

# Summary of Benefits for 2026

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## 2026

January 1, 2026 to  
December 31, 2026

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## HealthSpring True Choice (PPO)

Wake County Government  
H7787 – 801  
Enhanced Drug List  
Pharmacy Network: Medicare Broad Network

Freedom to choose your own doctor  
with no referrals required  
Out-of-network coverage available

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## TO JOIN

You must be entitled  
to Medicare Part A, be  
enrolled in Medicare  
Part B and live in our  
service area.

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The HealthSpring True Choice (PPO) service area  
includes all 50 states, the District of Columbia,  
Puerto Rico and the U.S. Virgin Islands.

# Introduction

## What's Inside

- 1 About this Plan
- 2 Monthly Premium Deductible and Limits
- 3 Covered Medical and Hospital Benefits
- 4 Prescription Drug Benefits

This Summary of Benefits gives you a summary of what **HealthSpring True Choice (PPO)** covers and what you pay. It doesn't list every service that we cover or every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage (EOC) Snapshot* online at [myHealthSpring.com](https://myHealthSpring.com) or call Customer Service to request a copy.

### To Join

To join this plan, you must be entitled to Medicare Part A and be enrolled in Medicare Part B, and live in our service area.

### Comparing coverage

If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits*. Or, use the *Medicare Plan Finder* on [www.medicare.gov](https://www.medicare.gov).

### More about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current **Medicare & You** handbook.

View the handbook online at <https://www.medicare.gov/medicare-and-you>

Get a copy of the handbook 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**.

### Need help?

Call toll-free **1-888-281-7867 (TTY 711)**. Customer Service is available October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, federal holidays and after hours.

You can also visit our website at: [HealthSpring.com/GroupMA](https://HealthSpring.com/GroupMA)

## 1 About this plan

### **Which doctors, hospitals and pharmacies can I use?**

HealthSpring True Choice (PPO) has a network of doctors, hospitals, and other providers and pharmacies. You may also choose to use providers that are out-of-network and there will not be a change to your copay or coinsurance.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Your plan uses the Medicare Broad Network.

You can see our plan's Provider and Pharmacy Directory at our website, **HealthSpring.com/GroupMA**.

### **What do we cover?**

- Like all Medicare health plans, we cover everything that Original Medicare covers - and more.
- Our members get all the benefits covered by Original Medicare.
- Our members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this *Summary of Benefits*.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the plan's complete Comprehensive Prescription Drug List which lists the Part D prescription drugs along with any restrictions on our website, **HealthSpring.com/GroupMA**.
- Or, call us and we will send you a copy of the Enhanced Drug List.

## 2 Monthly Premium, Deductible & Limits

Benefit	HealthSpring True Choice (PPO)
How much is the monthly premium?	Please contact your Plan Sponsor. In addition, you must keep paying your Medicare Part B premium.
How much is the Medical Deductible?	<b>\$0</b> per year for medical services.
Is there any limit on how much I will pay for my covered services?	<p>Your yearly limit(s) in this plan:</p> <p><b>\$0</b> for services you receive from in-network and out-of-network providers combined for Medicare-covered benefits.</p> <p>This limit is the most you pay for copays, coinsurance, and other costs for Medicare-covered services for the year. If you reach the limit on out-of-pocket costs, you will keep getting in-network and out-of-network covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-share for your Part D prescription drugs.</p>
What pharmacy network is connected to my plan?	Medicare Broad Network
How much is the Pharmacy (Part D) Deductible?	<b>\$0</b> per year for Part D prescription drugs
Is there any limit on how much I will pay for my covered prescriptions?	The most you will pay for your Part D prescription drugs is <b>\$2,000</b> .

### 3 Covered Medical & Hospital Benefits

Benefit	What you Pay
	In-Network and Out-of-Network
<b>Note:</b> Services with a <sup>1</sup> may require prior authorization.	
<b>Inpatient Hospital Coverage<sup>1</sup></b>	
Our plan covers an unlimited number of days for an inpatient hospital stay.	<b>\$0</b> copay per admission
<b>Outpatient Hospital Services</b>	
Outpatient Hospital <sup>1</sup>	<b>\$0</b> copay
Outpatient Observation <sup>1</sup>	<b>\$0</b> copay
<b>Ambulatory Surgical Center (ASC) Services</b>	
ASC Services (ASC) <sup>1</sup>	<b>\$0</b> copay
<b>Doctors Visits</b>	
Primary Care Physician	<b>\$0</b> copay
Specialists	<b>\$0</b> copay
<b>Preventive Care</b>	
<p>Our plan covers many Medicare-covered preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screening and counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, multi-target stool DNA tests, screening barium enemas, flexible sigmoidoscopy)</li> </ul>	<p><b>\$0</b> copay</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. Please see your <i>Evidence of Coverage (EOC)</i> for frequency of covered services.</p>

Benefit	What you Pay
	In-Network and Out-of-Network
<ul style="list-style-type: none"> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma tests</li> <li>• Hepatitis B Virus (HBV) infection screening</li> <li>• Hepatitis C screening</li> <li>• HIV screening</li> <li>• Lung cancer screening with low dose computed tomography (LDCT)</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines; including COVID-19, Flu shots/Influenza, Hepatitis B shots, Pneumococcal shots</li> <li>• <i>Welcome to Medicare</i> preventive visit (one-time)</li> <li>• Yearly <i>Wellness</i> visit</li> </ul>	
<b>Emergency Care</b>	
Emergency Care Services	<b>\$0</b> copay
Worldwide Emergency/Urgent Coverage/Emergency Transportation	<b>\$0</b> copay Maximum worldwide coverage amount \$50,000.
<b>Urgently Needed Services</b>	
Urgent Care Services	<b>\$0</b> copay

Benefit	What you Pay
	In-Network and Out-of-Network
<b>Diagnostic Services, Labs and Imaging</b> <i>(Costs for these services may vary based on place of service or type of service)</i>	
Diagnostic Procedures and Tests <sup>1</sup>	<b>\$0</b> copay
Lab Services <sup>1</sup>	<b>\$0</b> copay
Genetic Testing <sup>1</sup>	<b>\$0</b> copay
Diagnostic Radiological Services (MRIs, CT scans, etc.) <sup>1</sup>	<b>\$0</b> copay
Therapeutic Radiological Services <sup>1</sup>	<b>\$0</b> copay
X-ray Services	<b>\$0</b> copay
<b>Hearing Services</b>	
Hearing Exams (Medicare-covered) Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. A separate physician cost-share will apply if additional services requiring cost-sharing are rendered.	<b>\$0</b> copay
Routine Hearing Exams You can get one routine hearing exam from an in-network provider or an out-of-network provider. But you can't get an exam from both.	<b>\$0</b> copay for one routine exam every year
Hearing Aid Evaluation/Fitting You can get one hearing aid fitting from an in-network provider or an out-of-network provider. But you can't get a fitting from both.	<b>\$0</b> copay for one fitting evaluation per hearing aid every 3 years
Hearing Aids	<b>\$0</b> copay Plan maximum coverage amount for hearing aids of <b>\$1,400</b> every 3 years.

Benefit	What you Pay
	In-Network and Out-of-Network
<b>Dental Services (Medicare-covered)<sup>1</sup></b>	
Limited dental services (this does not include services in connection with care, treatment, filling removal or replacement of teeth)	<b>\$0</b> copay
<b>Vision Services</b>	
<p>Eye Exams (Medicare-covered)</p> <p>A separate physician cost-share may apply if additional services requiring cost-sharing are rendered (e.g., but not limited to, if a medical eye condition is discovered during a preventive routine eye exam). A facility cost-share may apply for procedures performed at an outpatient surgical center.</p>	<p><b>\$0</b> copay for diabetic retinopathy screening</p> <p><b>\$0</b> copay for all other Medicare-covered vision services.</p>
<p>Routine Eye Exam</p> <p>You are covered for a yearly routine eye exam, including eye refraction.</p> <p>You can get your routine vision services from an in-network provider or an out-of-network provider. But you can't get services from both.</p>	<b>\$0</b> copay for one routine exam every year
Glaucoma Screening (Medicare-covered)	<b>\$0</b> copay
Eyewear (Medicare-covered)	<b>\$0</b> copay
<p>Routine Eyewear</p> <p>Use your yearly allowance for one 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 fittings)</li> <li>• Upgrades</li> </ul>	<b>\$0</b> copay until you've spent your \$200 yearly allowance; in-network and out-of-network combined.

Benefit	What you Pay
	In-Network and Out-of-Network
<b>Mental Health Services</b>	
Inpatient <sup>1</sup> Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	\$0 copay per admission
Outpatient Individual or Group Therapy Visit <sup>1</sup>	\$0 copay
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	
Our plan covers up to 100 days per benefit period.	\$0 copay per day for days 1–100
<b>Rehabilitation Services</b>	
Cardiac (heart) Rehab Services	\$0 copay
Intensive Cardiac (heart) Rehab Services <sup>1</sup>	\$0 copay
Pulmonary Rehab Services	\$0 copay
Occupational Therapy Services	\$0 copay
Physical Therapy, Speech and Language Therapy Services	\$0 copay
Physical Therapy, Speech and Language Therapy Virtual Services	\$0 copay
<b>Ambulance<sup>1</sup></b>	
Ground Service (one-way trip)	\$0 copay
Air Service (one-way trip)	\$0 copay
<b>Transportation</b>	
	Not Covered
<b>Medicare Part B Drugs</b>	
Medicare Part B Insulin Drugs	\$0 copay
Medicare Part B	\$0 copay

Benefit	What you Pay
	In-Network and Out-of-Network
Chemotherapy/Radiation Drugs <sup>1</sup>	
Other Medicare Part B Drugs <sup>1</sup> Medicare-covered Part B Drugs may be subject to step therapy requirements.	<b>\$0</b> copay This plan has Part D prescription drug coverage. See Section 4 in this <i>Summary of Benefits</i> .
<b>Acupuncture Services</b>	
Acupuncture Services (Medicare-Covered) <sup>1</sup>	<b>\$0</b> copay
Routine Acupuncture Services	Not Covered
<b>Chiropractic Care</b>	
Chiropractic Services (Medicare-Covered) <sup>1</sup>	<b>\$0</b> copay
Routine Chiropractic Services	Not Covered
<b>Diabetic Service and Supplies</b>	
Diabetic monitoring supplies, therapeutic shoes or inserts, and diabetes self-management training. Coverage for certain supplies may depend on the brand. See your <i>Evidence of Coverage Snapshot</i> for details.	<b>\$0</b> copay for diabetic monitoring supplies. <sup>1</sup> <b>\$0</b> copay for therapeutic shoes or inserts. <sup>1</sup> <b>\$0</b> copay for diabetes self-management training.
<b>Fitness &amp; Wellness Programs</b>	
You get a fitness center membership, digital fitness tools and resources, and 1 home fitness kit, which may include a wearable fitness tracker option.	<b>\$0</b> copay Kits are based on availability and subject to change. Once selected, kits cannot be exchanged.
<b>Foot Care (Podiatry Services)</b>	
Podiatry Services Medicare-covered	<b>\$0</b> copay
Routine Podiatry Services	Not Covered
<b>Home Delivered Meals</b>	
Get up to 14 meals per discharge from a qualifying inpatient hospital or skilled nursing	<b>\$0</b> copay for covered home-delivered meals. If you have been released from an emergency

Benefit	What you Pay
	In-Network and Out-of-Network
<p>facility stay, up to 3 stays each year. Get up to 56 meals each year if you're enrolled in our end-stage renal disease (ESRD) care management program.</p>	<p>room, observation stay, or outpatient visit, this benefit does not apply.</p>
<b>Home Health Care<sup>1</sup></b>	
<p>If you're eligible for home health care, covered services include:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul>	<p><b>\$0</b> copay</p>
<b>Hospice</b>	
<p>Hospice care must be provided by a Medicare-certified hospice program. Our plan covers hospice consultation services (one-time only) before you select hospice. Hospice is covered outside of our plan. You may have to pay part of the cost for drugs and respite care. Please contact the plan for more details.</p>	<p><b>\$0</b> copay</p>
<b>Medical Equipment and Supplies</b>	
<p>Durable Medical Equipment (wheelchairs, oxygen, etc.)<sup>1</sup></p>	<p><b>\$0</b> copay</p>
<p>Prosthetic &amp; Orthotic Devices (braces, artificial limbs, etc.)<sup>1</sup></p>	<p><b>\$0</b> copay</p>
<p>Medical Supplies<sup>1</sup></p>	<p><b>\$0</b> copay</p>
<b>Opioid Treatment Services<sup>1</sup></b>	
<p>FDA-approved treatment medications in addition to testing, counseling, and therapy.</p>	<p><b>\$0</b> copay</p>

Benefit	What you Pay
	In-Network and Out-of-Network
<b>Outpatient Substance Abuse<sup>1</sup></b>	
Individual or Group Therapy Visit	<b>\$0</b> copay
<b>Over-the-Counter Items (OTC)</b>	
	Not Covered
<b>Telehealth - MDLIVE</b>	
For nonemergency urgent care, including allergies, cough, headache, sore throat and other minor illnesses, talk with an MDLIVE® telehealth provider via smartphone, computer or tablet. They also offer mental health and dermatology care.	<p><b>\$0</b> copay for non-emergency urgent care virtual visits</p> <p><b>\$0</b> copay for mental health therapy virtual visits<sup>1</sup></p> <p><b>\$0</b> copay for dermatology care virtual visits<sup>1</sup></p>
<b>Extra Benefits Included in your plan</b>	
<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. You can get an exam from an in-network provider or an out-of-network provider. But you can't get an exam from both.	<b>\$0</b> copay
<b>HealthSpring Flex Card</b>	
Use your HealthSpring Flex Card to easily access certain allowance benefits that may be part of your plan.	<p>Amounts depend on your plan's benefits. Funds are loaded on your HealthSpring Flex Card.</p> <p>Any unused amounts do not carry over to the next quarter or the following plan year.</p>
<b>Caregiver Support</b>	
You get virtual help with caregiving and finding resources for your loved one. Those include information about stress management and connections to health-related social needs.	<b>\$0</b> copay for caregiver support, including one-on-one coaching by phone or through the program's website.

**Benefit**

**What you Pay**

**In-Network and Out-of-Network**

**Wigs for Hair Loss Due to Cancer Treatment**

**\$350** allowance per year

## 4 Prescription Drug Benefits

### Medicare Part D Drugs - Initial Coverage

The following chart shows the cost-share amounts for covered drugs under this plan.<sup>^</sup> After you pay your yearly deductible (if applicable), you pay the following until your total yearly drug costs reach **\$2,100**. Total yearly drug costs are the total drug costs paid by both you and our plan.

Your costs may be different if you qualify for *Extra Help*. Your copay or coinsurance is based on the drug tier for your medication, which you can find in the Enhanced Drug List) on our website [HealthSpring.com/GroupMA](http://HealthSpring.com/GroupMA)

Or, call us and we will send you a copy of the Enhanced Drug List.

Pharmacy Network: Medicare Broad Network			
Tier	Supply	Retail Cost-Share	Mail-Order Cost-Share
Tier 1	30-day	\$10	\$10
	60-day	\$20	\$20
	90-day	\$20	\$20
Tier 2	30-day	35% (\$80 max)	35% (\$80 max)
	60-day	35% (\$160 max)	35% (\$160 max)
	90-day	35% (\$240 max)	35% (\$160 max)
Tier 3	30-day	50% (\$120 max)	50% (\$120 max)
	60-day	50% (\$240 max)	50% (\$240 max)
	90-day	50% (\$360 max)	50% (\$240 max)
Tier 4*	30-day	33% (\$300 max)	33% (\$300 max)
	60-day	N/A	N/A
	90-day	N/A	N/A

**\*Specialty drugs are limited to a 30-day supply**

<sup>^</sup> Cost-sharing may vary depending on the member's Part D coverage phase. Costs may differ based on pharmacy type or status, for example, mail order, long-term care (LTC), home infusion, and 30, 60-, 90-day supply.

You can get your prescription from an out-of-network pharmacy, but you may pay more than you would pay at an in-network pharmacy. If you reside in a long-term care facility, you would pay the standard retail cost-sharing at an in-network pharmacy.

## Catastrophic Coverage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$2,100** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will pay **\$0** for all covered Part D drugs through the end of the calendar year.

## Out-of-Network Coverage

If you get your drug at an out-of-network pharmacy, you will pay the same cost-share you would pay for a 30-day supply at an in-network retail pharmacy. If you reside in a long-term care facility, you will pay the standard retail cost-share at an in-network pharmacy. Your Medicare Pharmacy Network is: Medicare Broad Network.

We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

**Coverage is limited to certain situations; see Chapter 5 of the Evidence of Coverage booklet for details.**

## What you pay for Insulin

- You won't pay more than \$35 for 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.

## Additional Benefits Offered

**Prescription Vitamins** - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

**Weight Loss Weight Gain Drugs<sup>^</sup>** - Drugs used for anorexia, weight loss, or weight gain

**Cough and Cold Drugs** - drugs used for symptomatic relief of cough and colds

**Courtesy Drugs/DESI Buy Up** - Courtesy Drugs: Drugs normally covered under commercial pharmacy plans but are excluded by CMS. DESI (Drug Efficacy Study Implementation) Drugs: Drugs that were introduced between 1938-1962 and

Your plan covers additional drugs not normally covered in a Medicare Prescription Drug Plan as indicated in the Formulary Drug List by the + symbol. Please see your 2026 Formulary document for details. The cost-share you pay on these drugs do not count toward your annual True Out-of-Pocket (TrOOP).

<sup>^</sup>Some drugs are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories.

## Additional Benefits Offered

approved for safety but not effectiveness. DESI drugs are not “grandfathered” or generally recognized as safe and effective (GRAS/E).

The following preventive benefits are covered at a \$0 copay (deductible does not apply):

**Adherence Package** - Preventive Preferred Brand and Generic Drugs and Diabetic Drugs and Supplies

### **Covered Diabetic Test Strips and Meters**

You will not pay more than \$0 for preferred products.

### **Covered Diabetic Lancets and Control Solutions**

You will not pay more than \$0 for this benefit.

Your plan includes the following clinical management edits. Refer to your 2026 Formulary for more information.

<b>PA</b>	This drug requires prior authorization.
<b>QL</b>	This drug has quantity limits.
<b>ST</b>	This drug has step therapy requirements.
<b>*</b>	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a one-month supply.
<b>+</b>	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
<b>^</b>	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
<b>HRM PA</b>	This high-risk medication requires prior authorization.
<b>B/D PA</b>	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
<b>LA</b>	Limited Availability drug. This drug may be available only at certain pharmacies.

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