

# 2026 Summary of Benefits

January 1, 2026 - December 31, 2026

## **HealthSpring True Choice (PPO) H7849-113-003**

Freedom to choose your own doctor with no referrals required; your benefits travel with you to other HealthSpring PPO networks across the country

### **Service Area:**

Alleghany, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Wilkes, and Yadkin counties, **NC**

# 1 | 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?

For more information, please 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.

## 2 | Premium, Deductible & Limits

| Benefit                     | HealthSpring True Choice (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly Plan Premium</b> | <p>You pay <b>\$0</b> per month.</p> <p>In addition, you must keep paying your Medicare Part B premium.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Medical Deductible</b>   | <p><b>\$710</b> Medicare Part A/B deductible applies to the following services both in network and out of network:</p> <ul style="list-style-type: none"> <li>• Cardiac &amp; Intensive Cardiac Rehab Services</li> <li>• Pulmonary Rehab Services</li> <li>• Supervised Exercise Therapy (SET) for Symptomatic PAD Services</li> <li>• Partial Hospitalization Program</li> <li>• Intensive Outpatient Program Services</li> <li>• Occupational Therapy</li> <li>• Physical Therapy &amp; Speech/Language Therapy</li> <li>• Opioid Treatment Program Services</li> <li>• Diagnostic Procedures/Tests</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-Ray Services</li> <li>• Outpatient Hospital Services</li> <li>• Observation Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Outpatient Substance Abuse – Individual &amp; Group</li> <li>• Ground &amp; Air Ambulance Services</li> <li>• Dialysis Services</li> <li>• Medicare-covered Dental Services</li> <li>• Medicare-covered Eye Exams</li> <li>• Medicare-covered Eyewear</li> <li>• Medicare-covered Hearing Exams</li> </ul> |

| Benefit                            | HealthSpring True Choice (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                    | <p>The deductible also applies to these services out of network:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Acute</li> <li>• Inpatient Hospital Psychiatric</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Home Health</li> <li>• Primary Care Physician (PCP)</li> <li>• Medicare-covered Chiropractic</li> <li>• Physician Specialist</li> <li>• Outpatient Mental Health - Individual &amp; Group</li> <li>• Medicare-covered Podiatry</li> <li>• Other Healthcare Professional</li> <li>• Outpatient Psychiatric – Individual &amp; Group</li> <li>• Lab Services</li> <li>• Outpatient Blood Services</li> <li>• Durable Medical Equipment (DME)</li> <li>• Prosthetic Devices</li> <li>• Medical Supplies</li> <li>• Diabetic Supplies</li> <li>• Diabetic Therapeutic Shoes/Inserts</li> <li>• Kidney Disease Education Services</li> <li>• Glaucoma Screening</li> <li>• Diabetes Self-Management Training</li> <li>• Digital Rectal Exams</li> <li>• EKG following Welcome Visit</li> <li>• Medicare Part B Chemotherapy/Radiation Drugs</li> <li>• Other Medicare Part B Drugs</li> </ul> |
| <b>Maximum Out-of-Pocket Limit</b> | <p>You pay no more than <b>\$4,900</b> each year for in-network Medicare-covered benefits.</p> <p>You pay no more than <b>\$10,100</b> each year for Medicare-covered benefits in network and out of network combined.</p> <p>This limit does not include the monthly plan premium, if any, and cost-sharing for covered Part D prescription drugs.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

# 3 | Medical Benefits

| Benefit                                                                                                                                                                                                                                                                                                                                                   | What You Pay                                                                                                                                           |                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
|                                                                                                                                                                                                                                                                                                                                                           | In-Network                                                                                                                                             | Out-of-Network                   |
| <p><b>Services with a <sup>1</sup> may require prior authorization.</b> Select services or medications may need approval from us before you are able to receive them.</p> <p><b>Services with a <sup>2</sup> may require a referral.</b> A referral is an approval from your primary care provider to visit a specialist or receive certain services.</p> |                                                                                                                                                        |                                  |
| <b>Inpatient Hospital Coverage<sup>1</sup></b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                        |                                  |
|                                                                                                                                                                                                                                                                                                                                                           | <p><b>\$295</b> copay per day for days 1-7.</p> <p><b>\$0</b> copay per day for days 8-90.</p> <p><b>\$0</b> copay per day for days 91 and beyond.</p> | <b>35%</b> coinsurance per stay. |
| <b>Outpatient Hospital Services</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                        |                                  |
| Outpatient Hospital <sup>1</sup>                                                                                                                                                                                                                                                                                                                          | <p><b>\$0</b> copay for surgical procedures during a colorectal screening.</p> <p><b>\$275</b> copay for all other outpatient services.</p>            | <b>35%</b> coinsurance           |
| Outpatient Observation <sup>1</sup>                                                                                                                                                                                                                                                                                                                       | <b>\$275</b> copay per stay.                                                                                                                           | <b>35%</b> coinsurance           |
| <b>Ambulatory Surgical Center (ASC) Services</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                        |                                  |
| ASC Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                 | <p><b>\$0</b> copay for surgical procedures during a colorectal screening.</p> <p><b>\$250</b> copay for all other outpatient services.</p>            | <b>35%</b> coinsurance           |
| <b>Doctor Visits</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                        |                                  |
| Primary Care Provider (PCP)                                                                                                                                                                                                                                                                                                                               | <b>\$0</b> copay                                                                                                                                       | <b>\$50</b> copay                |
| Specialists <sup>1</sup>                                                                                                                                                                                                                                                                                                                                  | <b>\$30</b> copay                                                                                                                                      | <b>\$65</b> copay                |

| Benefit                                                                                                                                                                                                                                                                                                                    | What You Pay                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                            | In-Network                                                                                                                                                                                                                                                                                                          | Out-of-Network                                                                                                                                                                                                                                                                                    |
| <b>Preventive Care</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                   |
| <p>You are covered for many Medicare-covered preventive care services such as:</p> <ul style="list-style-type: none"> <li>Breast cancer screenings (mammogram)</li> <li>Prostate cancer screenings (PSA)</li> <li>Vaccines, including COVID-19, flu/ influenza shots, hepatitis B shots, and pneumococcal shots</li> </ul> | <p><b>\$0</b> copay for preventive care services covered under Original Medicare at no cost-sharing.</p> <p>Any additional preventive care services approved by Medicare during the contract year will be covered.</p> <p>Most Part D vaccines, such as the shingles vaccine, may be covered at no cost to you.</p> | <p><b>\$50</b> copay for preventive care services covered under Original Medicare.</p> <p>Any additional preventive care services approved by Medicare during the contract year will be covered.</p> <p>Most Part D vaccines, such as the shingles vaccine, may be covered at no cost to you.</p> |
| <b>Emergency Care</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                   |
| Emergency Care Services                                                                                                                                                                                                                                                                                                    | <p><b>\$130</b> copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you do not pay this cost-share.</p>                                                                                                                                                                        | Same as in-network                                                                                                                                                                                                                                                                                |
| Worldwide Emergency/Urgent Coverage/Emergency Transportation                                                                                                                                                                                                                                                               | <p><b>\$130</b> copay</p> <p><b>\$50,000</b> yearly maximum coverage amount.</p>                                                                                                                                                                                                                                    | Same as in-network                                                                                                                                                                                                                                                                                |
| <b>Urgently Needed Services</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                   |
| Urgent Care Services                                                                                                                                                                                                                                                                                                       | <p><b>\$50</b> copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you do not pay this cost-share.</p>                                                                                                                                                                         | Same as in-network                                                                                                                                                                                                                                                                                |
| <b>Diagnostic Services, Labs &amp; Imaging</b>                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                   |
| Costs for these services may vary based on place or type of service.                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                   |
| Diagnostic Procedures & Tests <sup>1</sup>                                                                                                                                                                                                                                                                                 | <p><b>\$0</b> copay for EKG.</p> <p><b>\$95</b> copay for all other diagnostic procedures and tests.</p>                                                                                                                                                                                                            | <b>35%</b> coinsurance                                                                                                                                                                                                                                                                            |
| Lab Services <sup>1</sup>                                                                                                                                                                                                                                                                                                  | <b>\$0</b> copay                                                                                                                                                                                                                                                                                                    | <b>35%</b> coinsurance                                                                                                                                                                                                                                                                            |
| Genetic Testing <sup>1</sup>                                                                                                                                                                                                                                                                                               | <b>\$50</b> copay                                                                                                                                                                                                                                                                                                   | <b>35%</b> coinsurance                                                                                                                                                                                                                                                                            |

| Benefit                                                                                                                                                             | What You Pay                                                                                                                               |                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
|                                                                                                                                                                     | In-Network                                                                                                                                 | Out-of-Network                                                                   |
| Diagnostic Radiology (MRIs, CT scans, etc.)                                                                                                                         | <b>\$0–\$195</b> copay                                                                                                                     | <b>35%</b> coinsurance                                                           |
| Therapeutic Radiology <sup>1</sup>                                                                                                                                  | <b>\$85</b> copay                                                                                                                          | <b>35%</b> coinsurance                                                           |
| X-ray Services                                                                                                                                                      | <b>\$0</b> copay in a PCP or specialist office.<br><b>\$30</b> copay for all other facilities.                                             | <b>35%</b> coinsurance                                                           |
| <b>Hearing Services</b>                                                                                                                                             |                                                                                                                                            |                                                                                  |
| Medicare-covered Hearing Exams<br>Diagnostic hearing and balance exams.                                                                                             | <b>\$25</b> copay                                                                                                                          | <b>35%</b> coinsurance                                                           |
| Routine Hearing Exam<br>You can get a yearly routine hearing exam from an in-network provider or an out-of-network provider. But you can't get an exam from both.   | <b>\$0</b> copay for 1 routine hearing exam each year.                                                                                     | <b>50%</b> coinsurance for 1 routine hearing exam each year.                     |
| Hearing Aid Fitting Evaluation<br>You can get a yearly fitting from an in-network provider or an out-of-network provider. But you can't get a fitting from both.    | <b>\$0</b> copay for 1 hearing aid fitting each year.                                                                                      | <b>50%</b> coinsurance for 1 hearing aid fitting each year.                      |
| Hearing Aids                                                                                                                                                        | <b>\$399–\$1,800</b> copay per device, limited to 2 devices each year.<br>Your actual cost-share depends on the hearing aid(s) you choose. | You must get your hearing aid benefit from our hearing vendor to be covered.     |
| OTC Hearing Aids                                                                                                                                                    | <b>\$399</b> copay per OTC hearing aid kit, limited to 2 kits each year.<br>Kit includes 1 device for each ear and an optional charger.    | You must get your OTC hearing aid kit from our OTC hearing vendor to be covered. |
| <b>Dental Services</b>                                                                                                                                              |                                                                                                                                            |                                                                                  |
| Medicare-covered Dental Services <sup>1</sup><br>Limited dental services. This does not include services such as cleaning, routine dental exams, and dental X-rays. | <b>\$30</b> copay                                                                                                                          | <b>\$65</b> copay                                                                |

| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | What You Pay                                                                                                                                                                                                           |                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | In-Network                                                                                                                                                                                                             | Out-of-Network                                                                                                                                                                                                                    |
| <b>Preventive &amp; Comprehensive Dental Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |
| <p>Dental Allowance</p> <p>Helps pay for most preventive and comprehensive dental services.</p> <p>You can see any U.S.-licensed dentist who's not excluded by Medicare.</p> <p>This benefit is managed by Cigna Dental. They're our dental allowance vendor.</p> <p>To learn more, see your Dental Allowance Guide. Find it online at <b>HealthSpring.com/documents</b>. 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.</p> | <p><b>\$0</b> for preventive and comprehensive dental services until you've spent your yearly allowance.</p> <p>Cigna Dental Allowance (DPPO) providers will bill our dental allowance vendor directly.</p>            | <p><b>50%</b> coinsurance for preventive and comprehensive dental services until you've spent your yearly allowance.</p> <p>Out-of-network providers may ask for payment at the time of service.</p>                              |
| Maximum Coverage Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$1,400</b> yearly allowance, in network and out of network combined, for preventive and comprehensive dental services.                                                                                             | <b>\$1,400</b> yearly allowance, in network and out of network combined, for preventive and comprehensive dental services.                                                                                                        |
| <b>Vision Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |
| <p>Medicare-covered Eye Exam</p> <p>Exam to diagnose and treat conditions and diseases of the eye.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p><b>\$0</b> copay for Medicare-covered glaucoma screening.</p> <p><b>\$0</b> copay for Medicare-covered diabetic retinopathy screening.</p> <p><b>\$30</b> copay for all other Medicare-covered vision services.</p> | <p><b>\$0</b> copay for Medicare-covered glaucoma screening.</p> <p><b>35%</b> coinsurance for Medicare-covered diabetic retinopathy screening.</p> <p><b>35%</b> coinsurance for all other Medicare-covered vision services.</p> |
| Medicare-covered Eyewear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>\$0</b> copay                                                                                                                                                                                                       | <b>35%</b> coinsurance                                                                                                                                                                                                            |
| <p>Routine Eye Exam</p> <p>You are covered for a yearly routine eye exam, including eye refraction.</p> <p>You can get your routine vision services from an in-network provider or an out-of-network provider. But you can't get services from both.</p>                                                                                                                                                                                                                                                                                   | <b>\$0</b> copay for 1 routine eye exam each year.                                                                                                                                                                     | <b>50%</b> coinsurance for 1 routine eye exam each year.                                                                                                                                                                          |



| Benefit                                                                                                                                                                                                                                                                                    | What You Pay                                                                                              |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                            | In-Network                                                                                                | Out-of-Network                                                                                            |
| Routine Eyewear<br>Use your yearly allowance for 1 set of eyewear: <ul style="list-style-type: none"> <li>• Eyeglasses (lenses and frames)</li> <li>• Eyeglass lenses</li> <li>• Eyeglass frames</li> <li>• Contact lenses (including contact lens fitting)</li> <li>• Upgrades</li> </ul> | <b>\$0</b> until you've spent your <b>\$175</b> yearly allowance, in network and out of network combined. | <b>\$0</b> until you've spent your <b>\$175</b> yearly allowance, in network and out of network combined. |
| <b>Mental Health Services</b>                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                           |
| Inpatient <sup>1</sup>                                                                                                                                                                                                                                                                     | <b>\$595</b> copay per day for days 1-3.<br><b>\$0</b> copay per day for days 4-90.                       | <b>35%</b> coinsurance per stay.                                                                          |
| Outpatient Individual or Group Therapy Visit <sup>1</sup>                                                                                                                                                                                                                                  | <b>\$30</b> copay                                                                                         | <b>\$45</b> copay                                                                                         |
| <b>Acupuncture Services</b>                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                           |
| Medicare-covered Acupuncture <sup>1</sup><br>Services for chronic low back pain.                                                                                                                                                                                                           | <b>\$20</b> copay                                                                                         | <b>\$65</b> copay                                                                                         |
| <b>Ambulance<sup>1</sup></b>                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                           |
| Ground Service (one-way trip)                                                                                                                                                                                                                                                              | <b>\$270</b> copay                                                                                        | <b>\$270</b> copay                                                                                        |
| Air Service (one-way trip)                                                                                                                                                                                                                                                                 | <b>20%</b> coinsurance                                                                                    | <b>20%</b> coinsurance                                                                                    |
| <b>Annual Physical Exam</b>                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                           |
| 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.<br><br>You can get an exam from an in-network provider or an out-of-network provider. But you can't get an exam from both.              | <b>\$0</b> copay                                                                                          | <b>\$50</b> copay                                                                                         |
| <b>Chiropractic Care</b>                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                           |
| Medicare-covered Chiropractic Services <sup>1</sup><br>Manual manipulation of the spine to correct subluxation.                                                                                                                                                                            | <b>\$15</b> copay                                                                                         | <b>35%</b> coinsurance                                                                                    |

| Benefit                                                                                                                                                                                                                          | What You Pay                                                                                                                                                                                                     |                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                  | In-Network                                                                                                                                                                                                       | Out-of-Network                                                                                                                                                                                 |
| <b>Diabetic Services &amp; Supplies</b>                                                                                                                                                                                          |                                                                                                                                                                                                                  |                                                                                                                                                                                                |
| <p>Diabetic monitoring supplies, therapeutic shoes or inserts, and diabetes self-management training.</p> <p>Coverage for certain supplies may depend on the brand.</p> <p>See your <i>Evidence of Coverage</i> for details.</p> | <p><b>\$0</b> copay for diabetic monitoring supplies.<sup>1</sup></p> <p><b>20%</b> coinsurance for therapeutic shoes or inserts.<sup>1</sup></p> <p><b>\$0</b> copay for diabetes self-management training.</p> | <p><b>35%</b> coinsurance for diabetic monitoring supplies.</p> <p><b>35%</b> coinsurance for therapeutic shoes or inserts.</p> <p><b>\$0</b> copay for diabetes self-management training.</p> |
| <b>Fitness &amp; Wellness Programs</b>                                                                                                                                                                                           |                                                                                                                                                                                                                  |                                                                                                                                                                                                |
| <p>You get a fitness center membership, digital fitness tools and resources, and 1 home fitness kit, which may include a wearable fitness tracker option.</p>                                                                    | <p><b>\$0</b> copay</p> <p>Kits are based on availability and subject to change. Once selected, kits cannot be exchanged.</p>                                                                                    | <p>You must get your fitness benefit from our fitness vendor to be covered.</p>                                                                                                                |
| <b>Foot Care (Podiatry Services)</b>                                                                                                                                                                                             |                                                                                                                                                                                                                  |                                                                                                                                                                                                |
| <p>Medicare-covered Podiatry Services</p> <p>Podiatrist foot exams or treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases.</p>                               | <p><b>\$30</b> copay</p>                                                                                                                                                                                         | <p><b>35%</b> coinsurance</p>                                                                                                                                                                  |
| <b>HealthSpring Flex Card</b>                                                                                                                                                                                                    |                                                                                                                                                                                                                  |                                                                                                                                                                                                |
| <p>Use your HealthSpring Flex Card to easily access certain allowance benefits that may be part of your plan.</p>                                                                                                                | <p>Amounts depend on your plan's benefits.</p> <p>Funds are loaded on your HealthSpring Flex Card.</p> <p>Any unused amounts do not carry over to the next quarter or the following plan year.</p>               | <p>You must use your HealthSpring Flex Card to access these benefits.</p>                                                                                                                      |

| Benefit                                                                                                                                                                                                                                                | What You Pay                                                                                                                                                                    |                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                        | In-Network                                                                                                                                                                      | Out-of-Network                                                                                                                                                        |
| <b>Home-Delivered Meals</b>                                                                                                                                                                                                                            |                                                                                                                                                                                 |                                                                                                                                                                       |
| Get up to 14 meals per discharge from a qualifying inpatient hospital or skilled nursing facility stay, up to 3 stays each year.<br><br>Get up to 56 meals each year if you're enrolled in our end-stage renal disease (ESRD) care management program. | <b>\$0</b> copay for covered home-delivered meals.<br><br>If you have been released from an emergency room, observation stay, or outpatient visit, this benefit does not apply. | You must get home-delivered meals from our vendor to be covered.                                                                                                      |
| <b>Home Health Care<sup>1</sup></b>                                                                                                                                                                                                                    |                                                                                                                                                                                 |                                                                                                                                                                       |
| You must be homebound, and a doctor must certify that you need home health services.                                                                                                                                                                   | <b>\$0</b> copay                                                                                                                                                                | <b>35%</b> coinsurance                                                                                                                                                |
| <b>Hospice</b>                                                                                                                                                                                                                                         |                                                                                                                                                                                 |                                                                                                                                                                       |
| Hospice is covered outside of our plan.<br>Hospice care must be provided by a Medicare-certified hospice program.                                                                                                                                      | <b>\$0</b> copay for hospice consultation services (one time only) before you select hospice.<br><br>You may have to pay part of the cost for drugs and respite care.           | <b>\$0</b> copay for hospice consultation services (one time only) before you select hospice.<br><br>You may have to pay part of the cost for drugs and respite care. |
| <b>Medical Equipment &amp; Supplies</b>                                                                                                                                                                                                                |                                                                                                                                                                                 |                                                                                                                                                                       |
| Durable Medical Equipment (wheelchairs, oxygen, etc.) <sup>1</sup>                                                                                                                                                                                     | <b>20%</b> coinsurance                                                                                                                                                          | <b>35%</b> coinsurance                                                                                                                                                |
| Prosthetic & Orthotic Devices (braces, artificial limbs, etc.) <sup>1</sup>                                                                                                                                                                            | <b>20%</b> coinsurance                                                                                                                                                          | <b>35%</b> coinsurance                                                                                                                                                |
| Medical Supplies <sup>1</sup>                                                                                                                                                                                                                          | <b>20%</b> coinsurance                                                                                                                                                          | <b>35%</b> coinsurance                                                                                                                                                |
| <b>Medicare Part B Drugs</b>                                                                                                                                                                                                                           |                                                                                                                                                                                 |                                                                                                                                                                       |
| Medicare-covered Part B Drugs may be subject to step therapy requirements.                                                                                                                                                                             |                                                                                                                                                                                 |                                                                                                                                                                       |
| Medicare Part B Insulin Drugs                                                                                                                                                                                                                          | You will pay a maximum of <b>\$35</b> for each 1-month supply of Medicare-covered Part B insulin drugs. Any plan deductible does not apply.                                     | <b>35%</b> coinsurance                                                                                                                                                |
| Medicare Part B Chemotherapy/Radiation Drugs <sup>1</sup>                                                                                                                                                                                              | <b>0%–20%</b> coinsurance                                                                                                                                                       | <b>35%</b> coinsurance                                                                                                                                                |

| Benefit                                                                                                                                                                                                                                        | What You Pay                                                                                                                                                                |                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                | In-Network                                                                                                                                                                  | Out-of-Network                                                                                                                |
| Other Medicare Part B Drugs <sup>1</sup>                                                                                                                                                                                                       | <b>0%–20%</b> coinsurance<br>This plan has Part D prescription drug coverage. See Section 4 in this <i>Summary of Benefits</i> .                                            | <b>35%</b> coinsurance<br>This plan has Part D prescription drug coverage. See Section 4 in this <i>Summary of Benefits</i> . |
| <b>Rehabilitation Therapy Services</b>                                                                                                                                                                                                         |                                                                                                                                                                             |                                                                                                                               |
| Occupational Therapy Services <sup>1</sup>                                                                                                                                                                                                     | <b>\$30</b> copay                                                                                                                                                           | <b>\$65</b> copay                                                                                                             |
| Physical Therapy & Speech/Language Therapy Services <sup>1</sup>                                                                                                                                                                               | <b>\$30</b> copay                                                                                                                                                           | <b>\$65</b> copay                                                                                                             |
| <b>Skilled Nursing Facility (SNF)<sup>1</sup></b>                                                                                                                                                                                              |                                                                                                                                                                             |                                                                                                                               |
| You are covered for up to 100 days per benefit period.                                                                                                                                                                                         | <b>\$10</b> copay per day for days 1-20.<br><b>\$218</b> copay per day for days 21-60.<br><b>\$0</b> copay per day for days 61-100.                                         | <b>35%</b> coinsurance per stay.                                                                                              |
| <b>Telehealth – MDLIVE</b>                                                                                                                                                                                                                     |                                                                                                                                                                             |                                                                                                                               |
| For non-emergency urgent care, including allergies, cough, headache, sore throat, and other minor illnesses, talk with an MDLIVE® telehealth provider via smartphone, computer, or tablet. They also offer mental health and dermatology care. | <b>\$0</b> copay for each non-emergency urgent care visit.<br><b>\$30</b> copay for each mental health therapy visit.<br><b>\$30</b> copay for each dermatology care visit. | You must get MDLive telehealth benefits from MDLive to be covered.                                                            |

## 4 | 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.

**\$615** 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 **\$2,100**:

| Tier                                     | Supply | Mail Order Pharmacy |              | Retail Pharmacy |              |
|------------------------------------------|--------|---------------------|--------------|-----------------|--------------|
|                                          |        | Preferred           | Standard     | Preferred       | Standard     |
| <b>Tier 1</b><br>Preferred Generic Drugs | 30-day | <b>\$0</b>          | <b>\$10</b>  | <b>\$0</b>      | <b>\$10</b>  |
|                                          | 90-day | <b>\$0</b>          | <b>\$30</b>  | <b>\$0</b>      | <b>\$30</b>  |
| <b>Tier 2</b><br>Generic Drugs           | 30-day | <b>\$5</b>          | <b>\$20</b>  | <b>\$5</b>      | <b>\$20</b>  |
|                                          | 90-day | <b>\$0</b>          | <b>\$60</b>  | <b>\$15</b>     | <b>\$60</b>  |
| <b>Tier 3</b><br>Preferred Brand Drugs   | 30-day | <b>\$47</b>         | <b>\$47</b>  | <b>\$47</b>     | <b>\$47</b>  |
|                                          | 90-day | <b>\$141</b>        | <b>\$141</b> | <b>\$141</b>    | <b>\$141</b> |
| <b>Tier 4</b><br>Non-Preferred Drugs     | 30-day | <b>50%</b>          | <b>50%</b>   | <b>50%</b>      | <b>50%</b>   |
|                                          | 90-day | <b>50%</b>          | <b>50%</b>   | <b>50%</b>      | <b>50%</b>   |
| <b>Tier 5</b><br>Specialty Drugs         | 30-day | <b>25%</b>          | <b>25%</b>   | <b>25%</b>      | <b>25%</b>   |
|                                          | 90-day | <b>N/A</b>          | <b>N/A</b>   | <b>N/A</b>      | <b>N/A</b>   |

### Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage stage when your annual out-of-pocket drug costs reach **\$2,100**.

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. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Individuals may enroll in a plan only during specific times of the year and must have Medicare Parts A and B. You must live in the plan's service area to enroll in a HealthSpring Medicare Advantage plan. Prior authorization and/or referrals are required for certain services. This information is not a complete description of benefits.

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

To file a marketing complaint, contact HealthSpring at the Customer Service number below or call **1-800-MEDICARE** (24 hours a day/7 days a week). Please include the agent/broker name if possible.

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, HealthSpring Life and Health Insurance Company, HealthSpring of Florida, HealthSpring Healthcare of Colorado, Bravo Health of Pennsylvania, Bravo Health Mid-Atlantic, Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York, 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 these plans depends on contract renewal. © 2025 Health Care Service Corporation. All Rights Reserved.

