

Summary of Benefits



City of Memphis

Effective: January 1, 2015 – December 31, 2015

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Cigna-HealthSpring Preferred with Rx (HMO). Our plan is offered by HealthSpring of Tennessee and HealthSpring of Alabama, which is also called Cigna-HealthSpring, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Cigna-HealthSpring Preferred with Rx (HMO) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

Before you decide to leave Cigna-HealthSpring Preferred with Rx (HMO) please contact your Plan Sponsor for information about other plan options that may be available to you and any consequences for opting out of this group plan.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (Fee-for-Service) Medicare Plan. Another option is a Medicare health plan, like Cigna-HealthSpring Preferred with Rx (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Cigna-HealthSpring Preferred with Rx (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

WHERE IS CIGNA-HEALTHSPRING PREFERRED WITH RX (HMO) AVAILABLE?

Our service area includes these counties in **Tennessee**:

Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Cheatham, Chester, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Fayette, Fentress, Gibson, Giles, Grainger, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Haywood, Henderson, Hickman, Houston, Humphreys, Jackson, Jefferson, Knox, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sumner, Tipton, Trousdale, Union, Van Buren, Warren, Wayne, White, Williamson, Wilson.

Our service area includes these counties in **Mississippi**:

Covington, Desoto, Forrest, George, Hancock, Harrison, Hinds, Jackson, Jones, Madison, Marion, Marshall, Pearl River, Perry, Rankin, Stone, Tate

You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN CIGNA-HEALTHSPRING PREFERRED WITH RX (HMO)?

You can join Cigna-HealthSpring Preferred with Rx (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Cigna-HealthSpring Preferred with Rx (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Cigna-HealthSpring Preferred with Rx (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at <http://www.CignaHealthSpring.com>. Our customer

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service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

For HealthSpring Preferred with Rx (HMO), generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Cigna-HealthSpring Preferred with Rx (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.CignaHealthSpring.com>. Our customer service number is listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Cigna-HealthSpring Preferred with Rx (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG LIST?

Cigna-HealthSpring Preferred with Rx (HMO) uses a drug list. A drug list is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any change to the drug list that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a drug list to you and you can see our complete drug list on our Web site at <http://www.CignaHealthSpring.com>.

If you are currently taking a drug that is not on our drug list or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our drug list with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare

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costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see <http://www.medicare.gov> 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or * Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Cigna-HealthSpring Preferred with Rx (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Cigna-HealthSpring Preferred with Rx (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Cigna-HealthSpring Preferred with Rx (HMO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

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Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Cigna-HealthSpring Preferred with Rx (HMO) for more details.

-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

-- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.

-- Erythropoietin: By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

-- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

-- Some Oral Cancer Drugs: If the same drug is available in injectable form.

-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

-- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you can find the Plan Ratings information by using the Find health & drug plans web tool on [medicare.gov](http://www.medicare.gov) to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please contact the plan for further details. For more information about Cigna-HealthSpring Preferred with Rx (HMO) coverage or to speak with a Medicare specialist, call 1-888-281-7867 (TTY 711), 8 am - 8 pm, 7 days a week. Or visit the website at <http://www.CignaHealthSpring.com>. This information is available for free in other languages. Esta información está disponible de forma gratuita en otros idiomas. Por favor póngase en contacto con nuestro Departamento de servicio al cliente llamando al 1-888-281-7867 (TTY 711), 8 am - 8 pm, los siete días de la semana.

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit <http://www.medicare.gov> on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

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If you have any questions about this plan's benefits or costs, please contact Cigna-HealthSpring for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Cigna-HealthSpring Preferred with Rx (HMO)
IMPORTANT INFORMATION		
1 – Out-of-Pocket Limits	None	In-Network \$1500 out-of-pocket limit for Medicare-covered services.
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	In-Network You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).
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INPATIENT CARE		
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2014 the amounts for each benefit period were: Days 1 - 60: \$1,216 deductible Days 61 - 90: \$304 per day Days 91 - 150: \$608 per lifetime reserve day These amounts may change for 2015. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go	In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: \$0 per day copay – days 1-10 \$0 per day copay – days 11+ Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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	<p>into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	
<p>4 - Inpatient Mental Health Care</p>	<p>In 2014 the amounts for each benefit period were: Days 1 - 60: \$1,216 deductible Days 61 - 90: \$304 per day Days 91 - 150: \$608 per lifetime reserve day</p> <p>These amounts may change for 2015.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays: \$0 per day copay – days 1-10 \$0 per day copay – days 11-190</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2014 the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$152 per day</p> <p>These amounts may change for 2014.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p>

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	<p>100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>For SNF stays: \$0 per day copay – days 1-20 \$0 per day copay – days 21-100</p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 for Medicare-covered home health visits</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. Your plan will pay for a consultative visit before you select hospice.</p>
OUTPATIENT CARE		
<p>8 - Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>In-Network \$5 for each Medicare-covered primary care doctor visit. \$10 for each Medicare-covered specialist visit.</p>
<p>9 - Chiropractic Services</p>	<p>In-Network 20% coinsurance for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).</p>	<p>In-Network \$10 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).</p>

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10 - Podiatry Services	20% coinsurance for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically necessary foot care.	In-Network \$10 for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically necessary foot care.
11 - Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	General Authorization rules may apply. In-Network \$10 copay for each Medicare-covered individual therapy visit \$5 for each Medicare-covered group therapy visit \$10 of the cost for Medicare-covered partial hospitalization program services
12 - Outpatient Substance Abuse Care	20% coinsurance	General Authorization rules may apply. In-Network \$10 of the cost for Medicare-covered individual substance abuse outpatient treatment visits \$5 of the cost for Medicare-covered group substance abuse outpatient treatment visits
13 - Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	General Authorization rules may apply. In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit \$10 copay for each Medicare-covered outpatient hospital facility visit

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14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network \$0 for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	General \$50 for Medicare-covered emergency room visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the urgently-needed-care visit. NOT covered outside the U.S. except under limited circumstances.	General \$10 for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.

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17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered	General Authorization rules may apply. In-Network \$10 for Medicare-covered Occupational Therapy visits \$10 for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered durable medical equipment
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered prosthetic devices 10% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	General Authorization rules may apply. In-Network \$0 for Medicare-covered Diabetes self-management training \$0 of the cost for Medicare-covered Diabetes monitoring supplies \$10% of the cost for Medicare-covered Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies.

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21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - lab services</p> <p>\$0 copay to 10% for Medicare-covered diagnostic procedures and tests</p> <p>10% of the cost for Medicare-covered X-rays</p> <p>10% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>10% for Medicare-covered therapeutic radiology services</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$0 to 10% may apply</p>
22 - Cardiac and Pulmonary Rehabilitation Services	<p>20% coinsurance for Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 Medicare-covered Cardiac Rehabilitation Services</p> <p>\$10 for Medicare-covered Intensive Cardiac Rehabilitation Services</p> <p>\$10 copay for Medicare-covered Pulmonary Rehabilitation Services</p>
PREVENTIVE SERVICES		
23 -Preventive Services	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.</p>

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23 -Preventive Services	<ul style="list-style-type: none"> - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more 	

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23 -Preventive Services	<p>information.</p> <ul style="list-style-type: none"> - Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity - Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	
24 - Kidney Disease and Conditions	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	<p>In-Network</p> <p>\$10 for Medicare-covered renal dialysis</p> <p>\$0 for Medicare-covered kidney disease education services</p>

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25 - Outpatient Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B General</p> <p>10% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.</p> <p>Drugs covered under Medicare Part D General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.CignaHealthSpring.com on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p>
25 - Outpatient Prescription Drugs		<p>Your provider must get prior authorization from Cigna-HealthSpring Preferred with Rx (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription</p>

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<p>25 - Outpatient Prescription Drugs</p>		<p>Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Cigna-HealthSpring Preferred with Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug.</p> <p>In-Network \$0 deductible on all drugs</p> <p>Initial Coverage Your plan does not have a deductible. You pay the following until total yearly drug costs reach \$2,960:</p> <p>Retail Pharmacy Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs the following way(s): Tier 1: Preferred Generic - \$5 for a one-month (30-day) supply of drugs in this tier - \$10 for a two-month (60-day) supply of drugs in this tier - \$15 for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand - \$10 for a one-month (30-day) supply of drugs in this tier - \$20 for a two-month (60-day) supply of drugs in this tier - \$30 for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

Summary of Benefits



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Benefit	Original Medicare	Cigna-HealthSpring Preferred with Rx (HMO)
25 - Outpatient Prescription Drugs		<p>Tier 3: Non-Preferred/Specialty</p> <ul style="list-style-type: none"> - \$25 for a one-month (30-day) supply of drugs in this tier - \$50 for a two-month (60-day) supply of drugs in this tier - \$75 for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s):</p> <p>Tier 1: Preferred Generic - \$5 for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - \$10 for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred/Specialty - \$25 for a one-month (31-day) supply of drugs in this tier</p>
25 - Outpatient Prescription Drugs		<p>Mail Order Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs the following way(s):</p> <p>Tier 1: Preferred Generic - \$5 for a one-month (30-day) supply of drugs in this tier - - \$10 for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand - \$10 for a one-month (30-day) supply of drugs in this tier</p>

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Benefit	Original Medicare	Cigna-HealthSpring Preferred with Rx (HMO)
<p>25 - Outpatient Prescription Drugs</p>		<p>Tier 2: Preferred Brand - \$20 for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred/Specialty - \$25 for a one-month (30-day) supply of drugs in this tier - \$50 for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,960, you will continue to pay the same copays as the Initial Coverage Stage until the total out of pocket reaches \$4,700. At that point, you will go into the Catastrophic Coverage Stage</p> <p>After your total yearly drug costs reach \$2,960, you receive the same coverage as the Initial Coverage Stage.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: -5% coinsurance, or - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copay for all other drugs.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Cigna-HealthSpring Preferred with Rx (HMO).</p> <p>You can get out-of-network drugs the following way:</p>

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		<p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,960:</p> <p>Tier 1: Preferred Generic - 30% for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - 30% for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred/Specialty - 30% for a one-month (30-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>General Authorization rules may apply. In-Network</p> <p>Dental Services not covered</p>
27 - Hearing Services	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>Routine hearing exams not covered. \$10 copay for Medicare covered hearing exam</p>

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Benefit	Original Medicare	Cigna-HealthSpring Preferred with Rx (HMO)
28 - Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk</p> <p>Supplemental routine eye exams and eyeglasses (lenses and frames) not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery</p>	<p>In-Network \$10 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk</p> <p>Routine eye exams not covered</p> <p>\$200 allowance for - one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery - up to 1 pair(s) of eyeglasses (lenses and frames) every year - contact lenses</p>
Wellness/Education and Other Supplemental Benefits & Services	Not covered.	<p>In-Network The plan covers the following supplemental education/wellness programs: - Nursing Hotline</p>
Over-the-Counter Items	Not covered.	<p>General The plan does not cover Over-the-Counter items.</p>
Transportation (Routine)	Not covered.	<p>In-Network This plan does cover supplemental routine transportation.</p>
Acupuncture and Other Alternative Therapies	Not covered.	<p>In-Network This plan does not cover Acupuncture and other alternative therapies.</p>
Urgent Foreign Travel	Not Covered	Not Covered

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