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	**0%** or **20%** coinsurance*	
Over-the-Counter Items *(OTC)*		
	$200 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.

Benefit	What You Pay	What You Should Know
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

Benefit	Cigna-HealthSpring TotalCare (HMO SNP)
Prescription Drug Benefits	
Medicare Part D Drugs Initial Coverage (after you pay your deductible, if applicable)	Depending on your income and institutional status, you pay the following: • For generic drugs (including brand drugs treated as generic): – **25%** cost-share or – **$0** copay / **$1.25** copay / **$3.40** copay / **15%** cost-share • For all other drugs: – **25%** cost-share or – **$0** copay / **$3.80** copay / **$8.50** copay / **15%** cost-share You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
Catastrophic Coverage	Depending on your income and institutional status, you pay the following after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**: • **$0** copay or • **$3.40** (generic) / **$8.50** (brand) or • **5%** cost-share

5 SUMMARY OF MEDICAID-COVERED BENEFITS FOR CONTRACT H3949-009-000

This section demonstrates the Medicaid benefit package for full benefit dual-eligible recipients in the state of Pennsylvania. The services offered in your Medicaid benefit package are based on your Medicaid eligibility. The services listed below are available only to those SNP customers eligible under Medicaid for medical services. For more information about your Medicaid benefits and copayments, please contact the State Medicaid Office.

The benefits described below are covered by Medicaid for individuals who qualify for full Medicaid, QMB + full Medicaid, full Medicaid + SLMB. The benefits described in the Covered Medical and Hospital Benefits section of the *Summary of Benefits* are covered by Medicare. If you join Cigna-HealthSpring, you do not have to pay for deductibles, copayments or coinsurance for services that are covered by Medicare. Certain Medicare recipients qualify for Medicaid to pay their Medicare Part A (hospital insurance) OR Part B (supplemental medical insurance) premiums. These recipients do not qualify for any of the covered services listed below.

These programs include:

- **QI-1:** Medicaid pays the Medicare Part B premium only.
- **SLMB:** Medicaid pays Medicare Part B premiums only.
- **QMB:** Medicaid pays Medicare Part B premiums, Medicare deductibles and co-insurance. In some cases, Medicaid may also pay their Part A premium.

Benefit Category (Excludes Medicare-covered services)	**Pennsylvania Medicaid-Covered Services**	**Cigna-HealthSpring TotalCare (HMO SNP)** *Cost-sharing is based on your level of Medicaid eligibility
Ambulance Services	**$0** copay for Medicaid-covered benefits.	Ground service (one-way trip): **0%** or **20%** coinsurance** Air service (one-way trip): **0%** or **20%** coinsurance**
Non-Emergency Transportation (NET)	For non-emergency medical transportation only. Only to and from MA covered services; **$0** copay for Medicaid-covered benefits.	**$0** for unlimited trips to plan-approved locations per year.

Benefit Category (Excludes Medicare-covered services)	**Pennsylvania Medicaid-Covered Services**	**Cigna-HealthSpring TotalCare (HMO SNP)** *Cost-sharing is based on your level of Medicaid eligibility
Dental Services	1 oral examination per 180 days per beneficiary. 1 dental prophylaxis per 180 days per beneficiary. 1 panoramic-maxilla or mandible, single film per five years. A Benefit Limit Exception is required for oral examinations and prophylaxis more often than once per 180 days, for crowns and adjunctive crown services, and for periodontal and endodontic services. 1 upper arch (complete or partial denture) and 1 lower arch (complete or partial denture) per lifetime. Denture relines (full or partial) limited to 1 arch, every 2 years. **$0** - **$3.80** copay (sliding scale based on Medicaid fee for service).	Dental Services (Medicare-covered): **$0** or **$40** copay* Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth) Preventive Dental Services: **$0** copay • 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) Frequency limits vary depending on the type of covered service. Comprehensive Dental Services: **$0** copay up to a maximum coverage amount of **$3,000** every year • Restorative • Periodontics • Extractions • Prosthodontics/Oral surgery
Doctor's Office Visits	**$0** - **$3.80** copay (sliding scale based on Medicaid fee for service).	Primary Care Physician visit: **0%** or **20%** coinsurance* Specialist visit: **$0** or **$40** copay*

Benefit Category (Excludes Medicare-covered services)	**Pennsylvania Medicaid-Covered Services**	**Cigna-HealthSpring TotalCare (HMO SNP)** *Cost-sharing is based on your level of Medicaid eligibility
Eye Care Services	2 visits (exams) per calendar year. Beneficiaries 21 years of age and older diagnosed with aphakia are limited to: 4 eyeglass lenses per calendar year, 4 contact lenses per calendar year, 2 eyeglass frames per calendar year (deluxe frames not included) **$0** - **$3.80** copay (sliding scale based on Medicaid fee for service).	Eye Exams (Medicare-covered): **$0** copay for diabetic retinal exams. **$0** or **$40** copay* for all other Medicare-covered vision services. Routine Eye Exam (one every year): **$0** copay Eyewear (Medicare-covered): **$0** copay Routine Eyewear: **$0** copay up to plan maximum coverage amount of **$500** every year • Eye Glasses (Lenses and Frames) (one every year) • Eye Glass Lenses (one every year) • Eye Glass Frames (one every year) • Contact Lenses (unlimited) • Upgrades
Home Health Services	Unlimited for first 28 days; limited to 15 days every month thereafter. **$0** copay for Medicaid-covered benefits.	**$0** copay for Medicare-covered home health care visits.
Hospice Services	Coverage for inpatient respite care is limited to no more than five (5) consecutive days in a 60-day certification period.	**$0** copay Hospice care must be provided by a Medicare-certified hospice program.
Psychiatric Hospital Services	**$3.00** per day up to **$21.00** per admission	**Inpatient** Our plan covers 90 days for an inpatient psychiatric hospital stay. **$0** or **$324** copay* per day: Days 1 through 5 **$0** copay per day: Days 6 through 90 **Outpatient** Outpatient individual or group therapy visit: **0%** or **20%** coinsurance*
Laboratory and X-ray Services	**$1.00** copay for Medicaid covered benefits	Lab services: **$0** copay X-ray services: **0%** or **20%** coinsurance*

Benefit Category (Excludes Medicare-covered services)	**Pennsylvania Medicaid-Covered Services**	**Cigna-HealthSpring TotalCare (HMO SNP)** *Cost-sharing is based on your level of Medicaid eligibility
Prescription Drugs	**$1.00** generic/**$3.00** brand; certain drug categories are excluded from copays.	For Part B drugs such as chemotherapy drugs: **0%** or **20%** coinsurance* Drugs covered under Medicare Part D: • Depending on your income and institutional status, you pay the following: – For generic drugs (including brand drugs treated as generic): ▪ **25%** cost-share or ▪ **$0** copay / **$1.25** copay / **$3.40** copay / **15%** cost-share – For all other drugs: ▪ **25%** cost-share or ▪ **$0** copay / **$3.80** copay / **$8.50** copay / **15%** cost-share
Renal Dialysis Services	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year. **$0** copay for Medicaid-covered benefits.	• **0%** - **20%** of the cost* for Medicare-covered renal dialysis • **$0** copay for Medicare-covered kidney disease education services.

Benefit Category (Excludes Medicare-covered services)	**Pennsylvania Medicaid-Covered Services**	**Cigna-HealthSpring TotalCare (HMO SNP)** *Cost-sharing is based on your level of Medicaid eligibility
Medical Equipment and Supplies and Appliances	**$0** - **$3.80** copay (sliding scale based on the Medicaid fee for the service). Prosthetic and orthotic devices, hearing aids and orthopedic shoes are not covered for adults. Coverage for molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such degree that the beneficiary is unable to wear ordinary sturdy shoes with or without corrections or modifications. Coverage for modifications to orthopedic shoes and molded shoes is limited to only those modifications necessary for the application of a brace or a splint. Coverage of low vision aids or eye prostheses is limited to 1 per beneficiary per two years. An eye ocular is limited to 1 per year. Oxygen and related equipment - Beneficiaries must have had a comprehensive cardiopulmonary evaluation that resulted in an established diagnosis of the cause of a respiratory disability.	**Durable Medical Equipment (wheelchairs, oxygen, etc.)** **0%** or **20%** coinsurance* **Prosthetic Devices (braces, artificial limbs, etc.)** • Prosthetic devices: **0%** or **20%** coinsurance* • Related medical supplies: **0%** or **20%** coinsurance* **Diabetes Supplies and Services** • **$0** copay for diabetes self-management training • **0%** or **20%** coinsurance* for therapeutic shoes or inserts* • **0%** or **20%** coinsurance*, 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.
Transportation	For non-emergency medical transportation only. Only to and from MA covered services; **$0** copay for Medicaid-covered benefits.	**$0** for unlimited trips to plan-approved locations per year. Routine health-related transportation benefit includes specified quantity of one-way trips by taxi, van or medical transport. Authorization is required where the travel distance to provider exceeds the mileage limit of 60 miles.

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