HealthSpring

*HealthSpring True Choice (PPO) offered by HealthSpring*

# ANNUAL NOTICE OF CHANGE FOR 2027

You're enrolled as a member of HealthSpring True Choice (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in our plan.
- To change to a **different plan,** visit Medicare.gov or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.healthspring.com or call Customer Service at 1-800-668-3813 (TTY users call 711) to get a copy by mail.

**More Resources**

- This document is available for free in Spanish.
- Call Customer Service at 1-800-668-3813 (TTY users call 711) for more information. Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. This call is free.
- To get information from us in a way that works for you, please call Customer Service. We can give you information in braille, in large print, and other alternate formats if you need it.

**About HealthSpring True Choice (PPO)**

- 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.
- When this booklet says "we," "us," or "our," it means HealthSpring. When it says "plan" or "our plan," it means HealthSpring True Choice (PPO).
- HealthSpring may reach out to you via phone regarding the administration of your plan benefits. This communication helps us let you know about scheduled services or available programs so you get the most out of your plan. You can opt out of these calls at any time by contacting Customer Service.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in HealthSpring True Choice (PPO).** Starting January 1, 2027, you'll get your medical and drug coverage through HealthSpring True Choice (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

---

H7849_27_4486726797_M

OMB Approval 0938-1051 (Expires: July 31, 2029)

27_A_H7849_143

# *Annual Notice of Change for 2027*
# *Table of Contents*

**Summary of Important Costs for 2027** ..... **3**

**SECTION 1 Changes to Benefits & Costs for Next Year** ..... **5**

Section 1.1 Changes to the Monthly Plan Premium ..... 5

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount ..... 5

Section 1.3 Changes to the Provider Network ..... 5

Section 1.4 Changes to the Pharmacy Network ..... 6

Section 1.5 Changes to Benefits & Costs for Medical Services ..... 6

Section 1.6 Changes to Part D Drug Coverage ..... 10

Section 1.7 Changes to Prescription Drug Benefits & Costs ..... 10

**SECTION 2 Administrative Changes** ..... **13**

**SECTION 3 How to Change Plans** ..... **13**

Section 3.1 Deadlines for Changing Plans ..... 13

Section 3.2 Are there other times of the year to make a change? ..... 13

**SECTION 4 Get Help Paying for Prescription Drugs** ..... **14**

**SECTION 5 Questions?** ..... **14**

## Summary of Important Costs for 2027

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Monthly plan premium*** <br>* Your premium can be higher or lower than this amount. Go to Section 1.1 for details. | $0 | **$15** |
| **Deductible** | $325 except for insulin furnished through an item of durable medical equipment. | **$325 except for insulin furnished through an item of durable medical equipment.** |
| **Maximum out-of-pocket amount** <br>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (Go to Section 1.2 for details.) | From network providers: <br>$6,800 <br>From in-network and out-of-network providers combined: <br>$11,000 | **From network providers:** <br>**$7,500** <br>**From in-network and out-of-network providers combined:** <br>**$11,000** |
| **Primary care office visits** | In-Network <br>$0 copayment per visit <br>Out-of-Network <br>50% coinsurance per visit | **In-Network** <br>**$0 copayment per visit** <br>**Out-of-Network** <br>**50% coinsurance per visit** |
| **Specialist office visits** | In-Network <br>$40 copayment per visit <br>Out-of-Network <br>50% coinsurance per visit | **In-Network** <br>**$40 copayment per visit** <br>**Out-of-Network** <br>**50% coinsurance per visit** |
| **Inpatient hospital stays** <br>Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | In-Network <br>$345 per day for days 1-4; <br>$0 per day for days 5-90 <br>Out-of-Network <br>50% per stay | **In-Network** <br>**$345 per day for days 1-4;** <br>**$0 per day for days 5-90** <br>**Out-of-Network** <br>**50% per stay** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Part D drug coverage**<br>(Go to Section 1.7 for details including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | Part D drug coverage deductible:<br>$250 for Tier 3, Tier 4 and Tier 5 drugs except for covered insulin products and most adult Part D vaccines<br>Copayments or Coinsurance during the Initial Coverage Stage:<br>• Drug Tier 1:<br>*Standard cost sharing:*<br>$10 copayment<br>*Preferred cost sharing:*<br>$0 copayment<br>• Drug Tier 2:<br>*Standard cost sharing:*<br>$20 copayment<br>*Preferred cost sharing:*<br>$5 copayment<br>• Drug Tier 3:<br>*Standard cost sharing:*<br>$47 copayment<br>*Preferred cost sharing:*<br>$47 copayment<br>You will pay no more than $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 4:<br>*Standard cost sharing:*<br>50% coinsurance<br>*Preferred cost sharing:*<br>50% coinsurance<br>You will pay no more than $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 5:<br>*Standard cost sharing:*<br>30% coinsurance<br>*Preferred cost sharing:*<br>30% coinsurance<br>You will pay no more than $35 per month supply of each covered insulin product on this tier.<br>Catastrophic Coverage:<br>During this payment stage you pay nothing for your covered Part D drugs.<br>You can have cost sharing for drugs that are covered under our enhanced benefit. | **Part D drug coverage deductible:**<br>**$500 for Tier 3, Tier 4 and Tier 5 drugs except for covered insulin products and most adult Part D vaccines**<br>**Copayments or Coinsurance during the Initial Coverage Stage:**<br>• **Drug Tier 1:**<br>***Standard cost sharing:***<br>**$10 copayment**<br>***Preferred cost sharing:***<br>**$0 copayment**<br>• **Drug Tier 2:**<br>***Standard cost sharing:***<br>**$20 copayment**<br>***Preferred cost sharing:***<br>**$8 copayment**<br>• **Drug Tier 3:**<br>***Standard cost sharing:***<br>**20% coinsurance**<br>***Preferred cost sharing:***<br>**20% coinsurance**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.**<br>• **Drug Tier 4:**<br>***Standard cost sharing:***<br>**25% coinsurance**<br>***Preferred cost sharing:***<br>**25% coinsurance**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.**<br>• **Drug Tier 5:**<br>***Standard cost sharing:***<br>**28% coinsurance**<br>***Preferred cost sharing:***<br>**28% coinsurance**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.**<br>**Catastrophic Coverage:**<br>**During this payment stage you pay nothing for your covered Part D drugs.**<br>**You can have cost sharing for drugs that are covered under our enhanced benefit.** |

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Monthly plan premium**<br>(You must also continue to pay your Medicare Part B premium.) | $0 | **$15** |

**Factors that could change your Part D Premium Amount**

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare drug coverage.
- Extra Help - Your monthly premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **In-network maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copayments and deductibles) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount. | $6,800 | **$7,500**<br>**Once you've paid $7,500 combined out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.** |
| **Combined maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount.<br>Your plan premium and costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services. | $11,000 | **$11,000**<br>**Once you've paid $11,000 combined out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.** |

### Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider and Pharmacy Directory* at https://www.healthspring.com/medicare/member-resources/provider-pharmacy-directories to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at www.healthspring.com.

- Call Customer Service at 1-800-668-3813 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-800-668-3813 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

## Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Provider and Pharmacy Directory* at https://www.healthspring.com/medicare/member-resources/provider-pharmacy-directories to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy Directory:*

- Visit our website at www.healthspring.com.
- Call Customer Service at 1-800-668-3813 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-800-668-3813 (TTY users call 711) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Prior authorization** | Prior authorization is not required for the following services:<br>• **Medicare-covered X-ray services** | **Prior authorization may be required for the following services:**<br>• **Medicare-covered X-ray services** |
| **Acupuncture for chronic lower back pain** | In-Network<br>You pay a copayment of $20 for each Medicare-covered acupuncture visit. | **In-Network**<br>**You pay a copayment of $40 for each Medicare-covered acupuncture visit.** |
| **Additional telehealth services** | In-Network<br>You pay a copayment of $0 for each Medicare-covered virtual Physical therapy visit.<br>You pay a copayment of $0 for each Medicare-covered virtual Speech and Language therapy visit. | **In-Network**<br>**You pay a copayment of $35 for each Medicare-covered virtual Physical therapy visit.**<br>**You pay a copayment of $35 for each Medicare-covered virtual Speech and Language therapy visit.** |
| **Ambulance services** | Out-of-Network<br>You pay a copayment of $300 for each one-way Medicare-covered ground ambulance trip. | **Out-of-Network**<br>**You pay a copayment of $295 for each one-way Medicare-covered ground ambulance trip.** |
| **Cardiac rehabilitation services** | In-Network<br>You pay a copayment of $25 for each Medicare-covered cardiac rehabilitative therapy visit. | **In-Network**<br>**You pay a copayment of $30 for each Medicare-covered cardiac rehabilitative therapy visit.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | You pay a copayment of $25 for each Medicare-covered intensive cardiac rehabilitative therapy visit. | **You pay a copayment of $40 for each Medicare-covered intensive cardiac rehabilitative therapy visit.** |
| **Dental services (Routine)** | In-Network and Out-of-Network<br>We provide a dental allowance of $500 every year (combined preventive and comprehensive) for routine dental services. | **In-Network and Out-of-Network**<br>**We provide a dental allowance of $300 every year (combined preventive and comprehensive) for routine dental services.** |
| **Diabetes self-management training, diabetic services and supplies** | In-Network<br>You pay a copayment of $0 for Medicare-covered preferred brand diabetic monitors.<br>You pay a copayment of $0 for Medicare-covered preferred brand diabetic supplies.<br>Out-of-Network<br>You pay a copayment of $0 for Medicare-covered diabetes self-management training. | **In-Network**<br>**You pay a coinsurance of 0% for preferred brand Medicare-covered diabetic monitors.**<br>**You pay a coinsurance of 20% for non-preferred brand Medicare-covered diabetic monitors when purchased at a pharmacy.**<br>**You pay a coinsurance of 0% for preferred brand Medicare-covered diabetic supplies.**<br>**You pay a coinsurance of 20% for non-preferred brand Medicare-covered diabetic supplies when purchased at a pharmacy.**<br>**Non-preferred brands may require prior authorization.**<br>**Out-of-Network**<br>**You pay a coinsurance of 50% for Medicare-covered diabetes self-management training.** |
| **Emergency care** | In-Network and Out-of-Network<br>You pay a copayment of $115 for Medicare-covered Worldwide emergency transportation. | **In-Network and Out-of-Network**<br>**You pay a coinsurance of 20% for Medicare-covered Worldwide emergency transportation.** |
| **Fitness** | You pay a copayment of $0 for a fitness membership and/or one Home Fitness Kit. | **Not covered.** |
| **Hearing services (Routine)** | In-Network<br>You pay a copayment of $0 for one routine hearing exam every year.<br>You pay a copayment of $0 for fitting evaluation for hearings aids every year.<br>You pay a copayment of $399 - $1,800 per device for prescribed Hearing Aids.<br>Out-of-Network<br>You pay a coinsurance of 50% (visit limit combined with in-network) for routine hearing exam every year. | **Not covered.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | You pay a coinsurance of 50% (visit limit combined with in-network) for fitting evaluation for hearing aids every year. | |
| **Home-delivered Meals** | You pay a copayment of $0 for home-delivered meals up to 3 times each year.<br>Eligible ESRD members may qualify for additional meals each year. | **Not covered.** |
| **Outpatient diagnostic tests and therapeutic services and supplies test** | In-Network<br>You pay a copayment of $0 for Medicare-covered lab services.<br>You pay a copayment of $50 for Medicare-covered genetic tests.<br>You pay a copayment of $0 or $225 for Medicare-covered diagnostic radiology services (not including X-rays). $0 for mammography and ultrasounds. $225 for all other diagnostic and nuclear medicine radiological services.<br>You pay a copayment of $60 for Medicare-covered therapeutic radiology services.<br>You pay a copayment of $50 for Medicare-covered X-rays. | **In-Network**<br>**You pay a coinsurance of 0% for Medicare-covered lab services.**<br>**You pay a coinsurance of 20% for Medicare-covered genetic tests.**<br>**You pay a copayment of $0 or $195 for Medicare-covered diagnostic radiology services (not including X-rays). $0 for mammography and ultrasounds. $195 for all other diagnostic and nuclear medicine radiological services.**<br>**You pay a copayment of $85 for Medicare-covered therapeutic radiology services.**<br>**You pay a copayment of $0 or $25 for Medicare-covered X-rays. $0 in a PCP or specialist office. $25 in all other locations.** |
| **Outpatient hospital observation** | In-Network<br>You pay a copayment of $375 per stay for Medicare-covered outpatient hospital observation. | **In-Network**<br>**You pay a copayment of $345 per stay for Medicare-covered outpatient hospital observation.** |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** | In-Network<br>You pay a copayment of $0 or $325 for each Medicare-covered ambulatory surgical center visit. $0 for any surgical procedures (i.e. polyp removal) during a colorectal screening. $325 for all other Ambulatory Surgical Center (ASC) services. | **In-Network**<br>**You pay a copayment of $0 or $345 for each Medicare-covered ambulatory surgical center visit. $0 for any surgical procedures (i.e. polyp removal) during a colorectal screening. $345 for all other Ambulatory Surgical Center (ASC) services.** |
| **Over-the-Counter (OTC) Hearing Aids** | You pay a copayment of $399 for each OTC hearing aid kit. Each kit includes one OTC hearing aid per ear and a charger (if needed). Limited to 2 OTC hearing aid kits per year.<br>Kits must be purchased through our hearing vendor. | **Not covered.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Over-the-Counter Items** | $25 every 3 months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog. | **Not covered.** |
| **Partial hospitalization services and Intensive outpatient services** | In-Network<br>You pay a copayment of $105 Medicare-covered partial hospitalization program services.<br>You pay a copayment of $105 Medicare-covered intensive outpatient program services. | **In-Network**<br>**You pay a copayment of $115 for Medicare-covered partial hospitalization program services.**<br>**You pay a copayment of $115 for Medicare-covered intensive outpatient program services.** |
| **Prostate cancer screening exams** | Out-of-Network<br>You pay a copayment of $0 for Medicare-covered digital rectal exams. | **Out-of-Network**<br>**You pay a coinsurance of 50% for Medicare-covered digital rectal exams.** |
| **Services to treat kidney disease and conditions** | Out-of-Network<br>You pay a copayment of $0 for Medicare-covered kidney disease education services. | **Out-of-Network**<br>**You pay a coinsurance of 50% for Medicare-covered kidney disease education services.** |
| **Skilled nursing facility (SNF) care** | In-Network<br>For each Medicare-covered SNF stay you pay a copayment of:<br>$0 per day for days 1-20;<br>$218 per day for days 21-100 | **In-Network**<br>**For each Medicare-covered SNF stay you pay a copayment of:**<br>**$0 per day for days 1-20;**<br>**$221 per day for days 21-100** |
| **Vision services (Medicare-covered)** | In-Network<br>You pay a copayment of $0 or $40 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screening and diabetic retinal screening. $40 for all other Medicare-covered vision services.<br>Out-of-Network<br>You pay a copayment of $0 for Medicare-covered glaucoma screening. | **In-Network**<br>**You pay a copayment of $0 or $30 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 copayment for glaucoma screening and diabetic retinal screening. $30 for all other Medicare-covered vision services.**<br>**Out-of-Network**<br>**You pay a coinsurance of 50% for Medicare-covered glaucoma screening.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Vision services (Routine)** | Allowance of $150 every year for routine eyewear. Annual eyewear allowance applies to the retail value only. | **Allowance of $100 every year for routine eyewear. Annual eyewear allowance applies to the retail value only.** |
| **Welcome to Medicare Preventive Visit** | Out-of-Network<br>You pay a copayment of $0 for Medicare-covered EKG following Welcome Visit. | **Out-of-Network**<br>**You pay a coinsurance of 50% for Medicare-covered EKG following Welcome Visit.** |

## Section 1.6 Changes to Part D Drug Coverage

### Changes to our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is posted online at https://www.healthspring.com/medicare/member-resources/drug-list-formulary. The Drug List includes many but not all, of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete Drug List*** by calling Customer Service at 1-800-668-3813 (TTY users call 711) or visiting our website at https://www.healthspring.com/medicare/member-resources/drug-list-formulary.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. Call Customer Service at 1-800-668-3813 (TTY users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

**Do you get Extra Help to pay for your drug coverage costs?**

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn't get this material, call Customer Service at 1-800-668-3813 (TTY users call 711) and ask for the *LIS Rider.*

**Drug Payment Stages**

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred), and Tier 5 (Specialty) drugs until you have reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach $2,400.

- ***Stage 3: Catastrophic Coverage***

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit. You generally stay in this stage for the rest of the calendar year.

**Drug Costs in Stage 1: Yearly Deductible**

The table shows your cost per prescription during this stage.

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Yearly Deductible** | $250<br>During this stage, you pay Stage 2: Initial Coverage Stage (see table below) cost-sharing for drugs on*:* Tier 1 (Preferred Generic) and Tier 2 (Generic) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred) and Tier 5 (Specialty) until you've reached the yearly deductible. | **$500**<br>**During this stage, you pay Stage 2: Initial Coverage Stage (see table below) cost-sharing for drugs on*:* Tier 1 (Preferred Generic) and Tier 2 (Generic) and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred) and Tier 5 (Specialty) until you've reached the yearly deductible.** |

**Drug Costs in Stage 2: Initial Coverage**

For drugs on Tier 3 (Preferred Brand), your cost-sharing in the Initial Coverage Stage is changing from a copayment to a coinsurance. Go to the following table for the changes from 2026 to 2027.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6, of your *Evidence of Coverage.*

Once you've paid $2,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Tier 1: (Preferred Generic Drugs)**<br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. | *Standard cost-sharing:* You pay $10 per prescription.<br>Your cost for a one-month mail-order prescription is $10.<br>*Preferred cost-sharing:* You pay $0 per prescription.<br>Your cost for a one-month mail-order prescription is $0. | ***Standard cost-sharing:* You pay $10 per prescription.**<br>**Your cost for a one-month mail-order prescription is $10.**<br>***Preferred cost-sharing:* You pay $0 per prescription.**<br>**Your cost for a one-month mail-order prescription is $0.** |
| **Tier 2: (Generic Drugs)** | *Standard cost-sharing:* You pay $20 per prescription.<br>Your cost for a one-month mail-order prescription is $20.<br>*Preferred cost-sharing:* You pay $5 per prescription.<br>Your cost for a one-month mail-order prescription is $5. | ***Standard cost-sharing:* You pay $20 per prescription.**<br>**Your cost for a one-month mail-order prescription is $20.**<br>***Preferred cost-sharing:* You pay $8 per prescription.**<br>**Your cost for a one-month mail-order prescription is $8.** |
| **Tier 3: (Preferred Brand Drugs)** | *Standard cost-sharing:* You pay $47 per prescription.<br>Your cost for a one-month mail-order prescription is $47. | ***Standard cost-sharing:* You pay 20% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 20%.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | *Preferred cost-sharing:* You pay $47 per prescription.<br>Your cost for a one-month mail-order prescription is $47.<br>You will pay no more than $35 per month supply of each covered insulin product on this tier. | ***Preferred cost-sharing:* You pay 20% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 20%.**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.** |
| **Tier 4: (Non-Preferred Drugs)** | *Standard cost-sharing:* You pay 50% of the total cost.<br>Your cost for a one-month mail-order prescription is 50%.<br>*Preferred cost-sharing:* You pay 50% of the total cost.<br>Your cost for a one-month mail-order prescription is 50%.<br>You will pay no more than $35 per month supply of each covered insulin product on this tier. | ***Standard cost-sharing:* You pay 25% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 25%.**<br>***Preferred cost-sharing:* You pay 25% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 25%.**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.** |
| **Tier 5: (Specialty Drugs)** | *Standard cost-sharing:* You pay 30% of the total cost.<br>Your cost for a one-month mail-order prescription is 30%.<br>*Preferred cost-sharing:* You pay 30% of the total cost.<br>Your cost for a one-month mail-order prescription is 30%.<br>You will pay no more than $35 per month supply of each covered insulin product on this tier. | ***Standard cost-sharing:* You pay 28% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 28%.**<br>***Preferred cost-sharing:* You pay 28% of the total cost.**<br>**Your cost for a one-month mail-order prescription is 28%.**<br>**You will pay no more than $35 per month supply of each covered insulin product on this tier.** |

*There are a limited number of medications available for a 30-day supply through the preferred mail-order pharmacy. Drugs on Tier 1, Tier 2, Tier 3 and Tier 4 are available for long-term supplies through the preferred mail-order pharmacy. Please contact Customer Service to ensure your prescription is eligible for 30-day supply through the preferred mail-order pharmacy. All prescriptions are available for 30-day supply through our standard mail-order pharmacies.*

## SECTION 2 Administrative Changes

| Description | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Diabetic Preferred Brand Supplies** | You are eligible for up to 3 preferred brand glucose monitor sensors per 30-day period, depending on your monitor. | **You are eligible for up to 5 preferred brand glucose monitor sensors per 30-day period, depending on your monitor.** |
| **Urgently needed services and Worldwide urgent care** | Urgent care copayment is waived if admitted for the same condition within 24 hours.<br><br>Worldwide urgent care copayment is waived if admitted for the same condition within 24 hours. | **Urgent care copayment is not waived if admitted for the same condition within 24 hours.**<br><br>**Worldwide urgent care copayment is not waived if admitted for the same condition within 24 hours.** |

## SECTION 3 How to Change Plans

**To stay in our plan, you don't need to do anything.** Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you will automatically be enrolled in our HealthSpring True Choice (PPO) plan.

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from HealthSpring True Choice (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from HealthSpring True Choice (PPO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-800-668-3813 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit Medicare.gov, check the *Medicare & You* 2027 handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).
- As a reminder, HealthSpring offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

### Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

### Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid

- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time.** You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Also, people who qualify will not have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778;
  - Your State Medicaid Office.
- **Prescription Cost-Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, you must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Alabama AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you're currently enrolled, how to continue getting help, call the Alabama AIDS Drug Assistance Program at 1-866-574-9964. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**
  Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, please contact us at 1-800-668-3813 (TTY 711) or visit Medicare.gov.

## SECTION 5 Questions?

### Get Help from HealthSpring True Choice (PPO)

- **Call Customer Service at 1-800-668-3813 (TTY users call 711).**
  We're available for phone calls October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.
- **Read your 2027 *Evidence of Coverage***
  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for HealthSpring True Choice (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.healthspring.com or call Customer Service at 1-800-668-6813 (TTY users call

711) to ask us to mail you a copy.

- **Visit www.healthspring.com**
  Our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

**Get Free Counseling about Medicare**

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Alabama, the SHIP is called Alabama State Health Insurance Assistance Program.

Call Alabama State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Alabama State Health Insurance Assistance Program at 1-800-243-5463.

**Get Help from Medicare**

- **Call 1-800-MEDICARE (1-800-633-4227)**
  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Chat live with Medicare.gov**
  You can chat live at Medicare.gov/talk-to-someone.
- **Write to Medicare**
  You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit Medicare.gov**
  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.
- **Read *Medicare & You* 2027**
  The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or 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.

HealthSpring products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company. © 2026 Health Care Service Corporation. All Rights Reserved.

# Notice of Nondiscrimination

Discrimination is against the law.

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation).

We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids, or language assistance services free of charge, please call the customer service toll-free number listed on the back of your Member ID card.

If you believe that HealthSpring has failed to provide any of these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**HealthSpring**
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: **1-855-664-7270 (voicemail)**
TTY/TDD: **1-855-661-6965**

Fax: **1-855-661-6960**

You can file a grievance by phone, mail or fax. If you need help filing a grievance, please call the customer service toll-free number listed on the back of your Member ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW,
Room 509F,
HHH Building
Washington, DC 20201

**1-800-368-1019, 1-800-537-7697 (TDD)**

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**

HealthSpring℠

HealthSpring Medicare products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company. © 2025 Health Care Service Corporation. All Rights Reserved

HealthSpring℠

# Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

| | |
|---|---|
| English: | ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the plan for more information or speak to your provider. |
| Español (Spanish): | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También puede solicitar, sin costo alguno, servicios o herramientas especiales para acceder a la información en formatos accesibles. Llame al plan para obtener más información o hable con su proveedor. |
| 中文 (Chinese Mandarin): | 注意：如果您说中文，我们可以为您免费提供语言协助服务。我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电计划以获取更多信息或与您的服务提供者联系。 |
| 中文 (Chinese Cantonese): | 注意：如果您說中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電本計劃查詢更多資訊或諮詢您的醫療服務提供者。 |
| Tagalog (Tagalog): | PAGBIGAY-PANSIN: Kung nagsasalita ka ng wikang tagalog, available para sa iyo ang mga serbisyo ng libreng tulong sa wika. Available din nang walang bayad ang mga wastong dagdag na tulong at serbisyo na makapagbibigay-impormasyon sa mga naa-access na format. Balikan ang plano para sa higit pang impormasyon o makipag-usap sa iyong provider. |
| Français (French): | ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits peuvent être mis à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez votre régime d'assurance maladie pour obtenir des informations supplémentaires, ou adressez-vous à votre prestataire. |
| Việt (Vietnamese): | CHÚ Ý: Nếu quý vị nói tiếng việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Hãy gọi cho chương trình để biết thêm thông tin hoặc trao đổi với nhà cung cấp dịch vụ của quý vị. |
| Deutsch (German): | BITTE BEACHTEN: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Hilfsdienstleistungen zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Für weitere Informationen wenden Sie sich bitte an den Kundendienst Ihrer Versicherung bzw. an Ihren Versicherungsberater. |

| | |
|---|---|
| 한국어 (Korean): | 참조: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 도구 및 서비스도 무료로 제공해 드립니다. 자세한 정보는 플랜에 전화하거나 서비스 제공업체에 문의하십시오. |
| Русский (Russian): | ВНИМАНИЕ: Если вам удобнее для общения русский язык, вы можете воспользоваться бесплатными услугами языковой поддержки. Также доступны необходимые вспомогательные средства и услуги предоставления информации в доступном формате для людей с ограниченными возможностями. Для получения дополнительной информации позвоните или обратитесь к своему поставщику. |
| اللغة العربية (Arabic): | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالخطة للحصول على مزيد من المعلومات أو للتحدث مع مقدم الخدمة الذي تتعامل معه. |
| हिंदी (Hindi): | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। प्लान के बारे में अधिक जानकारी के लिए कॉल करें या अपने प्रदाता से बात करें। |
| Italiano (Italian): | ATTENZIONE: Se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiami il numero corrispondente al Suo piano per ulteriori informazioni o si rivolga al Suo fornitore. |
| Português (Portuguese): | ATENÇÃO: Se fala português, tem à sua disposição serviços gratuitos de assistência linguística. Também estão disponíveis equipamentos e serviços de assistência adequados que lhe permitem ter acesso às informações em formatos acessíveis, de forma gratuita. Contacte o plano para obter mais informações ou fale com o seu prestador. |
| Kreyòl Ayisyen (Haitian Creole): | ATANSYON: Si ou pale kreyòl ayisyen, w ap jwenn sèvis asistans lengwistik gratis. Gen èd ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma ki aksesib, ki disponib gratis tou. Rele plan an pou jwenn plis enfòmasyon oswa pou w pale ak pwofesyonèl swen sante w la. |
| Polski (Polish): | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie wsparcie i usługi pomocnicze w celu zapewnienia informacji w przystępnych formatach są również dostępne bezpłatnie. Dodatkowe informacje można uzyskać dzwoniąc do planu lub rozmawiając ze świadczeniodawcą. |
| 日本語 (Japanese): | 注：お客様が[日本語]を話す場合は、無料の言語アシスタンス・サービスを利用できます。アクセスしやすい形式で情報提供を行うための、適切な補助器具やサービスも無料でご利用いただけます。詳細はプランにお電話いただくか、プロバイダーにご相談ください。 |

HealthSpring products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company. © 2026 Health Care Service Corporation. All Rights Reserved.