HealthSpring℠

2027 Summary of Benefits

January 1, 2027 - December 31, 2027

HealthSpring Preferred Savings (HMO) H0439-016

Service Area:

Barrow, Butts, Carroll, Cherokee, Clayton, Coweta, DeKalb, Fayette, Forsyth, Fulton, Gwinnett, Heard, Henry, Newton, Pickens, Rockdale, and Spalding counties, **GA**

Introduction

HealthSpring Preferred Savings (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service that we cover or every limitation or exclusion. To get a complete list of services we cover, please call us and ask for the Evidence of Coverage (EOC) or access it online at **HealthSpring.com**.

This document is available in other formats such as Braille, large print, or audio CD.

To Join

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our Network

We have a network of doctors, hospitals, and other providers. Except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

And you must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Original Medicare

For coverage and costs of Original Medicare, look in your current **Medicare & You** handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Questions?

Visit our website at **HealthSpring.com** or call us:

- **Already a member**
  1-800-668-3813 (TTY 711) to speak with a Customer Service Representative.
- **Not a member yet**
  1-800-313-0973 (TTY 711) to speak with a Licensed Insurance Agent.

Our hours are 8 a.m. – 8 p.m. local time:
October – March: 7 days a week;
April – September: Monday – Friday.

Messaging service used weekends, after hours, and on federal holidays.

Premium, Deductible & Limits

Benefit	HealthSpring Preferred Savings (HMO)
Monthly Plan Premium	You pay **$0** per month. In addition, you must keep paying your Medicare Part B premium. We will lower your Medicare Part B premium by up to **$109** per month.
Medical Deductible	**$250** Medicare Part B deductible applies to the following services: • Cardiac & Intensive Cardiac Rehab Services • Pulmonary Rehab Services • Supervised Exercise Therapy (SET) for Symptomatic PAD Services • Partial Hospitalization Program • Intensive Outpatient Program Services • Occupational Therapy • Physical Therapy & Speech/Language Therapy • Opioid Treatment Program Services • Diagnostic Procedures/Tests • Diagnostic Radiological Services • Therapeutic Radiological Services • Outpatient X-Ray Services • Outpatient Hospital Services • Observation Services • Ambulatory Surgical Center (ASC) Services • Outpatient Substance Abuse – Individual & Group • Ground & Air Ambulance Services • Dialysis Services • Medicare-covered Dental Services • Medicare-covered Eye Exams • Medicare-covered Eyewear • Medicare-covered Hearing Exams
Maximum Out-of-Pocket Limit	You pay no more than **$9,850** each year for in-network Medicare-covered benefits. This limit does not include the monthly plan premium, if any, and cost-sharing for covered Part D prescription drugs.

Medical Benefits

Benefit	What You Pay
Services with a [1] may require prior authorization. Select services or medications may need approval from us before you are able to receive them**.** **Services with a [2] may require a referral.** A referral is an approval from your primary care provider to visit a specialist or receive certain services.	
Inpatient Hospital Coverage[1]	
You are covered for an unlimited number of days per stay.	**$400** copay per day for days 1-6. **$0** copay per day for days 7-90. **$0** copay per day for days 91 and beyond.
Outpatient Hospital Services	
Outpatient Hospital[1]	**$0** copay for surgical procedures during a colorectal screening. **$425** copay for all other outpatient services.
Outpatient Observation[1]	**$400** copay per stay.
Ambulatory Surgical Center (ASC) Services	
ASC Services[1]	**$0** copay for surgical procedures during a colorectal screening. **$400** copay for all other outpatient services.
Doctor Visits	
Primary Care Provider (PCP)	**$0** copay
Specialists[1]	**$50** copay
Preventive Care	
You are covered for many Medicare-covered preventive care services such as: • Breast cancer screenings (mammogram) • Prostate cancer screenings (PSA) • Vaccines, including COVID-19, flu/ influenza shots, hepatitis B shots, and pneumococcal shots	**$0** copay for preventive care services covered under Original Medicare at no cost-sharing. Any additional preventive care services approved by Medicare during the contract year will be covered. Most Part D vaccines, such as the shingles vaccine, may be covered at no cost to you.

Benefit	What You Pay
Emergency Care	
Emergency Care Services	**$115** copay If you are admitted to the hospital within 24 hours for the same condition, you do not pay this cost-share.
Worldwide Emergency/Urgent Care/ Emergency Transportation	**$115** copay for worldwide emergency and urgent care. **20%** coinsurance for worldwide emergency transportation. **$50,000** yearly maximum coverage amount.
Urgently Needed Services	
Urgent Care Services	**$40** copay
Diagnostic Services, Labs & Imaging Costs for these services may vary based on place or type of service.	
Diagnostic Procedures & Tests[1]	**$0** copay for EKG. **$95** copay for all other diagnostic procedures and tests.
Lab Services[1]	**$0** copay
Genetic Testing[1]	**20%** coinsurance
Diagnostic Radiology (MRIs, CT scans, etc.)[1]	**$0** copay for mammography and ultrasound. **$400** copay for all other diagnostic and nuclear medicine radiology services.
Therapeutic Radiology[1]	**20%** coinsurance
X-ray Services[1]	**$50** copay
Hearing Services	
Medicare-covered Hearing Exams Diagnostic hearing and balance exams.	**$50** copay
Routine Hearing Exam	**$0** copay for 1 routine hearing exam each year.
Hearing Aid Fitting Evaluations	**$0** copay for hearing aid fitting evaluations.
Hearing Aids You must get your hearing aids from our hearing vendor.	**$399**–**$1,800** copay for each device. Limited to 1 hearing aid per ear per year. Your actual cost-share depends on the hearing aid(s) you choose.
OTC Hearing Aids You must get your OTC hearing aid kit from our hearing vendor.	**$399** copay for each OTC hearing aid kit. Limited to 2 kits each year. Kit includes 1 device for each ear and an optional charger.

Benefit	What You Pay
Dental Services	
Medicare-covered Dental Services[1] Limited dental services. This does not include services such as cleanings, routine dental exams, and dental X-rays.	**$50** copay
Preventive & Comprehensive Dental Services	
Dental Allowance Helps pay for most preventive and comprehensive dental services. You can see any U.S.-licensed dentist who's not excluded by Medicare. Our dental allowance vendor, Cigna Dental, manages this benefit. To learn more, see your Dental Allowance Guide. Find it at **HealthSpring.com/Documents**. Or call Dental Customer Service at 1-866-213-7295 (TTY 711), 8 a.m. – 8 p.m. local time: October – March: 7 days a week; April – September: Monday – Friday.	**$0** for preventive and comprehensive dental services until you've spent your yearly allowance. Cigna Dental Allowance (DPPO) providers will bill our dental allowance vendor directly. Out-of-network dentists may ask to be paid at the time of service.
Maximum Coverage Amount	**$500** yearly allowance for preventive and comprehensive dental services.
Vision Services	
Medicare-covered Eye Exam Exam to diagnose and treat conditions and diseases of the eye.	**$0** copay for Medicare-covered glaucoma screening. **$0** copay for Medicare-covered diabetic retinopathy screening. **$50** copay for all other Medicare-covered vision services.
Medicare-covered Eyewear	**$0** copay
Routine Eye Exam You get a yearly routine eye exam, including eye refraction. For your routine vision services to be covered, you must get them from a provider in our vision vendor's network.	**$0** copay for 1 routine eye exam each year.

Benefit	What You Pay
Routine Eyewear Use your yearly allowance for 1 set of eyewear: • Eyeglasses (lenses and frames) • Eyeglass lenses • Eyeglass frames • Contact lenses (including contact lens fitting) • Upgrades	**$0** until you've spent your **$100** yearly allowance.
Mental Health Services	
Inpatient[1]	**$400** copay per day for days 1-5. **$0** copay per day for days 6-90.
Outpatient Individual or Group Therapy Visit[1]	**$30** copay
Acupuncture Services	
Medicare-covered Acupuncture[1] Services for chronic low back pain.	**$50** copay
Ambulance	
Ground Service (one-way trip)	**$300** copay
Air Service (one-way trip)[1]	**20%** coinsurance
Annual Physical Exam	
You get 1 physical exam each year. This is in addition to the Medicare-covered Annual Wellness Visit and the Welcome to Medicare Preventive Visit.	**$0** copay
Chiropractic Care	
Medicare-covered Chiropractic Services[1] Manual manipulation of the spine to correct subluxation.	**$15** copay

Benefit	What You Pay
Diabetic Services & Supplies	
Diabetic monitoring supplies, therapeutic shoes or inserts, and diabetes self-management training. Prior authorization may be required for non-preferred brands. See your EOC for details.	**0%** coinsurance for 1 preferred brand blood glucose monitor and 1 preferred brand continuous glucose monitoring device every 2 years.[1] Or **20%** coinsurance for 1 non-preferred brand blood glucose monitor and 1 non-preferred brand continuous glucose monitoring device every 2 years.[1] **0%** coinsurance for preferred brand diabetic supplies.[1] Or **20%** coinsurance for non-preferred brand diabetic supplies.[1] **20%** coinsurance for therapeutic shoes or inserts.[1] **$0** copay for diabetes self-management training.
Fitness & Wellness Programs	
You get a fitness center membership. You also get 1 Home Fitness Kit that may include a wearable fitness tracker option. You can also choose up to 2 DVD kit options. Plus, you get one-on-one Well-Being Coaching and digital fitness tools and resources.	**$0** copay Kits are based on availability and subject to change. Once selected, kits cannot be exchanged.
Home-Delivered Meals	
Up to 14 meals per discharge from a qualifying inpatient hospital or skilled nursing facility stay, up to 3 stays each year. Up to 56 meals each year when you're enrolled in our end-stage renal disease (ESRD) care management program.	**$0** copay for home-delivered meals that we cover. This benefit does not apply to releases from an emergency room, observation stay, or outpatient visit.
Home Health Care[1]	
You must be homebound, and a doctor must certify that you need home health services.	**$0** copay
Hospice	
Hospice is covered outside of our plan. Hospice care must be provided by a Medicare-certified hospice program.	**$0** copay for hospice consultation services (one time only) before you select hospice. You may have to pay part of the cost for drugs and respite care.

Benefit	What You Pay
Medical Equipment & Supplies	
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**20%** coinsurance
Prosthetic & Orthotic Devices (braces, artificial limbs, etc.)[1]	**20%** coinsurance
Medical Supplies[1]	**20%** coinsurance
Medicare Part B Drugs Medicare-covered Part B Drugs may be subject to step therapy requirements.	
Medicare Part B Insulin Drugs	You will pay a maximum of **$35** for each 1–month supply of Medicare–covered Part B insulin drugs. Any plan deductible does not apply.
Medicare Part B Chemotherapy/ Radiation Drugs[1]	**0%–20%** coinsurance
Other Medicare Part B Drugs[1]	**0%–20%** coinsurance This plan has Part D prescription drug coverage. See the Prescription Drug Benefits section in this Summary of Benefits.
Podiatry Services (Foot Care)	
Medicare-covered Podiatry Services Podiatrist foot exams or treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases.	**$50** copay
Rehabilitation Therapy Services	
Occupational Therapy Services[1]	**$35** copay
Physical Therapy & Speech/Language Therapy Services[1]	**$35** copay
Skilled Nursing Facility (SNF)[1]	
You are covered for up to 100 days per benefit period.	**$0** copay per day for days 1-20. **$221** copay per day for days 21-100.
Telehealth Services with MD Live	
24/7 non-emergency urgent care for issues such as allergies, cough, headache, sore throat, and other minor illnesses. Talk with an MD Live® provider by phone, computer, or tablet. They also offer mental health and dermatology care.	**$0** copay for each non-emergency urgent care visit. **$0** copay for each mental health and behavioral health therapy visit. **$50** copay for each dermatology care visit.

Prescription Drug Benefits

This chart shows the cost-sharing for your Part D prescription drugs covered under this plan.* Your cost-sharing may be different if you qualify for Extra Help.

Part D Deductible

$0 deductible for drugs in Tiers 1 and 2. Your coverage for Part D prescription drugs in these tiers begins in the Initial Coverage Stage.

$700 deductible for all other tiers. You pay the full cost of these drugs until you reach the deductible amount. Once you reach the deductible amount, you enter the Initial Coverage Stage.

Initial Coverage Stage

During this stage, you pay the following until your annual out-of-pocket drug costs reach **$2,400**:

		Mail Order Pharmacy		Retail Pharmacy	
Tier	**Supply**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 Preferred Generic Drugs	30-day	**$0**	**$10**	**$0**	**$10**
	100-day	**$0**	**$30**	**$0**	**$30**
Tier 2 Generic Drugs	30-day	**$4**	**$20**	**$4**	**$20**
	100-day	**$0**	**$60**	**$12**	**$60**
Tier 3 Preferred Brand Drugs	30-day	**20%**	**20%**	**20%**	**20%**
	100-day	**20%**	**20%**	**20%**	**20%**
Tier 4 Non-Preferred Drugs	30-day	**25%**	**25%**	**25%**	**25%**
	100-day	**25%**	**25%**	**25%**	**25%**
Tier 5 Specialty Drugs	30-day	**25%**	**25%**	**25%**	**25%**
	90-day	**N/A**	**N/A**	**N/A**	**N/A**

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage stage when your annual out-of-pocket drug costs reach **$2,400**.

Once you are in the Catastrophic Coverage stage, you will pay **$0** for all covered Part D drugs for the rest of the year.

*Your cost-sharing may also differ based on which Part D coverage stage you are in, the pharmacy type or status (such as preferred/non-preferred, mail order, long-term care (LTC), home infusion), and whether you are filling a 30-, 60-, or 90-/100-day supply. Some pharmacies may have day supply restrictions based on their dispensing policies.

What You Pay for Insulin

- You won't pay more than **$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
- If your insulin is on a tier where cost-sharing is lower than **$35,** you will pay the lower cost for your insulin.
- If your plan has a Part D deductible, the above will apply even if you haven't paid your deductible.

Dental Allowance: The preventive and comprehensive dental services are administered through Cigna Health and Life Insurance Company and, in New York, Cigna Health and Life Adjuster Services. Not all dental services are covered. Please see the Dental Allowance Guide for more information.

Benefits, features, and/or devices vary by plan/service area. Limitations, copayments, exclusions, and restrictions may apply. Contact the plan for more information.

Out-of-network/non-contracted providers are under no obligation to treat plan members except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions, call Customer Service at 1-800-668-3813 (TTY 711). Our hours are 8 a.m. – 8 p.m. local time, October – March: 7 days a week. April – September: Monday – Friday. Messaging service used weekends, after hours, and on federal holidays.

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