

Dear Cigna Medicare Advantage Customer,

We are glad you have chosen us to be your health plan. We value you as a customer and we want to help you stay as healthy as possible. One way we do this is by asking you a few questions about your health and lifestyle. We then work closely with your primary care doctor to make sure we give you the best possible care.

A quick survey about your health.

Below, you will find a few questions about your current health. By answering them, you can help us know how we can serve you better. It will only take about 10 minutes. If you are unable to fill it out, another person who knows about your health may help you.

Mark your answers by completely filling in the circle next to your answer.

Please use a dark blue or black ink pen when completing the survey. When you have finished answering the questions, please mail or fax the form to:

Attn: HRA Department
Cigna Medicare Advantage
500 Great Circle Road, Nashville, TN 37228
HRA Fax Number: 1-877-440-9340

The information you provide will be treated with absolute confidentiality and will help us learn more about you and your health needs. Information you provide may be reviewed by a care coordinator and health coach staff and will only be used to help your physician and other healthcare providers offer you high quality care. Completion and submission of this form implies that you agree to have this information used for this purpose.

If you have any questions, please call one of our Health Risk Assessment Representatives at 1-800-331-6769 — they'll be glad to help. TTY users may call 711.

Thank you for choosing Cigna Medicare Advantage. We're committed to getting you healthier.

Sincerely,

Health Risk Assessment Department

Today's date (please complete):

M M D D Y Y Y Y

Customer ID:

Name:

Address:

Phone Number:



Please call Customer Service at 1-800-668-3813 (TTY 711) to make address and/or phone number changes.

General questions

- 1. What is your height? Feet ... Inches ...

- 2. What is your weight? (Pounds (lbs)) ...
3. In general, how would you rate your health? ...

- 4. Have you had a flu shot this year or are you planning to receive one this year? ...

Table with 6 columns: In the last year, In the last 2-4 years, In the last 5 years, In the last 10 years, Never, Not applicable. Rows for Pneumonia vaccine, Breast cancer screening, Colorectal cancer screening, Cervical cancer screening.

- 9. Do you exercise regularly or take part in a physical exercise program? ...

<Customer Name>

<Customer ID>

Your health

10. What medical conditions do you have or have you had in the past? *(Please indicate all that apply.)*
- | | | |
|---|---|--|
| <input type="radio"/> A) Anxiety | <input type="radio"/> H) Depression | <input type="radio"/> O) Schizophrenia |
| <input type="radio"/> B) Asthma | <input type="radio"/> I) Diabetes | <input type="radio"/> P) Stroke |
| <input type="radio"/> C) Bi-polar disorder | <input type="radio"/> J) Hearing problems | <input type="radio"/> Q) None |
| <input type="radio"/> D) Cancer | <input type="radio"/> K) Heart failure | <input type="radio"/> R) Vision problems |
| <input type="radio"/> E) COPD/emphysema | <input type="radio"/> L) Hypertension | <input type="radio"/> S) Other |
| <input type="radio"/> F) Coronary heart disease | <input type="radio"/> M) Organ transplant | |
| <input type="radio"/> G) Dementia | <input type="radio"/> N) Renal/kidney failure | |
11. Which of the following are you currently receiving treatment for? *(Please indicate all that apply.)*
- | | | |
|---|---|--|
| <input type="radio"/> A) Anxiety | <input type="radio"/> H) Depression | <input type="radio"/> O) Schizophrenia |
| <input type="radio"/> B) Asthma | <input type="radio"/> I) Diabetes | <input type="radio"/> P) Stroke |
| <input type="radio"/> C) Bi-polar disorder | <input type="radio"/> J) Hearing problems | <input type="radio"/> Q) None |
| <input type="radio"/> D) Cancer | <input type="radio"/> K) Heart failure | <input type="radio"/> R) Vision problems |
| <input type="radio"/> E) COPD/emphysema | <input type="radio"/> L) Hypertension | <input type="radio"/> S) Other |
| <input type="radio"/> F) Coronary heart disease | <input type="radio"/> M) Organ transplant | |
| <input type="radio"/> G) Dementia | <input type="radio"/> N) Renal/kidney failure | |
12. How often do you take medications? A) Daily B) Weekly C) As needed D) Never
13. How many medications do you take? A) 0 B) 1-3 C) 4-5 D) 6-7 E) 8+
14. Do you find that you sometimes have to choose between buying groceries or medications? A) Yes B) No
15. Have you fallen in the past 6 months? *(A fall is when your body goes to the ground without being pushed.)* A) Yes B) No
16. In the past 3 months, how many times did you go to the Emergency Room?
 A) 0 B) 1 C) 2 D) 3 or more

<Customer Name>

<Customer ID>

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17. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital? A) 0 B) 1 C) 2 D) 3 or more
18. Has your doctor recently told you that you need to lose weight? A) Yes B) No
19. Are you on a special diet recommended by your doctor (*low sodium, low cholesterol, low fat*)? A) Yes B) No
20. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (*1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.*)
 A) 0 B) 1-2 C) 3 D) 4+
21. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (*1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.*)
 A) 0 B) 1-2 C) 3-4 D) 5+
22. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)
 A) 0 B) 1 C) 2-3 D) 4+
23. In the past 7 days, how many sugar-sweetened (*not diet*) beverages did you typically consume each day? A) 0 B) 1 C) 2-3 D) 4+
24. In the past 2 weeks, have you experienced a change in the amount you normally eat, either poor appetite or overeating? A) Yes B) No
25. When was the last time you smoked or used any tobacco products? (*cigarettes, chew, snuff, pipes, cigars, vapor cigarettes*)
 A) Today B) Last week C) Last month D) Last 3 months
 E) Last year F) A year to 5 years ago G) Longer than 5 years ago H) Never
26. Are you interested in quitting? A) Yes B) No C) Not applicable
27. In the past 2 weeks, have you felt stressed or anxious? A) Yes B) No
28. In the past 2 weeks, have you had little interest or pleasure in doing things that you normally like to do? A) Yes B) No

29. In the past 2 weeks, have you been feeling downhearted, depressed or "blue" more than usual? A) Yes B) No
30. Are you using any street drugs or abusing medications? A) Yes B) No
31. Do you drink alcohol? A) Yes B) No
32. Have you ever thought you should cut down your drug or alcohol use? Yes No Not Applicable
33. Have you ever felt annoyed when people have commented on your drug or alcohol use? A) Yes B) No C) Not applicable
34. Have you ever felt guilty or badly about your drug or alcohol use? A) Yes B) No C) Not applicable
35. Have you ever used drugs to ease withdrawal symptoms, or to avoid feeling low after using drugs or alcohol? A) Yes B) No C) Not applicable
36. Have you ever been treated for drug or alcohol abuse? A) Yes B) No C) Not applicable
37. In the past 4 weeks, how much body pain have you had?
 A) None B) Mild C) Very mild D) Moderate E) Severe F) Very severe
38. During the past 4 weeks, how much did pain interfere with your normal activities?
 A) Not at all B) A little bit C) Moderately
 D) Quite a bit E) Extremely
39. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?
 A) Not at all B) A little bit C) Moderately
 D) Quite a bit E) Extremely

Do you need help doing the following?

	Yes	No		Yes	No
40. Standing up from a sitting position?	<input type="radio"/> A)	<input type="radio"/> B)	41. Walking in the house?	<input type="radio"/> A)	<input type="radio"/> B)
42. Walking outside of the house?	<input type="radio"/> A)	<input type="radio"/> B)	43. Preparing a meal?	<input type="radio"/> A)	<input type="radio"/> B)
44. Eating a meal?	<input type="radio"/> A)	<input type="radio"/> B)	45. Getting dressed?	<input type="radio"/> A)	<input type="radio"/> B)
46. Bathing?	<input type="radio"/> A)	<input type="radio"/> B)	47. Using the toilet?	<input type="radio"/> A)	<input type="radio"/> B)
48. Organizing your day?	<input type="radio"/> A)	<input type="radio"/> B)	49. Driving or getting to places?	<input type="radio"/> A)	<input type="radio"/> B)

50. If you answered "Yes" to any of the above questions, do you have someone who can assist you? A) Yes B) No
51. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? A) Always B) Usually C) Sometimes D) Never
52. In the past 2 weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much? A) Yes B) No

Advanced care planning

53. Do you have a Medical Power of Attorney? (*Someone to make medical decisions for you in the event you are unable to*) A) Yes B) No C) Don't know/don't remember
54. Do you have a living will/advance directive? (*Documents that makes your health care wishes known*) A) Yes B) No C) Don't know/don't remember
55. Is a copy of your advance directive on file at your doctor's office? A) Yes B) No C) Don't know/don't remember

About you

My health is important to me.	Strongly disagree	Disagree	Agree	Strongly Agree
56. I am ultimately the one responsible for taking care of my health and wellness.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)
57. It is important for me to take an active role in my health care.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)
58. I am confident I can prevent or reduce problems associated with my health.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)
59. I am confident I know when I need to seek medical care and when I am able take care of myself.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)
60. I am confident I can talk to my doctor about my health concerns even when he or she does not ask.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)
61. I am confident I can follow through on medical treatments I may need to do at home.	<input type="radio"/> A)	<input type="radio"/> B)	<input type="radio"/> C)	<input type="radio"/> D)

62. Who completed this survey form? A) Myself B) Relative of mine C) Friend of mine D) Professional caregiver of mine
63. Do you live?
 A) Alone C) With other family member E) Nursing home or assisted living facility
 B) With Spouse D) With non-relative
64. What is your primary Language? A) English B) Spanish C) Other
65. What is the highest grade or level of school that you completed?
 A) 8th grade or less B) Some high school, but did not graduate C) High school graduate or GED
 D) Some college or 2 year degree E) 4 year college graduate F) More than a 4 year college degree
66. What is your ethnicity?
 A) African American B) Native American C) Hispanic D) Native Hawaiian E) Indian
 F) Asian G) Caucasian H) Pacific Islander I) Other
67. Do you ever choose not to seek medical care because of religious or personal beliefs? A) Yes B) No C) Prefer not to answer

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