



# Summary of Benefits

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## 2022

January 1, 2022 to  
December 31, 2022

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## Cigna Preferred Plus Medicare (HMO) H3949-013

Low out-of-pocket costs and no referrals required

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### To Join

You must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

### Service Area

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

Cigna Preferred Plus Medicare (HMO) H3949-013



# Introduction

This *Summary of Benefits* gives you a summary of what **Cigna Preferred Plus Medicare (HMO)** 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 **CignaMedicare.com**, or call us to request a copy.

## Comparing coverage

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**.

## More about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook.

View the handbook online at:  
**www.medicare.gov**

Get a copy of the handbook 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**.

## Need help?

### Already a customer

Call toll-free **1-800-668-3813 (TTY 711)**. Customer Service is available October 1 to March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 to September 30, Monday to Friday 8 a.m. to 8 p.m. local time. Our automated phone system may answer your call during weekends, holidays and after hours.

### Not a customer

Call toll-free **1-800-313-0973 (TTY 711)**, licensed agents are available October 1 to March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 to September 30, Monday to Friday 8 a.m. to 8 p.m. local time. Our automated phone system may answer your call during weekends, holidays and after hours.

You can also visit our website at:  
**CignaMedicare.com**

# 1 | About this Plan

## Which doctors, hospitals and pharmacies can I use?

**Cigna Preferred Plus Medicare (HMO)** 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, **CignaMedicare.com**.

## 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 *Comprehensive Prescription Drug List* which lists the Part D prescription drugs along with any restrictions on our website, **CignaMedicare.com**.
- › Or, call us and we will send you a copy of the plan's *Comprehensive Prescription Drug List*.

## 2 | Monthly Premium, Deductible and Limits

Benefit	Cigna Preferred Plus Medicare (HMO)
<b>Monthly Premium</b>	<b>\$135</b> monthly premium. In addition, you must keep paying your Medicare Part B premium.
<b>Medical Deductible</b>	This plan does not have a deductible
<b>Pharmacy (Part D) Deductible</b>	This plan does not have a deductible
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Original Medicare does not have annual limits on out-of-pocket costs.</p> <p>Your yearly limit(s) in this plan:  <b>\$4,900</b> for services you receive from in-network providers for Medicare-covered benefits.</p> <p>This limit is the most you pay for copays, coinsurance and other costs for Medicare services for the year. If you reach the limit on out-of-pocket costs, you will keep getting in-network covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>

# 3 | Covered Medical and Hospital Benefits

Benefit	What You Pay
<p><b>Note: Services with a <sup>1</sup> may require prior authorization.</b>  <b>Services with a <sup>2</sup> may require a referral from your doctor.</b></p>	
<p><b>Inpatient Hospital Coverage<sup>1</sup></b></p>	
<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with Day 1 each time you are admitted.</p> <p>There is a <b>\$0</b> copayment per lifetime reserve day.</p>	<p><b>\$225</b> per day for days 1–7  <b>\$0</b> per day for days 8–90</p>
<p><b>Outpatient Surgery</b></p>	
<p>Ambulatory Surgical Center (ASC)<sup>1</sup></p>	<p><b>\$0–\$125</b> copay</p>
<p>Outpatient Services<sup>1</sup></p>	<p><b>\$0–\$225</b> copay</p>
<p>Outpatient Observation<sup>1</sup></p>	<p><b>\$225</b> per stay</p>
<p><b>Doctors Visits</b></p>	
<p>Primary Care Physician (PCP)</p>	<p><b>\$0</b> copay</p>
<p>Specialists<sup>1</sup></p>	<p><b>\$25</b> copay</p>

Benefit	What You Pay
<b>Preventive Care</b>	
<p>Our plan covers many Medicare-covered preventive services, including:</p> <ul style="list-style-type: none"> <li>› Abdominal aortic aneurysm screening</li> <li>› Alcohol misuse screenings and counseling</li> <li>› Bone mass measurement</li> <li>› Breast cancer screening (mammogram)</li> <li>› Cardiovascular disease (behavioral therapy)</li> <li>› Cardiovascular screenings</li> <li>› Cervical and vaginal cancer screening</li> <li>› Colorectal cancer screening (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy)</li> <li>› Depression screenings</li> <li>› Diabetes screenings</li> <li>› Diabetes self-management training</li> <li>› Glaucoma tests</li> <li>› Hepatitis B Virus (HBV) infection screening</li> <li>› Hepatitis C screening</li> <li>› HIV screening</li> <li>› Lung cancer screening with low dose computed tomography (LDCT)</li> <li>› Medical nutrition therapy services</li> <li>› Obesity screening and counseling</li> <li>› Prostate cancer screenings (PSA)</li> <li>› Sexually transmitted infections screening and counseling</li> <li>› Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>› Vaccines; including COVID-19, Flu shots, Hepatitis B shots and Pneumococcal shots</li> <li>› Welcome to Medicare preventive visit (one-time)</li> <li>› Yearly Wellness visit</li> </ul>	<p><b>\$0</b> copay</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. Please see your <i>Evidence of Coverage</i> (EOC) for frequency of covered services.</p>
<b>Emergency Care</b>	
Emergency Care Services	<p><b>\$90</b> copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care.</p>
Worldwide Emergency/Urgent Coverage/Emergency Transportation	<p><b>\$90</b> copay</p> <p>Maximum worldwide coverage amount <b>\$50,000</b></p>

Benefit	What You Pay
<b>Urgently Needed Services</b>	
Urgent Care Services	<b>\$50</b> copay If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for urgent care.
<b>Diagnostic Services, Labs and Imaging</b> Costs for these services may vary based on place of service or type of service	
Diagnostic Procedures and Tests <sup>1</sup>	<b>\$0–\$50</b> copay
Lab Services <sup>1</sup> For COVID-19 testing a prior authorization is not required.	<b>\$0</b> copay
Therapeutic Radiological Services <sup>1</sup>	<b>\$60</b> copay
X-ray Services	<b>\$20</b> copay
Diagnostic Radiological Services (MRIs, CT scans, etc.) <sup>1</sup>	<b>\$0–\$75</b> copay
<b>Hearing Services</b>	
Hearing Exams (Medicare-covered) A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	<b>\$25</b> copay
Routine Hearing Exams	<b>\$0</b> copay for one routine exam every year
Hearing Aid Evaluation/Fitting	<b>\$0</b> copay for one hearing aid fitting evaluation every three years
Hearing Aids	<b>\$0</b> copay up to plan maximum coverage amount for hearing aids of <b>\$700</b> per ear per device every three years
<b>Dental Services (Medicare-covered)<sup>1</sup></b>	
Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth)	<b>\$25</b> copay
<b>Preventive Dental Services</b>	
Oral exams (four every year)	<b>\$0–\$55</b> copay
Cleanings (two every year)	<b>\$0–\$45</b> copay
Fluoride treatments	<b>\$0–\$15</b> copay
Dental x-rays	<b>\$0–\$81</b> copay

Benefit	What You Pay
<b>Comprehensive Dental Services</b>	
Diagnostic Services (unlimited)	<b>\$0</b> copay
Restorative Services (unlimited)	<b>\$0–\$815</b> copay
Endodontics (unlimited)	<b>\$38–\$675</b> copay
Periodontics (unlimited)	<b>\$0–\$115</b> copay
Extractions (unlimited)	<b>\$0</b> copay
Prosthodontics/oral surgery (unlimited)	<b>\$0–\$970</b> copay
<b>Vision Services</b>	
<p>Eye Exams (Medicare-covered)<sup>1</sup></p> <p>A separate physician cost-share will apply if additional services requiring cost-sharing are rendered. A facility cost-share may apply for procedures performed at an outpatient surgical center.</p>	<p><b>\$0</b> copay for Medicare-covered diabetic retinopathy screening</p> <p><b>\$25</b> copay for all other Medicare-covered vision services</p>
Routine Eye Exam	<b>\$0</b> copay for one routine exam every year
Glaucoma Screening (Medicare-covered) <sup>1</sup>	<b>\$0</b> copay
Eyewear (Medicare-covered)	<b>\$0</b> copay
<p>Routine Eyewear</p> <ul style="list-style-type: none"> <li>➤ Contact lenses</li> <li>➤ Eyeglasses-lenses and frames</li> <li>➤ Eyeglass lenses</li> <li>➤ Eyeglass frames</li> <li>➤ Upgrades</li> </ul>	<p><b>\$0</b> copay up to plan maximum coverage amount of <b>\$500</b> every year</p> <p>The plan specified allowance may be applied to one set of the member's choice of eyewear once per year, to include the eyeglass frame/lenses/lens options combination or contact lenses (to include related professional fees) in lieu of eyeglasses.</p>
<b>Mental Health Services</b>	
<p>Inpatient<sup>1</sup></p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>For each Medicare-covered hospital stay, you are required to pay the applicable cost-sharing, starting with Day 1 each time you are admitted.</p> <p>There is a <b>\$0</b> copayment per lifetime reserve day.</p>	<p><b>\$225</b> per day for days 1–7</p> <p><b>\$0</b> per day for days 8–90</p>
<p>Outpatient<sup>1</sup></p> <p>Individual or Group Therapy Visit</p>	<b>\$0</b> copay



Benefit	What You Pay
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	
Our plan covers up to 100 days in the SNF.	<b>\$0</b> per day for days 1–20 <b>\$188</b> per day for days 21–100
<b>Rehabilitation Services</b>	
Cardiac (Heart) Rehab Services <sup>1</sup>	<b>\$10</b> copay
Pulmonary Rehab Services <sup>1</sup>	<b>\$10</b> copay
Occupational Therapy Services <sup>1</sup>	<b>\$40</b> copay
Physical Therapy, Speech and Language Therapy Services <sup>1</sup>	<b>\$40</b> copay
Physical Therapy, Speech and Language Therapy Telehealth Services <sup>1</sup>	<b>\$0</b> copay
<b>Ambulance<sup>1</sup></b>	
Ground Service (one-way trip)	<b>\$245</b> copay
Air Service (one-way trip)	<b>20%</b> coinsurance
<b>Transportation</b>	
	Not Covered
<b>Prescription Drugs<sup>1</sup></b>	
Medicare Part B Drugs Medicare-covered Part B Drugs may be subject to step therapy requirements.	<b>20%</b> coinsurance This plan has Part D prescription drug coverage. See Section 4 in the <i>Summary of Benefits</i> .
<b>Foot Care (Podiatry Services)</b>	
Podiatry Services (Medicare-covered)	<b>\$25</b> copay
Routine Podiatry Services	Not Covered
<b>Medical Equipment and Supplies</b>	
Durable Medical Equipment (wheelchairs, oxygen, etc.) <sup>1</sup>	<b>20%</b> coinsurance
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies <sup>1</sup>	<b>20%</b> coinsurance
Diabetes Supplies and Services <sup>1</sup> Brand limitations apply to certain supplies.	<b>\$0</b> copay for diabetes self-management training <b>20%</b> coinsurance for therapeutic shoes or inserts <b>0%</b> or <b>20%</b> coinsurance for diabetic monitoring supplies

Benefit	What You Pay
<b>Fitness and Wellness Programs</b>	
<p>Fitness Program</p> <p>The program offers the flexibility of a fitness center membership, digital fitness tools, and a home fitness kit.</p>	\$0 copay
<b>Health Information Line</b>	
<p>Talk one-on-one with a Nurse Advocate* to get timely answers to your health-related questions at no additional cost, anytime day or night.</p> <p>*Nurse Advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.</p>	\$0 copay
<b>Chiropractic Care<sup>1</sup></b>	
Chiropractic Services (Medicare-covered)	\$15 copay
Routine Chiropractic Services	Not Covered
<b>Home Health<sup>1</sup></b>	
	\$0 copay
<b>Hospice</b>	
<p>Hospice care must be provided by a Medicare-certified hospice program.</p> <p>Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.</p>	\$0 copay
<b>Outpatient Substance Abuse<sup>1</sup></b>	
Individual or Group Therapy Visit	\$40 copay
<b>Opioid Treatment Services<sup>1</sup></b>	
FDA-approved treatment medications in addition to testing, counseling and therapy.	\$40 copay
<b>Over-the-Counter Items (OTC)</b>	
Over-the-counter drugs and other health-related pharmacy products, as listed in the <i>OTC Catalog</i> .	\$75 quarterly allowance

Benefit	What You Pay
<b>Home Delivered Meals<sup>1</sup></b>	
	<p><b>\$0</b> copayment for home delivered meals</p> <p>Limited to 14 meals per discharge from a qualified hospital stay or skilled nursing facility (up to three stays per year), ESRD care management is limited to 56 meals per benefit period.*</p> <p>*Authorization and/or referral applies to ESRD meals.</p>
<b>Telehealth Services (Medicare-covered)</b>	
<p>For nonemergency care, talk with a telehealth doctor via phone or video for certain telehealth services, including: allergies, cough, headache, sore throat, and other minor illnesses.</p>	<p><b>\$0</b> copay</p>
<b>Acupuncture Services</b>	
<p>Acupuncture Services (Medicare-covered)<sup>1</sup></p> <p>Services for chronic lower back pain.</p>	<p><b>\$20</b> copay</p>
<p>Supplemental Acupuncture Services</p>	<p>Not Covered</p>
<b>Additional Benefits</b> Enjoy these extra benefits included in your plan.	
<p>In-Home Safety<sup>1</sup></p> <p>Member may be required to contact plan for coordination and an assessment may be performed by an Occupational Therapist where available.</p>	<p><b>\$0</b> for <b>\$1,500</b> per lifetime combined limit for bathroom safety assessment and devices.</p> <p>Charges will be reimbursed up to the maximum plan benefit coverage once per lifetime.</p>
<p>Annual Physical Exam</p>	<p><b>\$0</b> copay</p>

# 4 | Prescription Drug Benefits

## Medicare Part D Drugs Initial Coverage

The following charts show the cost-sharing amounts for covered drugs under this plan. After you pay your yearly Part D deductible, you pay the following until your total yearly drug costs reach **\$4,430**. Total yearly drug costs are the total drug costs paid by both you and our plan.

You may get your drugs at preferred or standard network retail pharmacies, or preferred mail order pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy because it has a preferred agreement with your plan.

You can get your prescription from an out-of-network pharmacy, but may pay more than you would pay at an in-network pharmacy. If you reside in a long term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.

Your costs may be different if you qualify for *Extra Help*. Your copay or coinsurance is based on the drug tier for your medication, which you can find in the plan *Comprehensive Prescription Drug List* on our website **CignaMedicare.com**. Or, call us and we will send you a copy of the *Comprehensive Prescription Drug List*.

Tier	Supply	Mail Order Cost-Sharing		Retail Cost-Sharing	
		Preferred	Standard	Preferred	Standard
Tier 1 Preferred Generic Drugs	30-day	\$0	\$9	\$0	\$9
	60-day	\$0	\$18	\$0	\$18
	90-day	\$0	\$18	\$0	\$18
Tier 2 Generic Drugs	30-day	\$5	\$15	\$5	\$15
	60-day	\$10	\$30	\$10	\$30
	90-day	\$0	\$30	\$10	\$30
Tier 3 Preferred Brand Drugs	30-day	\$42	\$47	\$42	\$47
	60-day	\$84	\$94	\$84	\$94
	90-day	\$126	\$141	\$126	\$141
Tier 4 Non-Preferred Drugs	30-day	\$95	\$100	\$95	\$100
	60-day	\$190	\$200	\$190	\$200
	90-day	\$285	\$300	\$285	\$300
Tier 5 Specialty Drugs	30-day	33%	33%	33%	33%
	60-day	Not Available	Not Available	Not Available	Not Available
	90-day	Not Available	Not Available	Not Available	Not Available

## Coverage Gap

Most Medicare prescription drug plans have a Coverage Gap (also called the Donut Hole). This means that there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after your total yearly prescription drug cost (including what our plan has paid and what you have paid) reaches **\$4,430**. Not everyone will enter the Coverage Gap.

After you enter the Coverage Gap, you pay **25%** of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your costs total **\$7,050**, which is the end of the Coverage Gap.

This plan offers some additional prescription drug coverage for Tier 1 drugs in the Coverage Gap. See the table that follows to find out how much you will pay.

## Catastrophic Coverage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$7,050** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Your share of the cost of covered drugs will be the greater of:

- › Coinsurance of **5%** of the cost of the drug, or
- › **\$3.95** for a generic drug or a drug that is treated like a generic and **\$9.85** for all other drugs.
  - Our plan pays the rest of the cost.

Tier	Supply	Mail Order Cost-Sharing		Retail Cost-Sharing	
		Preferred	Standard	Preferred	Standard
Tier 1 Preferred Generic Drugs	30-day	\$0	\$9	\$0	\$9
	60-day	\$0	\$18	\$0	\$18
	90-day	\$0	\$18	\$0	\$18

