HEALTHSPRING
More from Medicare. More from life.

HealthSpring Preferred (HMO)
HealthSpring Premier (HMO-POS)

2013

Summary of Benefits

H0150

Autauga, Baldwin, Bibb, Cherokee, Chilton, Cullman, Dallas, DeKalb, Elmore, Etowah, Fayette, Jefferson, Lamar, Limestone, Lowndes, Madison, Mobile, Montgomery, Morgan, Shelby, St. Clair, Talladega, Tuscaloosa, Walker Counties, AL.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in HealthSpring Preferred (HMO). Our plan is offered by HEALTHSPRING OF ALABAMA, INC., a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call HealthSpring Preferred (HMO) and ask for the "Evidence of Coverage".

Thank you for your interest in HealthSpring Premier (HMO-POS). Our plan is offered by HEALTHSPRING OF ALABAMA, INC., a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call HealthSpring Premier (HMO-POS) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare HealthSpring Preferred (HMO) and HealthSpring Premier (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS HEALTHSPRING PREFERRED (HMO) and HEALTHSPRING PREMIER (HMO-POS) AVAILABLE?

There is more than one plan listed in this Summary of Benefit. The service area for this plan includes: Autauga, Baldwin, Bibb, Cherokee, Chilton, Cullman, Dallas, DeKalb, Elmore, Etowah, Fayette, Jefferson, Lamar, Limestone, Lowndes, Madison, Mobile, Montgomery, Morgan, Shelby, St. Clair, Talladega, Tuscaloosa, Walker Counties, AL. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN HEALTHSPRING PREFERRED (HMO) and HEALTHSPRING PREMIER (HMO-POS)?

You can join HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

HealthSpring Preferred (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

HealthSpring Premier (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.myhealthspring.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

HealthSpring Preferred (HMO): If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

HealthSpring Premier (HMO-POS): Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

HealthSpring Preferred (HMO) and HealthSpring Premier (HMO-POS) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.myhealthspring.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

HealthSpring Preferred (HMO) and HealthSpring Premier (HMO-POS) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

HealthSpring Preferred (HMO) and HealthSpring Premier (HMO-POS) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.myhealthspring.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to

provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS) for more details.

-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

-- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.

-- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

-- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

-- Some Oral Cancer Drugs: If the same drug is available in injectable form.

-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
-- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If

you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Healthspring of Alabama, Inc. for more information about HealthSpring Preferred (HMO) or HealthSpring Premier (HMO-POS).

Visit us at www.myhealthspring.com or, call us:

Customer Service Hours for October 1 – February 14:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Central

Customer Service Hours for February 15 – September 30:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Central

Current members should call toll-free (800)-668-3813 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Prospective members should call toll-free (888)-767-1879 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Current members should call locally (800)-668-3813 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Prospective members should call locally (888)-767-1879 for questions related to the Medicare Advantage Program. (TTY/TDD 711)

Current members should call toll-free (800)-668-3813 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

Prospective members should call toll-free (888)-767-1879 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

Current members should call locally (800)-668-3813 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

Prospective members should call locally (888)-767-1879 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 711)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en un idioma que no sea Inglés. Para obtener información adicional, llame al servicio al cliente al número telefónico arriba indicado.

If you have any questions about this plan's benefits or costs, please contact Healthspring of Alabama, Inc. for details.

SECTION II - SUMMARY OF BENEFITS			
Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
IMPORTANT INFORMATION			
1 - Premium and Other Important Information	In 2012 the monthly Part B Premium was $99.90 and may change for 2013 and the annual Part B deductible amount was $140 and may change for 2013. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	General $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. In-Network $3,400 out-of-pocket limit for Medicare-covered services.	General $69.50 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. In-Network $2,950 out-of-pocket limit for Medicare-covered services.
2 - Doctor and Hospital Choice	You may go to any doctor, specialist or hospital that accepts Medicare.	In-Network You must go to network doctors, specialists, and hospitals.	In-Network Referral required for network hospitals and specialists (for certain benefits).

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)		Referral required for network hospitals and specialists (for certain benefits).	
SUMMARY OF BENEFITS			
INPATIENT CARE			
3 - Inpatient Hospital Care	In 2012 the amounts for each benefit period were: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day These amounts may change for 2013.	In-Network No limit to the number of days covered by the plan each hospital stay.	In-Network No limit to the number of days covered by the plan each hospital stay.
(includes Substance Abuse and Rehabilitation Services)		For Medicare-covered hospital stays:	For Medicare-covered hospital stays:
	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	- Days 1 - 6: $195 copay per day	- Days 1 - 6: $195 copay per day
	Lifetime reserve days can only be used once.	- Days 7 - 90: $0 copay per day	- Days 7 - 90: $0 copay per day
	A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	$0 copay for additional hospital days	$0 copay for additional hospital days
		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
4 - Inpatient Mental Health Care	In 2012 the amounts for each benefit period were: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 - 6: $195 copay per day - Days 7 - 90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: - Days 1 - 6: $195 copay per day - Days 7 - 90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $144.50 per day These amounts may change for 2013. 100 days for each benefit period.	General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required.	General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
5 - Skilled Nursing Facility (SNF)	A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	For SNF stays: - Days 1 - 5: $0 copay per day - Days 6 - 35: $75 copay per day - Days 36 - 100: $0 copay per day	For SNF stays: - Days 1 - 5: $0 copay per day - Days 6 - 35: $75 copay per day - Days 36 - 100: $0 copay per day
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	General Authorization rules may apply. In-Network $0 to $20 copay for each Medicare-covered home health visit	General Authorization rules may apply. In-Network $0 to $20 copay for each Medicare-covered home health visit
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	General Authorization rules may apply. In-Network $10 copay for each Medicare-covered primary care doctor visit. $35 copay for each Medicare-covered specialist visit.	General Authorization rules may apply. In-Network $10 copay for each Medicare-covered primary care doctor visit. $35 copay for each Medicare-covered specialist visit.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
9 - Chiropractic Services	Supplemental routine care not covered	In-Network $20 copay for each Medicare-covered chiropractic visit	In-Network $20 copay for each Medicare-covered chiropractic visit
	20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor.
10 - Podiatry Services	Supplemental routine care not covered.	General Authorization rules may apply.	General Authorization rules may apply.
	20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network $35 copay for each Medicare-covered podiatry visit	In-Network $35 copay for each Medicare-covered podiatry visit
		Medicare-covered podiatry visits are for medically-necessary foot care.	Medicare-covered podiatry visits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	35% coinsurance for most outpatient mental health services	General Authorization rules may apply.	General Authorization rules may apply.
	Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.	In-Network $35 copay for each Medicare-covered individual therapy visit	In-Network $35 copay for each Medicare-covered individual therapy visit
	"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$35 copay for each Medicare-covered group therapy visit	$35 copay for each Medicare-covered group therapy visit
		$35 copay for each Medicare-covered individual therapy visit with a psychiatrist	$35 copay for each Medicare-covered individual therapy visit with a psychiatrist
		$35 copay for each Medicare-covered group therapy visit with a psychiatrist	$35 copay for each Medicare-covered group therapy visit with a psychiatrist
		$35 copay for Medicare-covered partial hospitalization program services	$35 copay for Medicare-covered partial hospitalization program services

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
12 - Outpatient Substance Abuse Care	20% coinsurance	General Authorization rules may apply. In-Network $35 copay for Medicare-covered individual substance abuse outpatient treatment visits $35 copay for Medicare-covered group substance abuse outpatient treatment visits	General Authorization rules may apply. In-Network $35 copay for Medicare-covered individual substance abuse outpatient treatment visits $35 copay for Medicare-covered group substance abuse outpatient treatment visits
13 - Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	General Authorization rules may apply. In-Network $190 copay for each Medicare-covered ambulatory surgical center visit $190 copay for each Medicare-covered outpatient hospital facility visit	General Authorization rules may apply. In-Network $190 copay for each Medicare-covered ambulatory surgical center visit $190 copay for each Medicare-covered outpatient hospital facility visit
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered ambulance benefits. $100 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered ambulance benefits. $100 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.	General $65 copay for Medicare-covered emergency room visits $50,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	General $65 copay for Medicare-covered emergency room visits $50,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
15 - Emergency Care	You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.		
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.	General $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network $20 copay for Medicare-covered Occupational Therapy visits $20 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	General Authorization rules may apply. In-Network $20 copay for Medicare-covered Occupational Therapy visits $20 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered durable medical equipment
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered prosthetic devices	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered prosthetic devices

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training	General Authorization rules may apply.	General Authorization rules may apply.
	20% coinsurance for diabetes supplies	In-Network $0 copay for Medicare-covered Diabetes self-management training	In-Network $0 copay for Medicare-covered Diabetes self-management training
	20% coinsurance for diabetic therapeutic shoes or inserts	0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies	0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies
		Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies.	Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies.
		20% of the cost for Medicare-covered Therapeutic shoes or inserts	20% of the cost for Medicare-covered Therapeutic shoes or inserts
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays	General Authorization rules may apply.	General Authorization rules may apply.
	$0 copay for Medicare-covered lab services	In-Network $0 copay for Medicare-covered lab services	In-Network $0 copay for Medicare-covered lab services
	Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	$0 to $100 copay for Medicare-covered diagnostic procedures and tests	$0 to $100 copay for Medicare-covered diagnostic procedures and tests
		$25 copay for Medicare-covered X-rays	$25 copay for Medicare-covered X-rays
		$0 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays)	$0 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays)

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services		\$50 copay for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$10 to \$35 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$10 to \$35 may apply	\$50 copay for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$10 to \$35 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$10 to \$35 may apply
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	General Authorization rules may apply. In-Network \$20 copay for Medicare-covered Cardiac Rehabilitation Services \$20 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$20 copay for Medicare-covered Pulmonary Rehabilitation Services	General Authorization rules may apply. In-Network \$20 copay for Medicare-covered Cardiac Rehabilitation Services \$20 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$20 copay for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS			
23 -Preventive Services, Wellness/Education and other Supplemental Benefit Programs	No coinsurance, copayment or deductible for the following:	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
23 -Preventive Services, Wellness/Education and other Supplemental Benefit Programs	- Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening - Diabetes Screening - Influenza Vaccine - Hepatitis B Vaccine for people with Medicare who are at risk - HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease - Personalized Prevention Plan Services (Annual Wellness Visits)	In-Network This plan does not cover supplemental education/wellness programs.	In-Network This plan does not cover supplemental education/wellness programs.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
23 -Preventive Services, Wellness/Education and other Supplemental Benefit Programs	- Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity - Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.		
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	In-Network 20% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services	In-Network 20% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
PRESCRIPTION DRUG BENEFITS			
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part B General 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.	Drugs covered under Medicare Part B General 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.
		Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.myhealthspring.com on the web.	Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.myhealthspring.com on the web.
		Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers.	Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers.
		The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
		Total yearly drug costs are the total drug costs paid by both you and a Part D plan.	Total yearly drug costs are the total drug costs paid by both you and a Part D plan.
		The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
		Some drugs have quantity limits.	Some drugs have quantity limits.

		Your provider must get prior authorization from HealthSpring Preferred (HMO) for certain drugs.	Your provider must get prior authorization from HealthSpring Premier (HMO-POS) for certain drugs.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and HealthSpring Preferred (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,970: Retail Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of drugs in this tier - $6 copay for a two-month (60-day) supply of drugs in this tier - $9 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan	You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and HealthSpring Premier (HMO-POS) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,970: Retail Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of drugs in this tier - $6 copay for a two-month (60-day) supply of drugs in this tier - $9 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan

		for more information. Tier 2: Non-Preferred Generic	for more information. Tier 2: Non-Preferred Generic

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		- $10 copay for a one-month (30-day) supply of drugs in this tier - $20 copay for a two-month (60-day) supply of drugs in this tier - $30 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand - $45 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a two-month (60-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 4: Non-Preferred Brand - $85 copay for a one-month (30-day) supply of drugs in this tier - $170 copay for a two-month (60-day) supply of drugs in this tier - $255 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier	- $6 copay for a one-month (30-day) supply of drugs in this tier - $12 copay for a two-month (60-day) supply of drugs in this tier - $18 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand - $45 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a two-month (60-day) supply of drugs in this tier - $135 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 4: Non-Preferred Brand - $85 copay for a one-month (30-day) supply of drugs in this tier - $170 copay for a two-month (60-day) supply of drugs in this tier - $255 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		- 33% coinsurance for a two-month (60-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $10 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand - $45 copay for a one-month (31-day) supply of brand drugs in this tier Tier 4: Non-Preferred Brand - $85 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (31-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Mail Order Tier 1: Preferred Generic - $0 copay for a three-month (90-day) supply of drugs in this tier	- 33% coinsurance for a two-month (60-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic - $6 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand - $45 copay for a one-month (31-day) supply of brand drugs in this tier Tier 4: Non-Preferred Brand - $85 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (31-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Mail Order Tier 1: Preferred Generic - $0 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $21 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand - $125 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 4: Non-Preferred Brand - $245 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 5: Specialty Tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $9 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 3: Preferred Brand - $125 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 4: Non-Preferred Brand - $245 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 5: Specialty Tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. Additional Coverage Gap The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: Retail Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of all drugs covered in this tier - $6 copay for a two-month (60-day) supply of all drugs covered in this tier - $9 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $10 copay for a one-month (30-day) supply of select drugs covered in this tier - $20 copay for a two-month (60-day) supply of select drugs covered in this tier - $30 copay for a three-month (90-day) supply of select drugs covered in this tier	You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. Additional Coverage Gap The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: Retail Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of all drugs covered in this tier - $6 copay for a two-month (60-day) supply of all drugs covered in this tier - $9 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $6 copay for a one-month (30-day) supply of select drugs covered in this tier - $12 copay for a two-month (60-day) supply of select drugs covered in this tier - $18 copay for a three-month (90-day) supply of select drugs covered in this tier

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic - $10 copay for a one-month (31-day) supply of select drugs covered in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Mail Order Tier 1: Preferred Generic - $0 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $21 copay for a three-month (90-day) supply of select drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Please contact the plan for a complete list of drugs covered through the gap.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Tier 1: Preferred Generic - $3 copay for a one-month (31-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic - $6 copay for a one-month (31-day) supply of select drugs covered in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Mail Order Tier 1: Preferred Generic - $0 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Tier 2: Non-Preferred Generic - $9 copay for a three-month (90-day) supply of select drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Please contact the plan for a complete list of drugs covered through the gap.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: -5% coinsurance, or - $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.	Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: -5% coinsurance, or - $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.
		Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from HealthSpring Preferred (HMO).	Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from HealthSpring Premier (HMO-POS).
		Out-of-Network Initial Coverage You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970:	Out-of-Network Initial Coverage You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970:
		Tier 1: Preferred Generic	Tier 1: Preferred Generic
		- $3 copay for a one-month (30-day) supply of drugs in this tier	- $3 copay for a one-month (30-day) supply of drugs in this tier
		Tier 2: Non-Preferred Generic	Tier 2: Non-Preferred Generic
		- $10 copay for a one-month (30-day) supply of drugs in this tier	- $6 copay for a one-month (30-day) supply of drugs in this tier
		Tier 3: Preferred Brand	Tier 3: Preferred Brand
		- $45 copay for a one-month (30-day) supply of drugs in this tier	- $45 copay for a one-month (30-day) supply of drugs in this tier
		Tier 4: Non-Preferred Brand	Tier 4: Non-Preferred Brand

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		- $85 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Coverage Gap You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). Additional Out-of-Network Coverage Gap The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:	- $85 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Coverage Gap You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). Additional Out-of-Network Coverage Gap The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
25 - Outpatient Prescription Drugs		Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic - $10 copay for a one-month (30-day) supply of select drugs covered in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	Tier 1: Preferred Generic - $3 copay for a one-month (30-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic - $6 copay for a one-month (30-day) supply of select drugs covered in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: - 5% coinsurance, or - $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	General Authorization rules may apply. In-Network $0 copay for the following preventive dental benefits: - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) $35 copay for Medicare-covered dental benefits	General Authorization rules may apply. In-Network $0 copay for the following preventive dental benefits: - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) $35 copay for Medicare-covered dental benefits

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
26 - Dental Services		$1,000 plan coverage limit for preventive dental benefits every year	Plan offers additional comprehensive dental benefits. $1,000 plan coverage limit for dental benefits every year
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network In general, supplemental routine hearing exams and hearing aids not covered. $10 to $35 copay for Medicare-covered diagnostic hearing exams	In-Network In general, supplemental routine hearing exams and hearing aids not covered. $10 to $35 copay for Medicare-covered diagnostic hearing exams
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network $0 copay for - one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery - $0 to $35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. $0 copay for up to 1 supplemental routine eye exam(s) every year $0 copay for - up to 1 pair(s) of glasses every year - contacts $100 plan coverage limit for eye wear every year.	In-Network $0 copay for - one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery - $0 to $35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. $0 copay for up to 1 supplemental routine eye exam(s) every year $0 copay for - up to 1 pair(s) of glasses every year - contacts $200 plan coverage limit for eye wear every year.
Over-the-Counter Items	Not covered.	General The plan does not cover Over-the-Counter items.	General The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	General Authorization rules may apply. In-Network $0 copay for up to 20 one-way trip(s) to plan-approved location every year	In-Network This plan does not cover supplemental routine transportation.

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.
Point of Service	You may go to any doctor, specialist or hospital that accepts Medicare.	This benefit is not covered.	General Authorization rules may apply. Out-of-Network Point of Service coverage is available for the following benefits: Medicare-covered - Inpatient Hospital Acute - Inpatient Hospital Psychiatric - Skilled Nursing Facility (SNF) - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Ambulance Services

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
Point of Service			- Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - End-Stage Renal Disease - Medicare-covered Preventive Services - Kidney Disease Education Services - Diabetes Self-Management Training - Medicare Part B Rx Drugs - Comprehensive Dental - Eye Exams - Hearing Exams You may need a referral for the following Point-of-service benefits: Medicare-covered - Inpatient Hospital Acute - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Other Health Care Professional - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - End-Stage Renal Disease - Kidney Disease Education Services - Diabetes Self-Management Training - Comprehensive Dental - Eye Exams - Hearing Exams

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
Point of Service			30% of the cost per hospital stay. 30% of the cost per Inpatient Psychiatric Hospital stay. 30% of the cost for each SNF stay. 30% of the cost for Medicare-covered - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - End-Stage Renal Disease

Benefit	Original Medicare	HealthSpring Preferred (HMO)	HealthSpring Premier (HMO-POS)
Point of Service			- Medicare-covered Preventive Services - Kidney Disease Education Services - Diabetes Self-Management Training - Medicare Part B Rx Drugs - Comprehensive Dental - Eye Exams - Hearing Exams $100 copay [or 20% of the cost] for Medicare-covered - Ambulance Services

Summary of Benefits: Section III

Description of Services At-A-Glance *Please note authorization rules may apply for services. Contact the plan for details.*	HealthSpring Preferred (HMO) Member Copay/Coinsurance	HealthSpring Premier (HMO-POS) Member Copay/Coinsurance
Ambulance	20% coinsurance for air ambulance transportation $100 copay for ground ambulance transportation	20% coinsurance for air ambulance transportation $100 copay for ground ambulance transportation

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-668-3813. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-668-3813. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-668-3813。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-668-3813。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-668-3813. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-668-3813. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-668-3813 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-668-3813. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-668-3813번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-668-3813. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: لديان خدمات الترجمة مجانا للرد على أية أسئلة قد تكون لديك حول خدماتنا الصحية أو خطة المخدرات. للحصول على مترجم، فقط اتصل بنا على 1-800-668-3813. يمكن للشخص الذي يتحدث اللغة الإنجليزية / اللغة مساعدتك. هذا وه خدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-668-3813. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-668-3813. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-668-3813. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-668-3813. Ta usługa jest bezpłatna.

Hindi:

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Japanese: 当社の健康 健康保険と薬品
処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには 1-800-668-3813 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。