HealthSpring℠

2027 Summary of Benefits

January 1, 2027 - December 31, 2027

HealthSpring True Choice (PPO) H7849-102-001

Service Area:

Clay, Craighead, Crittenden, Cross, Greene, Independence, Jackson, Lawrence, Lee, Mississippi, Poinsett, Randolph, St. Francis, White, and Woodruff counties, **AR**

Introduction

HealthSpring True Choice (PPO) 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. You may also choose to use providers that are out-of-network, usually for a higher copay or coinsurance.

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 True Choice (PPO)
Monthly Plan Premium	You pay **$0** per month. In addition, you must keep paying your Medicare Part B premium.
Medical Deductible	**$1,000** Medicare Part A/B deductible applies to the following services both in-network and out-of-network: • 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

Benefit	HealthSpring True Choice (PPO)
	The deductible also applies to these services out-of-network: • Inpatient Hospital Acute • Inpatient Hospital Psychiatric • Skilled Nursing Facility (SNF) • Home Health • Primary Care Physician (PCP) • Medicare-covered Chiropractic • Physician Specialist • Outpatient Mental Health – Individual & Group • Medicare-covered Podiatry • Other Healthcare Professional • Outpatient Psychiatric – Individual & Group • Lab Services • Outpatient Blood Services • Durable Medical Equipment (DME) • Prosthetic Devices • Medical Supplies • Diabetic Supplies • Diabetic Monitors • Diabetic Therapeutic Shoes/Inserts • Kidney Disease Education Services • Glaucoma Screening • Diabetes Self-Management Training • Digital Rectal Exams • EKG following Welcome Visit • Medicare Part B Chemotherapy/Radiation Drugs • Other Medicare Part B Drugs
Maximum Out-of-Pocket Limit	You pay no more than **$9,850** each year for in-network Medicare-covered benefits. You pay no more than **$14,800** each year for Medicare-covered benefits in-network and out-of-network combined. 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	
	In-Network	Out-of-Network
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 in-network hospital stay.	**$375** copay per day for days 1-6. **$0** copay per day for days 7-90. **$0** copay per day for days 91 and beyond.	**50%** coinsurance per stay.
Outpatient Hospital Services		
Outpatient Hospital[1]	**$0** copay for surgical procedures during a colorectal screening. **$375** copay for all other outpatient services.	**50%** coinsurance
Outpatient Observation[1]	**$375** copay per stay.	**50%** coinsurance
Ambulatory Surgical Center (ASC) Services		
ASC Services[1]	**$0** copay for surgical procedures during a colorectal screening. **$375** copay for all other outpatient services.	**50%** coinsurance
Doctor Visits		
Primary Care Provider (PCP)	**$0** copay	**50%** coinsurance
Specialists[1]	**$50** copay	**50%** coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
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.	**50%** coinsurance for preventive care services covered under Original Medicare. 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.
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. **$150** copay for all other diagnostic procedures and tests.	**50%** coinsurance
Lab Services[1]	**$0** copay	**50%** coinsurance
Genetic Testing[1]	**20%** coinsurance	**50%** coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
Diagnostic Radiology (MRIs, CT scans, etc.)[1]	**$0** copay for mammography and ultrasound. **$225** copay for all other diagnostic and nuclear medicine radiology services.	**50%** coinsurance
Therapeutic Radiology[1]	**$60** copay	**50%** coinsurance
X-ray Services[1]	**$0** copay in a PCP or specialist office. **$50** copay for all other facilities.	**50%** coinsurance
Hearing Services		
Medicare-covered Hearing Exams Diagnostic hearing and balance exams.	**$20** copay	**50%** coinsurance
Routine Hearing Exam	Not covered	
Hearing Aid Fitting Evaluations	Not covered	
Hearing Aids	Not covered	
OTC Hearing Aids	Not covered	
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	**50%** coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
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, in-network and out-of-network combined, 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. **$30** copay for all other Medicare-covered vision services.	**50%** coinsurance for Medicare-covered glaucoma screening. **50%** coinsurance for Medicare-covered diabetic retinopathy screening. **50%** coinsurance for all other Medicare-covered vision services.
Medicare-covered Eyewear	**$0** copay	**50%** coinsurance
Routine Eye Exam You get a yearly routine eye exam, including eye refraction. One yearly routine eye exam is covered either in-network or out-of-network.	**$0** copay for 1 routine eye exam each year.	**50%** coinsurance for 1 routine eye exam each year.

Benefit	What You Pay	
	In-Network	Out-of-Network
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, in-network and out-of-network combined.	
Mental Health Services		
Inpatient[1]	**$345** copay per day for days 1-6. **$0** copay per day for days 7-90.	**50%** coinsurance per stay.
Outpatient Individual or Group Therapy Visit[1]	**$10** copay	**50%** coinsurance
Acupuncture Services		
Medicare-covered Acupuncture[1] Services for chronic low back pain.	**$50** copay	**50%** coinsurance
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. One yearly exam is covered, either in-network or out-of-network.	**$0** copay	**50%** coinsurance
Chiropractic Care		
Medicare-covered Chiropractic Services[1] Manual manipulation of the spine to correct subluxation.	**$15** copay	**50%** coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
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.	**50%** coinsurance for 1 blood glucose monitor and 1 continuous glucose monitoring device every 2 years. **50%** coinsurance for diabetic supplies. **50%** coinsurance for therapeutic shoes or inserts. **50%** coinsurance for diabetes self-management training.
Home Health Care[1]		
You must be homebound, and a doctor must certify that you need home health services.	**$0** copay	**50%** coinsurance
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.	
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	**20%** coinsurance	**50%** coinsurance
Prosthetic & Orthotic Devices (braces, artificial limbs, etc.)[1]	**20%** coinsurance	**50%** coinsurance

Benefit	What You Pay	
	In-Network	**Out-of-Network**
Medical Supplies[1]	**20%** coinsurance	**50%** 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.	**25%** coinsurance
Medicare Part B Chemotherapy/ Radiation Drugs[1]	**0%–20%** coinsurance	**25%** 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.	**25%** 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	**50%** coinsurance
Rehabilitation Therapy Services		
Occupational Therapy Services[1]	**$35** copay	**50%** coinsurance
Physical Therapy & Speech/Language Therapy Services[1]	**$35** copay	**50%** coinsurance
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.	**50%** coinsurance per stay.

Benefit	What You Pay	
	In-Network	Out-of-Network
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.	Coverage is limited to MD Live.

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**
	90-day	**$0**	**$30**	**$0**	**$30**
Tier 2 Generic Drugs	30-day	**$4**	**$20**	**$4**	**$20**
	90-day	**$0**	**$60**	**$12**	**$60**
Tier 3 Preferred Brand Drugs	30-day	**20%**	**20%**	**20%**	**20%**
	90-day	**20%**	**20%**	**20%**	**20%**
Tier 4 Non-Preferred Drugs	30-day	**25%**	**25%**	**25%**	**25%**
	90-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.

HealthSpring products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company. Health Care Service Corporation and its affiliates contract with Medicare to offer Medicare Advantage HMO and PPO plans and Part D Prescription Drug Plans (PDP) in select states, and with select State Medicaid programs. Enrollment in a HealthSpring plan depends on contract renewal. © 2026 Health Care Service Corporation. All Rights Reserved.

5004537.0626