

# 2027 Summary of Benefits

January 1, 2027 - December 31, 2027

**HealthSpring TotalCare (HMO D-SNP) H4513-060-005**

**Service Area:**

Collin, Dallas, Denton, Hood, Johnson, Parker, Tarrant, and Wise counties, **TX**

# Introduction

**HealthSpring TotalCare (HMO D-SNP)** 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](https://www.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 Medicaid, and live in our service area.

## Our Network

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

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

## Original Medicare

For coverage and costs of Original Medicare, look in your current **Medicare & You** handbook. View it online at [www.medicare.gov](https://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](https://www.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.

## Medicaid Eligibility

This plan is available to people who have both Medicare and Medicaid. Premiums, copays, coinsurance, deductibles, and benefits may vary based on the level of Medicaid and Extra Help you receive. Contact us for further details.

If your category of Medicaid eligibility changes, your cost-share may also increase or decrease. You must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

You can enroll in this plan if you are in one of these Medicaid categories:

### **Qualified Medicare Beneficiary (QMB):**

While QMB status provides you with Medicaid coverage of your Medicare cost-share, you are not eligible for full Medicaid benefits. This means that Medicaid pays only your Part A and Part B premiums, deductibles, and cost-share amounts. Medicaid does not cover your Part D prescription drug copays nor does it pay for services that Medicare Part A or Part B does not cover.

### **Specified Low-Income Medicare Beneficiary (SLMB):**

You do not have full Medicaid benefits as an SLMB. Medicaid pays only your Part B premium—not any cost-share amounts; however, you may find that some services do not require a member cost-share.

**Qualifying Individual (QI):** You do not have full Medicaid benefits as a QI, so Medicaid pays only your Part B premium—not any cost-share amounts; however, you may find that some services do not require a member cost-share.

### **Qualified Disabled and Working Individual (QDWI):**

As a QDWI, you do not have full Medicaid benefits. Medicaid pays only your Part A premium. While Medicaid does not pay any cost-share amounts, you may find that some services do not require a member cost-share.

### **Full Benefits Dual Eligible (FBDE):**

You are eligible for full Medicaid benefits as an FBDE; further, Medicaid may provide limited assistance with Medicare cost-share amounts. When both Medicare and Medicaid provide coverage for a service you receive, your cost-share is typically 0%; however, when Medicaid does not provide coverage for such service or other benefit, you may be required to pay a cost-share amount. This plan is closed to new enrollments for this Medicaid category in Dallas County.

# Premium, Deductible & Limits

This plan is available to people who have both Medicare and Medicaid. Premiums, copays, coinsurance, deductibles, and benefits may vary based on the level of Medicaid and Extra Help you receive. Contact us for further details.

| Benefit                     | HealthSpring TotalCare (HMO D-SNP)                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly Plan Premium        | You pay <b>\$0</b> per month.<br>In addition, you must keep paying your Medicare Part B premium.                                                                                                                                                                                                                                                                                              |
| Medical Deductible          | This plan does not have a deductible.                                                                                                                                                                                                                                                                                                                                                         |
| Maximum Out-of-Pocket Limit | You pay no more than <b>\$9,850</b> each year for in-network Medicare-covered benefits.<br>This limit does not include the monthly plan premium, if any, and cost-sharing for covered Part D prescription drugs.<br>If you have QMB, you pay <b>\$0</b> for covered services. If you have a Medicaid eligibility category other than QMB, you may be responsible for the listed cost-sharing. |

# Medical Benefits

| Benefit                                                                                                                                                                                                                                                                                                                                                   | What You Pay               |                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                           | With QMB                   | With SLMB, QI, QDWI, and FBDE                                                                                                             |
| <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>1,2</sup></b>                                                                                                                                                                                                                                                                                                          |                            |                                                                                                                                           |
| You are covered for an unlimited number of days per stay.                                                                                                                                                                                                                                                                                                 | <b>\$0</b> copay per stay. | <b>\$300</b> copay per day for days 1-5.<br><b>\$0</b> copay per day for days 6-90.<br><b>\$0</b> copay per day for days 91 and beyond.   |
| <b>Outpatient Hospital Services</b>                                                                                                                                                                                                                                                                                                                       |                            |                                                                                                                                           |
| Outpatient Hospital <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                        | <b>0%</b> coinsurance      | <b>0%</b> coinsurance for surgical procedures during a colorectal screening.<br><b>20%</b> coinsurance for all other outpatient services. |
| Outpatient Observation <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                     | <b>0%</b> coinsurance      | <b>20%</b> coinsurance                                                                                                                    |
| <b>Ambulatory Surgical Center (ASC) Services</b>                                                                                                                                                                                                                                                                                                          |                            |                                                                                                                                           |
| ASC Services <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                               | <b>0%</b> coinsurance      | <b>0%</b> coinsurance for surgical procedures during a colorectal screening.<br><b>20%</b> coinsurance for all other outpatient services. |
| <b>Doctor Visits</b>                                                                                                                                                                                                                                                                                                                                      |                            |                                                                                                                                           |
| Primary Care Provider (PCP)                                                                                                                                                                                                                                                                                                                               | <b>\$0</b> copay           | <b>\$0</b> copay                                                                                                                          |
| Specialists <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                                | <b>\$0</b> copay           | <b>\$0</b> copay                                                                                                                          |

| Benefit                                                                                                                                                                                                                                                                                                                    | What You Pay                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                            | With QMB                                                                                                                                                                                                                                                                                                            | With SLMB, QI, QDWI, and FBDE                                                                                                                                                                                                                                                                                       |
| <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>\$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> |
| <b>Emergency Care</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                     |
| Emergency Care Services                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copay                                                                                                                                                                                                                                                                                                    | <p><b>\$115</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>                                                                                                                                                                        |
| Worldwide Emergency/Urgent Care/ Emergency Transportation                                                                                                                                                                                                                                                                  | <p><b>\$115</b> copay for worldwide emergency and urgent care.</p> <p><b>20%</b> coinsurance for worldwide emergency transportation.</p> <p><b>\$50,000</b> yearly maximum coverage amount.</p>                                                                                                                     | <p><b>\$115</b> copay for worldwide emergency and urgent care.</p> <p><b>20%</b> coinsurance for worldwide emergency transportation.</p> <p><b>\$50,000</b> yearly maximum coverage amount.</p>                                                                                                                     |
| <b>Urgently Needed Services</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                     |
| Urgent Care Services                                                                                                                                                                                                                                                                                                       | <b>\$0</b> copay                                                                                                                                                                                                                                                                                                    | <b>\$40</b> copay                                                                                                                                                                                                                                                                                                   |
| <b>Diagnostic Services, Labs &amp; Imaging</b>                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                     |
| Costs for these services may vary based on place or type of service.                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                     |
| Diagnostic Procedures & Tests <sup>1,2</sup>                                                                                                                                                                                                                                                                               | <b>0%</b> coinsurance                                                                                                                                                                                                                                                                                               | <b>20%</b> coinsurance                                                                                                                                                                                                                                                                                              |
| Lab Services <sup>1,2</sup>                                                                                                                                                                                                                                                                                                | <b>\$0</b> copay                                                                                                                                                                                                                                                                                                    | <b>\$0</b> copay                                                                                                                                                                                                                                                                                                    |
| Genetic Testing <sup>1,2</sup>                                                                                                                                                                                                                                                                                             | <b>0%</b> coinsurance                                                                                                                                                                                                                                                                                               | <b>20%</b> coinsurance                                                                                                                                                                                                                                                                                              |

| Benefit                                                                                                                                                              | What You Pay                                                                                                                                                   |                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                      | With QMB                                                                                                                                                       | With SLMB, QI, QDWI, and FBDE                                                                                                                                  |
| Diagnostic Radiology (MRIs, CT scans, etc.) <sup>1,2</sup>                                                                                                           | <b>0%</b> coinsurance                                                                                                                                          | <b>20%</b> coinsurance                                                                                                                                         |
| Therapeutic Radiology <sup>1,2</sup>                                                                                                                                 | <b>0%</b> coinsurance                                                                                                                                          | <b>20%</b> coinsurance                                                                                                                                         |
| X-ray Services <sup>1,2</sup>                                                                                                                                        | <b>0%</b> coinsurance                                                                                                                                          | <b>20%</b> coinsurance                                                                                                                                         |
| <b>Hearing Services</b>                                                                                                                                              |                                                                                                                                                                |                                                                                                                                                                |
| Medicare-covered Hearing Exams <sup>2</sup><br>Diagnostic hearing and balance exams.                                                                                 | <b>\$0</b> copay                                                                                                                                               | <b>\$0</b> copay                                                                                                                                               |
| Routine Hearing Exam                                                                                                                                                 | <b>\$0</b> copay for 1 routine hearing exam each year.                                                                                                         | <b>\$0</b> copay for 1 routine hearing exam each year.                                                                                                         |
| Hearing Aid Fitting Evaluations                                                                                                                                      | <b>\$0</b> copay for hearing aid fitting evaluations.                                                                                                          | <b>\$0</b> copay for hearing aid fitting evaluations.                                                                                                          |
| Hearing Aids<br>You must get your hearing aids from our hearing vendor.                                                                                              | <b>\$399–\$1,800</b> copay for each device. Limited to 1 hearing aid per ear per year.<br><br>Your actual cost-share depends on the hearing aid(s) you choose. | <b>\$399–\$1,800</b> copay for each device. Limited to 1 hearing aid per ear per year.<br><br>Your actual cost-share depends on the hearing aid(s) you choose. |
| OTC Hearing Aids<br>You must get your OTC hearing aid kit from our hearing vendor.                                                                                   | <b>\$399</b> copay for each OTC hearing aid kit. Limited to 2 kits each year.<br><br>Kit includes 1 device for each ear and an optional charger.               | <b>\$399</b> copay for each OTC hearing aid kit. Limited to 2 kits each year.<br><br>Kit includes 1 device for each ear and an optional charger.               |
| <b>Dental Services</b>                                                                                                                                               |                                                                                                                                                                |                                                                                                                                                                |
| Medicare-covered Dental Services <sup>1</sup><br>Limited dental services. This does not include services such as cleanings, routine dental exams, and dental X-rays. | <b>\$0</b> copay                                                                                                                                               | <b>\$0</b> copay                                                                                                                                               |

| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What You Pay                                                                                                                                                                                                          |                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | With QMB                                                                                                                                                                                                              | With SLMB, QI, QDWI, and FBDE                                                                                                                                                                                         |
| <b>Preventive &amp; Comprehensive Dental Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                       |                                                                                                                                                                                                                       |
| <p>Dental Allowance</p> <p>Helps pay for most preventive and comprehensive dental services.</p> <p>You must see a Cigna Dental Allowance (DPPO) network provider.</p> <p>Our dental allowance vendor, Cigna Dental, manages this benefit.</p> <p>To learn more, see your Dental Allowance Guide. Find it 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>\$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>           |
| Maximum Coverage Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>\$2,500</b> yearly allowance for preventive and comprehensive dental services.                                                                                                                                     | <b>\$2,500</b> yearly allowance 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>\$0</b> copay for all other Medicare-covered vision services.</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>\$0</b> copay for all other Medicare-covered vision services.</p> |
| Medicare-covered Eyewear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>\$0</b> copay                                                                                                                                                                                                      | <b>\$0</b> copay                                                                                                                                                                                                      |
| <p>Routine Eye Exam</p> <p>You get a yearly routine eye exam, including eye refraction.</p> <p>For your routine vision services to be covered, you must get them from a provider in our vision vendor's network.</p>                                                                                                                                                                                                                                                                                            | <b>\$0</b> copay for 1 routine eye exam each year.                                                                                                                                                                    | <b>\$0</b> copay for 1 routine eye exam each year.                                                                                                                                                                    |

| Benefit                                                                                                                                                                                                                                                                                               | What You Pay                                                      |                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                       | With QMB                                                          | With SLMB, QI, QDWI, and FBDE                                                       |
| <p>Routine Eyewear</p> <p>Use your yearly allowance for 1 set of eyewear:</p> <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>\$200</b> yearly allowance. | <b>\$0</b> until you've spent your <b>\$200</b> yearly allowance.                   |
| <b>Mental Health Services</b>                                                                                                                                                                                                                                                                         |                                                                   |                                                                                     |
| Inpatient <sup>1</sup>                                                                                                                                                                                                                                                                                | <b>\$0</b> copay per stay.                                        | <b>\$300</b> copay per day for days 1-5.<br><b>\$0</b> copay per day for days 6-90. |
| Outpatient Individual or Group Therapy Visit <sup>1</sup>                                                                                                                                                                                                                                             | <b>\$0</b> copay                                                  | <b>\$0</b> copay                                                                    |
| <b>Acupuncture Services</b>                                                                                                                                                                                                                                                                           |                                                                   |                                                                                     |
| Medicare-covered Acupuncture <sup>1,2</sup><br>Services for chronic low back pain.                                                                                                                                                                                                                    | <b>\$0</b> copay                                                  | <b>\$0</b> copay                                                                    |
| <b>Ambulance</b>                                                                                                                                                                                                                                                                                      |                                                                   |                                                                                     |
| Ground Service (one-way trip)                                                                                                                                                                                                                                                                         | <b>0%</b> coinsurance                                             | <b>20%</b> coinsurance                                                              |
| Air Service (one-way trip) <sup>1</sup>                                                                                                                                                                                                                                                               | <b>0%</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.                                                                                                                                                    | <b>\$0</b> copay                                                  | <b>\$0</b> copay                                                                    |
| <b>Chiropractic Care</b>                                                                                                                                                                                                                                                                              |                                                                   |                                                                                     |
| Medicare-covered Chiropractic Services <sup>1,2</sup><br>Manual manipulation of the spine to correct subluxation.                                                                                                                                                                                     | <b>0%</b> coinsurance                                             | <b>20%</b> coinsurance                                                              |

| Benefit                                                                                                                                                                                                                                                            | What You Pay                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                    | With QMB                                                                                                                                                                                                                                                                                                                                             | With SLMB, QI, QDWI, and FBDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Diabetic Services &amp; Supplies</b>                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p>Diabetic monitoring supplies, therapeutic shoes or inserts, and diabetes self-management training.</p> <p>Prior authorization may be required for non-preferred brands. See your EOC for details.</p>                                                           | <p><b>0%</b> coinsurance for 1 blood glucose monitor and 1 continuous glucose monitoring device every 2 years.<sup>1</sup></p> <p><b>0%</b> coinsurance for diabetic supplies.<sup>1</sup></p> <p><b>0%</b> coinsurance for therapeutic shoes or inserts.<sup>1</sup></p> <p><b>\$0</b> copay for diabetes self-management training.<sup>2</sup></p> | <p><b>0%</b> coinsurance for 1 preferred brand blood glucose monitor and 1 preferred brand continuous glucose monitoring device every 2 years.<sup>1</sup> Or</p> <p><b>20%</b> coinsurance for 1 non-preferred brand blood glucose monitor and 1 non-preferred brand continuous glucose monitoring device every 2 years.<sup>1</sup></p> <p><b>0%</b> coinsurance for preferred brand diabetic supplies.<sup>1</sup> Or</p> <p><b>20%</b> coinsurance for non-preferred brand diabetic 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.<sup>2</sup></p> |
| <b>Fitness &amp; Wellness Programs</b>                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p>You get a fitness center membership. You also get 1 Home Fitness Kit that may include a wearable fitness tracker option. You can also choose up to 2 DVD kit options. Plus, you get one-on-one Well-Being Coaching and digital fitness tools and resources.</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><b>\$0</b> copay</p> <p>Kits are based on availability and subject to change. Once selected, kits cannot be exchanged.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Benefit                                                                                                                                                                                                                                                                                                                            | What You Pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                    | With QMB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | With SLMB, QI, QDWI, and FBDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Healthy Grocery Allowance</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>If you've been diagnosed with a qualifying health condition and are at an increased risk of hospitalization, you may get a healthy grocery allowance each quarter. It helps cover the cost of healthy foods. Those include dairy products, meats, breads, grains, fruits, vegetables, and more at our participating stores.</p> | <p><b>\$200</b> allowance each quarter to help pay for eligible healthy grocery items.</p> <p>Funds are automatically loaded on your HealthSpring Flex card. Any unused amount does not carry over to the next quarter or the following plan year and expires upon disenrollment from the plan.</p> <p>If the HealthSpring Flex card cannot be used at checkout, an alternative reimbursement process is available.</p> <p>Special Supplemental Benefit for Chronically Ill (SSBCI) members only. To be eligible to receive this benefit, you must be diagnosed with cardiovascular disorders, chronic heart failure, chronic lung disorders, diabetes, or stroke. Other eligibility and coverage criteria may apply. Contact the plan for more information.</p> | <p><b>\$200</b> allowance each quarter to help pay for eligible healthy grocery items.</p> <p>Funds are automatically loaded on your HealthSpring Flex card. Any unused amount does not carry over to the next quarter or the following plan year and expires upon disenrollment from the plan.</p> <p>If the HealthSpring Flex card cannot be used at checkout, an alternative reimbursement process is available.</p> <p>Special Supplemental Benefit for Chronically Ill (SSBCI) members only. To be eligible to receive this benefit, you must be diagnosed with cardiovascular disorders, chronic heart failure, chronic lung disorders, diabetes, or stroke. Other eligibility and coverage criteria may apply. Contact the plan for more information.</p> |
| <b>Home-Delivered Meals</b>                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>Up to 14 meals per discharge from a qualifying inpatient hospital or skilled nursing facility stay, up to 3 stays each year.</p> <p>Up to 56 meals each year when you're enrolled in our end-stage renal disease (ESRD) care management program.</p>                                                                            | <p><b>\$0</b> copay for home-delivered meals that we cover.</p> <p>This benefit does not apply to releases from an emergency room, observation stay, or outpatient visit.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p><b>\$0</b> copay for home-delivered meals that we cover.</p> <p>This benefit does not apply to releases from an emergency room, observation stay, or outpatient visit.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Benefit                                                                                                        | What You Pay                                                                                                                                                          |                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                | With QMB                                                                                                                                                              | With SLMB, QI, QDWI, and FBDE                                                                                                                                         |
| <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>\$0</b> copay                                                                                                                                                      |
| <b>Hospice</b>                                                                                                 |                                                                                                                                                                       |                                                                                                                                                                       |
| Hospice is covered outside of our plan. 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>\$0</b> copay                                                                                                                                                      | <b>\$0</b> copay                                                                                                                                                      |
| Prosthetic & Orthotic Devices (braces, artificial limbs, etc.) <sup>1</sup>                                    | <b>0%</b> coinsurance                                                                                                                                                 | <b>20%</b> coinsurance                                                                                                                                                |
| Medical Supplies <sup>1</sup>                                                                                  | <b>0%</b> coinsurance                                                                                                                                                 | <b>20%</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                                                                                  | <b>\$0</b> copay                                                                                                                                                      | 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.                           |
| Medicare Part B Chemotherapy/Radiation Drugs <sup>1</sup>                                                      | <b>0%</b> coinsurance                                                                                                                                                 | <b>0%–20%</b> coinsurance                                                                                                                                             |
| Other Medicare Part B Drugs <sup>1</sup>                                                                       | <b>0%</b> coinsurance<br><br>This plan has Part D prescription drug coverage. See the Prescription Drug Benefits section in this Summary of Benefits.                 | <b>0%–20%</b> coinsurance<br><br>This plan has Part D prescription drug coverage. See the Prescription Drug Benefits section in this Summary of Benefits.             |

| Benefit                                                                                                                                                                                                                                                                                                                 | What You Pay                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                         | With QMB                                                                                                                                                                                                                                                                                                                                                                                          | With SLMB, QI, QDWI, and FBDE                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Over-the-Counter (OTC) Allowance</b>                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>Get an allowance each quarter to help cover the cost of OTC drugs and other products that are health related. Those include bandages, aspirin, cold and sinus medicine, vitamins, and more.</p> <p>Use your allowance at our participating retailers (in-store and online) or by phone for home-delivered items.</p> | <p><b>\$45</b> allowance each quarter for eligible OTC items.</p> <p>Funds are automatically loaded on your HealthSpring Flex card. Any unused amounts do not carry over to the next quarter or the following plan year and will expire upon disenrollment from the plan.</p> <p>If the HealthSpring Flex card cannot be used at checkout, an alternative reimbursement process is available.</p> | <p><b>\$45</b> allowance each quarter for eligible OTC items.</p> <p>Funds are automatically loaded on your HealthSpring Flex card. Any unused amounts do not carry over to the next quarter or the following plan year and will expire upon disenrollment from the plan.</p> <p>If the HealthSpring Flex card cannot be used at checkout, an alternative reimbursement process is available.</p> |
| <b>Podiatry Services (Foot Care)</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>Medicare-covered Podiatry Services<sup>2</sup></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>                                                                                                          | <b>0%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                             | <b>20%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Rehabilitation Therapy Services</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                   |
| Occupational Therapy Services <sup>1,2</sup>                                                                                                                                                                                                                                                                            | <b>0%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                             | <b>20%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                            |
| Physical Therapy & Speech/Language Therapy Services <sup>1,2</sup>                                                                                                                                                                                                                                                      | <b>0%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                             | <b>20%</b> coinsurance                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Skilled Nursing Facility (SNF)<sup>1</sup></b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                   |
| You are covered for up to 100 days per benefit period.                                                                                                                                                                                                                                                                  | <b>\$0</b> copay per stay                                                                                                                                                                                                                                                                                                                                                                         | <p><b>\$0</b> copay per day for days 1-20.</p> <p><b>\$221</b> copay per day for days 21-100.</p>                                                                                                                                                                                                                                                                                                 |

| Benefit                                                                                                                                                                           | What You Pay                                                                 |                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|
|                                                                                                                                                                                   | With QMB                                                                     | With SLMB, QI, QDWI, and FBDE                                                |
| <b>Telehealth Services with MD Live</b>                                                                                                                                           |                                                                              |                                                                              |
| 24/7 non-emergency urgent care for issues such as allergies, cough, headache, sore throat, and other minor illnesses.                                                             | <b>\$0</b> copay for each non-emergency urgent care visit.                   | <b>\$0</b> copay for each non-emergency urgent care visit.                   |
| Talk with an MD Live® provider by phone, computer, or tablet.                                                                                                                     | <b>\$0</b> copay for each mental health and behavioral health therapy visit. | <b>\$0</b> copay for each mental health and behavioral health therapy visit. |
| They also offer mental health and dermatology care.                                                                                                                               | <b>\$0</b> copay for each dermatology care visit.                            | <b>\$0</b> copay for each dermatology care visit.                            |
| <b>Transportation</b>                                                                                                                                                             |                                                                              |                                                                              |
| Get routine (non-emergency) transportation. Your trips must be to approved locations that are health related. Those can include trips to and from doctor and dental appointments. | <b>\$0</b> copay for 20 one-way trips to plan-approved locations each year.  | <b>\$0</b> copay for 20 one-way trips to plan-approved locations each year.  |

# Prescription Drug Benefits

Most of our members qualify for and are already getting Extra Help from Medicare to pay for their Part D prescription drug costs. This chart shows the cost-sharing amounts for Part D drugs covered under this plan if you get Extra Help:

## Part D Deductible

**\$0** deductible for those who qualify for Extra Help.

## Initial Coverage Stage

If you receive Extra Help, you pay the following during this stage until your annual out-of-pocket drug costs reach **\$2,400**. Your cost-sharing is based on your level of Extra Help:

|                                                           |                                                                                                                                      |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Generic drugs (including brand drugs treated as generic): | <ul style="list-style-type: none"><li>• <b>\$0</b> copay or</li><li>• <b>\$1.65</b> copay or</li><li>• <b>\$5.80</b> copay</li></ul> |
| All other drugs:                                          | <ul style="list-style-type: none"><li>• <b>\$0</b> copay or</li><li>• <b>\$5</b> copay or</li><li>• <b>\$14.40</b> copay</li></ul>   |

## 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.

# Medicaid-covered Benefits

This section provides information for people who have both Medicare and Medicaid — called “dual-eligible.”

Dual-eligible means that in addition to being covered for the Medicare benefits described previously in this Summary of Benefits, you are also covered for the state-provided Medicaid benefits listed here:

- Regular checkups at the doctor
- Medicine and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions
- Home care and personal care, like having someone help monitor your health and help you with daily activities

- Having somebody take your child to their medical appointments
- Nursing home care
- A hospital for mental illnesses
- A place of care for people with intellectual disabilities

Keep in mind, all Medicaid-covered services are subject to change at any time.

For the most current Medicaid coverage information for your state, or if you have questions about the assistance you get from Medicaid, please contact your state Medicaid office at:

**Texas Health and Human  
Services Commission**

**1-800-252-8263 (TTY 1-800-735-2989)**

**<https://www.hhs.texas.gov/>**

# Care Management

## Personalized Support for your Health Journey

Managing your health care can get overwhelming. But you don't have to do it alone. You can get personal support for every step in your health journey from one of our care managers. And there's no added cost to you.

### Benefits of working with a care manager:

#### Guidance & Support

A care manager can:

- Help you create a plan to reach your health goals.
- Address your questions and concerns about managing your health and well-being.
- Help you and your caretakers better understand your health conditions, treatment options, and medications.
- Guide you through a transition to and from a health care facility.

#### Care Coordination & Resources

A care manager can:

- Work with your health care providers to develop and manage your overall plan of care.
- Coordinate referrals for different services such as home health care, durable medical equipment, and more.
- Help you find:
  - Transportation to appointments.
  - Financial assistance programs or other ways to lower costs.
  - Programs that include a team of nurses, social workers, dietitians, respiratory therapists, behavioral health specialists, and more.
  - Resources that go beyond medical treatment such as education on complex health conditions.

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.

This plan is available to individuals who have both Medicare and medical assistance from the state (Medicaid). Premiums, copays, coinsurance, deductibles, and benefits may vary based on the level of Medicaid and Extra Help you receive. Contact the plan 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.