HealthSpring℠

# 2027 Summary of Benefits

## January 1, 2027 - December 31, 2027

### HealthSpring Preferred (HMO) H0672-005

**Service Area:**

Bernalillo, Sandoval, Santa Fe, Torrance, and Valencia counties, **NM**

# Introduction

**HealthSpring Preferred (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 (HMO) |
|---|---|
| **Monthly Plan Premium** | You pay **$0** per month.<br>In addition, you must keep paying your Medicare Part B premium. |
| **Medical Deductible** | This plan does not have a deductible. |
| **Maximum Out-of-Pocket Limit** | You pay no more than **$4,300** each year for in-network Medicare-covered benefits.<br>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**.**<br>**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. | **$375** copay per day for days 1-5.<br>**$0** copay per day for days 6-90.<br>**$0** copay per day for days 91 and beyond. |
| **Outpatient Hospital Services** | |
| Outpatient Hospital[1] | **$0** copay for surgical procedures during a colorectal screening.<br>**$300** copay for all other outpatient services. |
| Outpatient Observation[1] | **$300** copay per stay. |
| **Ambulatory Surgical Center (ASC) Services** | |
| ASC Services[1] | **$0** copay for surgical procedures during a colorectal screening.<br>**$250** copay for all other outpatient services. |
| **Doctor Visits** | |
| Primary Care Provider (PCP) | **$0** copay |
| Specialists[1] | **$30** copay |
| **Preventive Care** | |
| You are covered for many Medicare-covered preventive care services such as:<br>• Breast cancer screenings (mammogram)<br>• Prostate cancer screenings (PSA)<br>• 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.<br>Any additional preventive care services approved by Medicare during the contract year will be covered.<br>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 | **$150** copay<br>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 | **$150** copay for worldwide emergency and urgent care.<br>**20%** coinsurance for worldwide emergency transportation.<br>**$50,000** yearly maximum coverage amount. |
| **Urgently Needed Services** | |
| Urgent Care Services | **$65** copay |
| **Diagnostic Services, Labs & Imaging**<br>Costs for these services may vary based on place or type of service. | |
| Diagnostic Procedures & Tests[1] | **$0** copay for EKG.<br>**$25** 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.<br>**$225** copay for all other diagnostic and nuclear medicine radiology services. |
| Therapeutic Radiology[1] | **20%** coinsurance |
| X-ray Services[1] | **$0** copay in a PCP or specialist office.<br>**$10** copay for all other facilities. |
| **Hearing Services** | |
| Medicare-covered Hearing Exams<br>Diagnostic hearing and balance exams. | **$30** 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<br>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.<br>Your actual cost-share depends on the hearing aid(s) you choose. |

| Benefit | What You Pay |
|---|---|
| OTC Hearing Aids<br>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.<br>Kit includes 1 device for each ear and an optional charger. |
| **Dental Services** | |
| Medicare-covered Dental Services[1]<br>Limited dental services. This does not include services such as cleanings, routine dental exams, and dental X-rays. | **$30** copay |
| **Preventive & Comprehensive Dental Services** | |
| Dental Allowance<br>Helps pay for most preventive and comprehensive dental services.<br>You can see any U.S.-licensed dentist who's not excluded by Medicare.<br>Our dental allowance vendor, Cigna Dental, manages this benefit.<br>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.<br>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 | **$1,200** yearly allowance for preventive and comprehensive dental services. |
| **Vision Services** | |
| Medicare-covered Eye Exam<br>Exam to diagnose and treat conditions and diseases of the eye. | **$0** copay for Medicare-covered glaucoma screening.<br>**$0** copay for Medicare-covered diabetic retinopathy screening.<br>**$30** copay for all other Medicare-covered vision services. |
| Medicare-covered Eyewear | **$0** copay |
| Routine Eye Exam<br>You get a yearly routine eye exam, including eye refraction.<br>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<br>Use your yearly allowance for 1 set of eyewear:<br>• Eyeglasses (lenses and frames)<br>• Eyeglass lenses<br>• Eyeglass frames<br>• Contact lenses (including contact lens fitting)<br>• Upgrades | **$0** until you've spent your **$100** yearly allowance. |
| **Mental Health Services** | |
| Inpatient[1] | **$375** copay per day for days 1-5.<br>**$0** copay per day for days 6-90. |
| Outpatient Individual or Group Therapy Visit[1] | **$10** copay |
| **Acupuncture Services** | |
| Medicare-covered Acupuncture[1]<br>Services for chronic low back pain. | **$30** copay |
| **Ambulance** | |
| Ground Service (one-way trip) | **$240** 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]<br>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.<br>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<br>**20%** coinsurance for 1 non-preferred brand blood glucose monitor and 1 non-preferred brand continuous glucose monitoring device every 2 years.[1]<br>**0%** coinsurance for preferred brand diabetic supplies.[1] Or<br>**20%** coinsurance for non-preferred brand diabetic supplies.[1]<br>**20%** coinsurance for therapeutic shoes or inserts.[1]<br>**$0** copay for diabetes self-management training. |
| **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.<br>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.<br>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.<br>Hospice care must be provided by a Medicare-certified hospice program. | **$0** copay for hospice consultation services (one time only) before you select hospice.<br>You may have to pay part of the cost for drugs and respite care. |
| **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 |

| Benefit | What You Pay |
|---|---|
| **Medicare Part B Drugs**<br>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<br>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<br>Podiatrist foot exams or treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases. | **$30** copay |
| **Rehabilitation Therapy Services** | |
| Occupational Therapy Services[1] | **$30** copay |
| Physical Therapy & Speech/Language Therapy Services[1] | **$30** copay |
| **Skilled Nursing Facility (SNF)[1]** | |
| You are covered for up to 100 days per benefit period. | **$20** copay per day for days 1-20.<br>**$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.<br>Talk with an MD Live® provider by phone, computer, or tablet.<br>They also offer mental health and dermatology care. | **$0** copay for each non-emergency urgent care visit.<br>**$0** copay for each mental health and behavioral health therapy visit.<br>**$30** 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.

**$500** deductible for Tiers 3, 4, and 5. 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 | **28%** | **28%** | **28%** | **28%** |
| | 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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