

2027 Summary of Benefits

January 1, 2027 - December 31, 2027

HealthSpring Premier (HMO-POS) H4513-084

Service Area:

Cook, DuPage, Kane, Kankakee, and Will counties, **IL**

Introduction

HealthSpring Premier (HMO-POS) 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 live in our service area.

Our Network

We have a network of doctors, hospitals, and other providers. You may also choose to use providers that are out-of-network, usually for a higher copay or coinsurance.

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

Out-of-Network Benefits Annual Coverage Limit

This plan has a yearly coverage limit of **\$25,000** for out-of-network benefits.

Original Medicare

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

Questions?

Visit our website at [HealthSpring.com](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.

Premium, Deductible & Limits

Benefit	HealthSpring Premier (HMO-POS)
Monthly Plan Premium	You pay \$0 per month. In addition, you must keep paying your Medicare Part B premium.
Medical Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Limit	You pay no more than \$4,450 each year for in-network Medicare-covered benefits. This limit does not include the monthly plan premium, if any, and cost-sharing for covered Part D prescription drugs.

Medical Benefits

Benefit	What You Pay	
	In-Network	Out-of-Network
Services with a ¹ may require prior authorization. Select services or medications may need approval from us before you are able to receive them. Services with a ² may require a referral. A referral is an approval from your primary care provider to visit a specialist or receive certain services.		
Inpatient Hospital Coverage¹		
You are covered for an unlimited number of days per in-network hospital stay.	\$230 copay per day for days 1-6. \$0 copay per day for days 7-90. \$0 copay per day for days 91 and beyond.	40% coinsurance per stay.
Outpatient Hospital Services		
Outpatient Hospital ¹	\$0 copay for surgical procedures during a colorectal screening. \$250 copay for all other outpatient services.	40% coinsurance
Outpatient Observation ¹	\$195 copay per stay.	40% coinsurance
Ambulatory Surgical Center (ASC) Services		
ASC Services ¹	\$0 copay for surgical procedures during a colorectal screening. \$195 copay for all other outpatient services.	40% coinsurance
Doctor Visits		
Primary Care Provider (PCP)	\$0 copay	40% coinsurance
Specialists ¹	\$20 copay	40% coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
Preventive Care		
You are covered for many Medicare-covered preventive care services such as: - Breast cancer screenings (mammogram) - Prostate cancer screenings (PSA) - Vaccines, including COVID-19, flu/ influenza shots, hepatitis B shots, and pneumococcal shots	\$0 copay for preventive care services covered under Original Medicare at no cost-sharing. Any additional preventive care services approved by Medicare during the contract year will be covered. Most Part D vaccines, such as the shingles vaccine, may be covered at no cost to you.	40% coinsurance for preventive care services covered under Original Medicare. Any additional preventive care services approved by Medicare during the contract year will be covered. Most Part D vaccines, such as the shingles vaccine, may be covered at no cost to you.
Emergency Care		
Emergency Care Services	\$150 copay If you are admitted to the hospital within 24 hours for the same condition, you do not pay this cost-share.	
Worldwide Emergency/Urgent Care/ Emergency Transportation	\$150 copay for worldwide emergency and urgent care. 20% coinsurance for worldwide emergency transportation. \$50,000 yearly maximum coverage amount.	
Urgently Needed Services		
Urgent Care Services	\$65 copay	
Diagnostic Services, Labs & Imaging		
Costs for these services may vary based on place or type of service.		
Diagnostic Procedures & Tests ¹	\$0 copay for EKG. \$50 copay for all other diagnostic procedures and tests.	40% coinsurance
Lab Services ¹	\$0 copay	40% coinsurance
Genetic Testing ¹	20% coinsurance	40% coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
Diagnostic Radiology (MRIs, CT scans, etc.) ¹	\$0 copay for mammography and ultrasound. \$195 copay for all other diagnostic and nuclear medicine radiology services.	40% coinsurance
Therapeutic Radiology ¹	20% coinsurance	40% coinsurance
X-ray Services ¹	\$0 copay	40% coinsurance
Hearing Services		
Medicare-covered Hearing Exams Diagnostic hearing and balance exams.	\$20 copay	40% coinsurance
Routine Hearing Exam	\$0 copay for 1 routine hearing exam each year.	Not covered
Hearing Aid Fitting Evaluations	\$0 copay for hearing aid fitting evaluations.	Not covered
Hearing Aids You must get your hearing aids from our hearing vendor.	\$399–\$1,800 copay for each device. Limited to 1 hearing aid per ear per year. Your actual cost-share depends on the hearing aid(s) you choose.	Not covered
OTC Hearing Aids You must get your OTC hearing aid kit from our hearing vendor.	\$399 copay for each OTC hearing aid kit. Limited to 2 kits each year. Kit includes 1 device for each ear and an optional charger.	Not covered
Dental Services		
Medicare-covered Dental Services ¹ Limited dental services. This does not include services such as cleanings, routine dental exams, and dental X-rays.	\$20 copay	40% coinsurance
Preventive Dental Services		
Oral exams	\$0 copay	Not covered
Cleanings	\$0 copay	Not covered

Benefit	What You Pay	
	In-Network	Out-of-Network
Fluoride treatments	\$0 copay	Not covered
Dental X-rays	\$0 copay	Not covered
Comprehensive Dental Services		
Restorative (such as fillings and crowns)	\$0–\$550 copay	Not covered
Endodontics (such as root canals)	\$0–\$675 copay	Not covered
Periodontics (such as scaling and root planing)	\$0–\$595 copay	Not covered
Prosthodontics (such as dentures)	\$25–\$615 copay	Not covered
Oral surgery (such as extractions)	\$0 copay	Not covered
To review a full list of covered services and what you'll pay, see your Dental Guide. Find it at HealthSpring.com/Documents . Or call Dental Customer Service at 1-866-213-7295 (TTY 711), 8 a.m. – 8 p.m. local time: October – March: 7 days a week; April – September: Monday – Friday.	This benefit is managed by Cigna Dental, our dental services vendor. You must choose a general dentist from the Cigna Dental Care (DHMO) network to be your primary dentist.	Not covered
Vision Services		
Medicare-covered Eye Exam Exam to diagnose and treat conditions and diseases of the eye.	\$0 copay for Medicare-covered glaucoma screening. \$20 copay for Medicare-covered diabetic retinopathy screening. \$20 copay for all other Medicare-covered vision services.	40% coinsurance for Medicare-covered glaucoma screening. 40% coinsurance for Medicare-covered diabetic retinopathy screening. 40% coinsurance for all other Medicare-covered vision services.
Medicare-covered Eyewear	\$0 copay	40% coinsurance
Routine Eye Exam You get a yearly routine eye exam, including eye refraction. For your routine vision services to be covered, you must get them from a provider in our vision vendor's network.	\$0 copay for 1 routine eye exam each year.	Not covered

Benefit	What You Pay	
	In-Network	Out-of-Network
Routine Eyewear Use your yearly allowance for 1 set of eyewear: • Eyeglasses (lenses and frames) • Eyeglass lenses • Eyeglass frames • Contact lenses (including contact lens fitting) • Upgrades	\$0 until you've spent your \$100 yearly allowance.	Not covered
Mental Health Services		
Inpatient ¹	\$230 copay per day for days 1-6. \$0 copay per day for days 7-90.	40% coinsurance per stay.
Outpatient Individual or Group Therapy Visit ¹	\$10 copay	40% coinsurance
Acupuncture Services		
Medicare-covered Acupuncture ¹ Services for chronic low back pain.	\$20 copay	40% coinsurance
Ambulance		
Ground Service (one-way trip)	\$260 copay	
Air Service (one-way trip) ¹	20% coinsurance	
Annual Physical Exam		
You get 1 physical exam each year. This is in addition to the Medicare-covered Annual Wellness Visit and the Welcome to Medicare Preventive Visit.	\$0 copay	Not covered
Chiropractic Care		
Medicare-covered Chiropractic Services ¹ Manual manipulation of the spine to correct subluxation.	\$20 copay	40% coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
Diabetic Services & Supplies		
Diabetic monitoring supplies, therapeutic shoes or inserts, and diabetes self-management training. Prior authorization may be required for non-preferred brands. See your EOC for details.	0% coinsurance for 1 preferred brand blood glucose monitor and 1 preferred brand continuous glucose monitoring device every 2 years.¹ Or 20% coinsurance for 1 non-preferred brand blood glucose monitor and 1 non-preferred brand continuous glucose monitoring device every 2 years.¹ 0% coinsurance for preferred brand diabetic supplies.¹ Or 20% coinsurance for non-preferred brand diabetic supplies.¹ 20% coinsurance for therapeutic shoes or inserts.¹ \$0 copay for diabetes self-management training.	40% coinsurance for 1 blood glucose monitor and 1 continuous glucose monitoring device every 2 years.¹ 40% coinsurance for diabetic supplies.¹ 40% coinsurance for therapeutic shoes or inserts.¹ 40% coinsurance for diabetes self-management training.
Fitness & Wellness Programs		
You get a fitness center membership. You also get 1 Home Fitness Kit that may include a wearable fitness tracker option. You can also choose up to 2 DVD kit options. Plus, you get one-on-one Well-Being Coaching and digital fitness tools and resources.	\$0 copay Kits are based on availability and subject to change. Once selected, kits cannot be exchanged.	Not covered
Home Health Care¹		
You must be homebound, and a doctor must certify that you need home health services.	\$0 copay	40% coinsurance

Benefit	What You Pay	
	In-Network	Out-of-Network
Hospice		
Hospice is covered outside of our plan. Hospice care must be provided by a Medicare-certified hospice program.	\$0 copay for hospice consultation services (one time only) before you select hospice. You may have to pay part of the cost for drugs and respite care.	
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	20% coinsurance	40% coinsurance
Prosthetic & Orthotic Devices (braces, artificial limbs, etc.) ¹	20% coinsurance	40% coinsurance
Medical Supplies ¹	20% coinsurance	40% coinsurance
Medicare Part B Drugs		
Medicare-covered Part B Drugs may be subject to step therapy requirements.		
Medicare Part B Insulin Drugs	You will pay a maximum of \$35 for each 1-month supply of Medicare-covered Part B insulin drugs. Any plan deductible does not apply.	40% coinsurance
Medicare Part B Chemotherapy/Radiation Drugs ¹	0%–20% coinsurance	40% coinsurance
Other Medicare Part B Drugs ¹	0%–20% coinsurance This plan has Part D prescription drug coverage. See the Prescription Drug Benefits section in this Summary of Benefits.	40% coinsurance This plan has Part D prescription drug coverage. See the Prescription Drug Benefits section in this Summary of Benefits.

Benefit	What You Pay	
	In-Network	Out-of-Network
Over-the-Counter (OTC) Allowance		
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. Use your allowance at our participating retailers (in-store and online) or by phone for home-delivered items.	\$70 allowance each quarter for eligible OTC items. 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. If the HealthSpring Flex card cannot be used at checkout, an alternative reimbursement process is available.	Not covered
Podiatry Services (Foot Care)		
Medicare-covered Podiatry Services Podiatrist foot exams or treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases.	\$20 copay	40% coinsurance
Rehabilitation Therapy Services		
Occupational Therapy Services ¹	\$20 copay	40% coinsurance
Physical Therapy & Speech/Language Therapy Services ¹	\$20 copay	40% coinsurance
Skilled Nursing Facility (SNF)¹		
You are covered for up to 100 days per benefit period.	\$20 copay per day for days 1-20. \$221 copay per day for days 21-100.	30% coinsurance per stay.

Benefit	What You Pay	
	In-Network	Out-of-Network
Telehealth Services with MD Live		
24/7 non-emergency urgent care for issues such as allergies, cough, headache, sore throat, and other minor illnesses. Talk with an MD Live® provider by phone, computer, or tablet. They also offer mental health and dermatology care.	\$0 copay for each non-emergency urgent care visit. \$0 copay for each mental health and behavioral health therapy visit. \$20 copay for each dermatology care visit.	Not covered
Transportation		
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.	\$0 copay for 30 one-way trips to plan-approved locations each year.	Not covered

Prescription Drug Benefits

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

Part D Deductible

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

\$500 deductible for Tiers 3, 4, and 5. You pay the full cost of these drugs until you reach the deductible amount. Once you reach the deductible amount, you enter the Initial Coverage Stage.

Initial Coverage Stage

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

Tier	Supply	Mail Order Pharmacy		Retail Pharmacy	
		Preferred	Standard	Preferred	Standard
Tier 1	30-day	\$0	\$10	\$0	\$10
Preferred Generic Drugs	100-day	\$0	\$30	\$0	\$30
Tier 2	30-day	\$4	\$20	\$4	\$20
Generic Drugs	100-day	\$0	\$60	\$12	\$60
Tier 3	30-day	20%	20%	20%	20%
Preferred Brand Drugs	100-day	20%	20%	20%	20%
Tier 4	30-day	25%	25%	25%	25%
Non-Preferred Drugs	100-day	25%	25%	25%	25%
Tier 5	30-day	28%	28%	28%	28%
Specialty Drugs	90-day	N/A	N/A	N/A	N/A

Catastrophic Coverage Stage

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

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

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

What You Pay for Insulin

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

Dental HMO: Cigna Dental Care and its operating companies provide covered dental services through the Cigna Dental Care (DHMO) network of dentists. Frequency limits vary depending on the type of covered service. Not all dental services are covered, such as cosmetic procedures, implants and orthodontia. Please see the Dental Guide for more information.

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

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

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

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