



January 1 – December 31, 2020

EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Cigna-HealthSpring Preferred (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2020. 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-HealthSpring Preferred (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-HealthSpring Preferred (HMO).)

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, or other alternate formats if you need it.

Benefits, deductible, and/or copayments/coinsurance may change on January 1, 2021.

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

2020 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1.	Getting started as a member	4
	Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, the Part D late enrollment penalty, your plan membership card, and keeping your membership record up to date.	
Chapter 2.	Important phone numbers and resources	16
	Tells you how to get in touch with our plan (Cigna-HealthSpring Preferred (HMO)) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
Chapter 3.	Using the plan’s coverage for your medical services	28
	Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.	
Chapter 4.	Medical Benefits Chart (what is covered and what you pay)	37
	Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.	
Chapter 5.	Using the plan’s coverage for your Part D prescription drugs	66
	Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan’s <i>List of Covered Drugs (Formulary)</i> to find out which drugs are covered. Tells which kinds of drugs are <i>not</i> covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan’s programs for drug safety and managing medications.	
Chapter 6.	What you pay for your Part D prescription drugs	81
	Tells about the four stages of drug coverage (Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the 5 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.	
Chapter 7.	Asking us to pay our share of a bill you have received for covered medical services or drugs	92
	Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.	
Chapter 8.	Your rights and responsibilities	98
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	

Chapter 9.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints).....	106
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
	<ul style="list-style-type: none">• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.	
Chapter 10.	Ending your membership in the plan.....	140
	Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 11.	Legal notices	146
	Includes notices about governing law and about nondiscrimination.	
Chapter 12.	Definitions of important words.....	150
	Explains key terms used in this booklet.	

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1	Introduction.....	6
Section 1.1	You are enrolled in Cigna-HealthSpring Preferred (HMO), which is a Medicare HMO	6
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?.....	6
Section 1.3	Legal information about the <i>Evidence of Coverage</i>	6
SECTION 2	What makes you eligible to be a plan member?.....	6
Section 2.1	Your eligibility requirements.....	6
Section 2.2	What are Medicare Part A and Medicare Part B?	6
Section 2.3	Here is the plan service area for our plan	7
Section 2.4	U.S. Citizen or Lawful Presence.....	7
SECTION 3	What other materials will you get from us?.....	7
Section 3.1	Your plan membership card — Use it to get all covered care and prescription drugs	7
Section 3.2	The <i>Provider and Pharmacy Directory</i> : Your guide to all providers in the plan's network.....	7
Section 3.3	The <i>Provider and Pharmacy Directory</i> : Your guide to pharmacies in our network	8
Section 3.4	The plan's <i>List of Covered Drugs (Formulary)</i>	8
Section 3.5	The <i>Part D Explanation of Benefits</i> (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs	8
SECTION 4	Your monthly premium for your plan.....	9
Section 4.1	How much is your plan premium?	9
SECTION 5	Do you have to pay the Part D “late enrollment penalty”?.....	9
Section 5.1	What is the Part D “late enrollment penalty”?.....	9
Section 5.2	How much is the Part D late enrollment penalty?.....	9
Section 5.3	In some situations, you can enroll late and not have to pay the penalty.....	10
Section 5.4	What can you do if you disagree about your Part D late enrollment penalty?	10
SECTION 6	Do you have to pay an extra Part D amount because of your income?.....	10
Section 6.1	Who pays an extra Part D amount because of income?	10
Section 6.2	How much is the extra Part D amount?	11
Section 6.3	What can you do if you disagree about paying an extra Part D amount?.....	11
Section 6.4	What happens if you do not pay the extra Part D amount?.....	11
SECTION 7	More information about your monthly premium.....	11
Section 7.1	If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty.....	11
Section 7.2	Can we change your monthly plan premium during the year?	12
SECTION 8	Please keep your plan membership record up to date	12
Section 8.1	How to help make sure that we have accurate information about you.....	12
SECTION 9	We protect the privacy of your personal health information.....	13
Section 9.1	We make sure that your health information is protected.....	13

SECTION 10	How other insurance works with our plan.....	13
Section 10.1	Which plan pays first when you have other insurance?	13

SECTION 1 Introduction**Section 1.1 You are enrolled in Cigna-HealthSpring Preferred (HMO), which is a Medicare HMO**

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Cigna-HealthSpring Preferred (HMO).

There are different types of Medicare health plans. Cigna-HealthSpring Preferred (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) 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.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of Cigna-HealthSpring Preferred (HMO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in our plan between January 1, 2020 and December 31, 2020.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?**Section 2.1 Your eligibility requirements**

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- — *and* — you live in our geographic service area (Section 2.3 below describes our service area)
- — *and* — you are a United States citizen or are lawfully present in the United States
- — *and* — you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician’s services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Arkansas: Craighead, Crittenden, Greene, Lawrence, Mississippi, Poinsett

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). 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.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Cigna if you are not eligible to remain a member on this basis. Cigna must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card — Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here’s a sample membership card to show you what yours will look like:

Cigna. <Plan Name>
<Plan Type>

ID <Customer ID> <contract/PBP>
Name <Customer Full Name>
Health Plan (80840)
[EffectiveDate: <Effective Date>] [MedicareRx] [Prescription Drug Coverage X]
PCP <PCP’s Name>
PCP Phone <XXX-XXX-XXXX> [RxBIN: <XXXXXXXX>]
PCP Network <Network> [RxPCN: <XXXXXXXX>]
[No Referral Required] COPSAYS [RxGRP: <XXXXXXXX>]
PCP <\$XX> Specialist <\$XX>
Emergency <\$XX> Urgent Care <\$XX>

This card does not guarantee coverage or payment.

<barcode>
Customer Service: <--Toll Free Number--> (TTY 711)
[Services may require [a referral or] [an] authorization by the Health Plan.]

Provider Services: <Phone Number>
Authorization: <Phone Number>
Provider Medical Claims: <Address>
[Pharmacy Help Desk: <Phone Number>
Pharmacy Claims: <Address>

<URL>

As long as you are a member of our plan, in most cases, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your Medicare card if you need hospital services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here’s why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Cigna-HealthSpring Preferred (HMO) membership card while you are a plan member, you may have to pay the full cost yourself. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The Provider and Pharmacy Directory: Your guide to all providers in the plan’s network

The *Provider and Pharmacy Directory* lists our network providers and durable medical equipment suppliers.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.cignamedicare.com.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. When you select a Primary Care Physician (PCP), you are also selecting an entire network (a specific group of Plan providers) of specialists and hospitals. Please call Customer Service for details regarding the specialists and hospitals you may use. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan’s coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don’t have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider and Pharmacy Directory* at www.cignamedicare.com, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 The *Provider and Pharmacy Directory*: Your guide to pharmacies in our network**What are “network pharmacies”?**

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignamedicare.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 2020 *Provider and Pharmacy Directory* to see which pharmacies are in our network.

The *Provider and Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don’t have the *Provider and Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.cignamedicare.com, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network pharmacies.

Section 3.4 The plan’s *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. The Drug List we provide to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.cignamedicare.com) or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.5 The *Part D Explanation of Benefits* (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

SECTION 1	Plan contacts (how to contact us, including how to reach Customer Service at the plan).....	17
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program).....	21
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	22
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)	22
SECTION 5	Social Security	22
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	23
SECTION 7	Information about programs to help people pay for their prescription drugs	24
SECTION 8	How to contact the Railroad Retirement Board	26
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	26

SECTION 1 Plan contacts

(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal 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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-888-766-6403
WRITE	Cigna, Attn: Member Services, 2800 North Loop West, Houston, TX 77092 LetUsHelpYou@healthspring.com
WEBSITE	www.cignamedicare.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-888-766-6403
WRITE	Cigna, Attn: Precertification Department, P.O. Box 20002, Nashville, TN 37202

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
CALL	1-800-511-6943 Calls to this number are free. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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. Hours are Monday – Friday, 7:00 a.m. – 9:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-800-931-0149
WRITE	Cigna, Attn: Part C Appeals, P.O. Box 24087, Nashville, TN 37202-4087

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
WRITE	Cigna, Attn: Member Grievances, P.O. Box 2888, Houston, TX 77252
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-866-845-7267
WRITE	Cigna, Attn: Coverage Determination & Exceptions, P.O. Box 20002, Nashville, TN 37202
WEBSITE	www.cignamedicare.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
FAX	1-866-593-4482
WRITE	Cigna, Attn: Part D Appeals, P.O. Box 24207, Nashville, TN 37202-9910
WEBSITE	www.cignamedicare.com

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Part D prescription drugs – Contact Information	
CALL	1-800-668-3813 Calls to this number are free. Customer Service is available October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
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, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
WRITE	Cigna, Attn: Member Grievances, P.O. Box 2888, Houston, TX 77252
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Payment Requests – Contact Information		
WRITE	Part C (Medical Services) Cigna Attn: Direct Member Reimbursement, Medical Claims P.O. Box 20002 Nashville, TN 37202	Part D (Prescription Drugs) Cigna Attn: Direct Member Reimbursement, Pharmacy P.O. Box 20002 Nashville, TN 37202
WEBSITE	www.cignamedicare.com	

SECTION 2 Medicare

(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	<p>1-800-MEDICARE or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>https://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program
 (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Arkansas, the SHIP is called Senior Health Insurance Information Program (SHIIP).

Senior Health Insurance Information Program (SHIIP) 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.

Senior Health Insurance Information Program (SHIIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior Health Insurance Information Program (SHIIP) counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Senior Health Insurance Information Program (SHIIP) (Arkansas' SHIP) – Contact Information
CALL	1-501-371-2782 or 1-800-224-6330
WRITE	Senior Health Insurance Information Program (SHIIP), Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201
WEBSITE	https://insurance.arkansas.gov/pages/consumer-services/senior-health/

SECTION 4 Quality Improvement Organization
 (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Arkansas, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Arkansas' Quality Improvement Organization) – Contact Information
CALL	1-888-315-0636 Hours are Mon. – Fri. 9:00 a.m. – 5:00 p.m., weekends and holidays: 11:00 a.m. – 3:00 p.m.
TTY	1-855-843-4776 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609
WEBSITE	www.keproqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Arkansas Medicaid.

Method	Arkansas Medicaid – Contact Information
CALL	1-800-482-8988 Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Arkansas Medicaid, Arkansas Division of Medical Services, Department of Human Services, Donaghey Plaza South, P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
WEBSITE	https://medicaid.mmis.arkansas.gov/

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription copayments. This “Extra Help” also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” 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. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this Chapter for contact information).

If you believe you have qualified for “Extra Help” and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please contact Customer Service to request assistance or to provide one of the documents listed below to establish your correct copay level. Please note that any document listed below must show that you were eligible for Medicaid during a month after June of the previous year:
 1. A copy of your Medicaid card which includes your name, eligibility date and status level;
 2. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status;
 3. A copy of a state document that confirms active Medicaid status;
 4. A printout from the State electronic enrollment file showing Medicaid status;
 5. A screen print from the State’s Medicaid systems showing Medicaid status;
 6. Other documentation provided by the State showing Medicaid status;
 7. A Supplemental Security Income (SSI) Notice of Award with an effective date; or
 8. An Important Information letter from the Social Security Administration (SSA) confirming that you are “...automatically eligible for Extra Help...”
- If you are a member that is institutionalized, please provide one or more of the following:
 1. A remittance from a long-term care facility showing Medicaid payment for a full calendar month;
 2. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on your behalf;
 3. A screen print from the State’s Medicaid systems showing your institutional status based on at least a full calendar month’s stay for Medicaid payment purposes.
 4. For Individuals receiving home and community based services (HCBS), you may submit a copy of:
 - a) A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary’s name and HCBS eligibility date during a month after June of the previous calendar year;
 - b) A State-approved HCBS Service Plan that includes the beneficiary’s name and effective date beginning during a month after June of the previous calendar year;
 - c) A State-issued prior authorization approval letter for HCBS that includes the beneficiary’s name and effective date beginning during a month after June of the previous calendar year;
 - d) Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,

- e) A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving “Extra Help.” For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the 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 through the Arkansas 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.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state's AIDS Drug Assistance Program (ADAP) at the phone number listed below.

Method	Arkansas AIDS Drug Assistance Program – Contact Information
CALL	1-501-661-2408 or 1-888-499-6544 Hours are Mon. – Fri. 8:00 a.m. – 4:30 p.m.
WRITE	Arkansas AIDS Drug Assistance Program, Arkansas Department of Health, 4815 W. Markham, Little Rock, AR 72205
WEBSITE	http://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

What if you get “Extra Help” from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get “Extra Help,” you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) 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.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
<p>CALL</p>	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>If you press “0,” you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday.</p> <p>If you press “1,” you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
<p>TTY</p>	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
<p>WEBSITE</p>	<p>https://secure.rrb.gov/</p>

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

*Using the plan's coverage
for your medical services*

Chapter 3. Using the plan's coverage for your medical services

SECTION 1	Things to know about getting your medical care covered as a member of our plan	29
Section 1.1	What are “network providers” and “covered services”?.....	29
Section 1.2	Basic rules for getting your medical care covered by the plan	29
SECTION 2	Use providers in the plan's network to get your medical care	29
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care	29
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?	30
Section 2.3	How to get care from specialists and other network providers	30
Section 2.4	How to get care from out-of-network providers	31
SECTION 3	How to get covered services when you have an emergency or urgent need for care or during a disaster	31
Section 3.1	Getting care if you have a medical emergency	31
Section 3.2	Getting care when you have an urgent need for services	32
Section 3.3	Getting care during a disaster	32
SECTION 4	What if you are billed directly for the full cost of your covered services?	32
Section 4.1	You can ask us to pay our share of the cost of covered services.....	32
Section 4.2	If services are not covered by our plan, you must pay the full cost	33
SECTION 5	How are your medical services covered when you are in a “clinical research study”?	33
Section 5.1	What is a “clinical research study”?.....	33
Section 5.2	When you participate in a clinical research study, who pays for what?	33
SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”	34
Section 6.1	What is a religious non-medical health care institution?	34
Section 6.2	What care from a religious non-medical health care institution is covered by our plan?	34
SECTION 7	Rules for ownership of durable medical equipment	35
Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?.....	35

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, you may have to pay the full cost of any skilled nursing facility care you get after our Plan's payment reaches the benefit limit. Once you have used up your benefit limit, additional payments you make for the service do not count toward your annual out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in

Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<https://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not voluntary* or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - — *and* — you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4

*Medical Benefits Chart
(what is covered and
what you pay)*

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1	Understanding your out-of-pocket costs for covered services	38
Section 1.1	Types of out-of-pocket costs you may pay for your covered services	38
Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?	38
Section 1.3	Our plan does not allow providers to “balance bill” you	38
SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered for you and how much you will pay	39
Section 2.1	Your medical benefits and costs as a member of the plan	39
SECTION 3	What services are not covered by the plan?	62
Section 3.1	Services we do <i>not</i> cover (exclusions)	62

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2020 is \$6,700. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are italicized in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of \$6,700, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has “balance billed” you, call Customer Service (phone numbers are printed on the back cover of this booklet).