2026 HealthSpring℠ Medicare Prescription Drug Plan (PDP) Enrollment Guide

January 1, 2026 – December 31, 2026

Together, we are so much more.℠

HealthSpring℠

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Welcome

Thank you for considering a Medicare Prescription Drug plan from HealthSpring. It's a big decision, and there's a lot of information to take in.

This guide provides an overview of our Medicare Prescription Drug plans in your service area. Our plans put you first, through flexible options and benefits that matter.

When it comes to deciding on the best Medicare plan for your health and wellness, HealthSpring is here. From understanding the plans, to finding the one that best fits your health goals, we're here to help.

With HealthSpring, more is within reach. We have an important goal – to create a community of care that empowers you to achieve your wellness goals and live a vibrant, healthy life. Affordable, accessible, and built with you in mind, solutions connect our members to quality care and flexible options. **Together, we are so much more.**℠

On behalf of our entire HealthSpring Medicare team, we wish you the best of health.

Need help reviewing your options or taking next steps?

We're here for you – before, during and long after you enroll.

- Call **1-877-534-0199 (TTY 711)**, 7 days a week, 8 a.m. – 8 p.m., local time. Our automated phone system may answer your call during weekends from April 1 – September 30.
- Visit **HealthSpring.com/Part-D**

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Starting Your Health Journey.

Our goal at HealthSpring? To empower your journey toward health and vitality.

As a true health partner, we're here to guide you to a Medicare Prescription Drug plan that makes it easy and affordable to get your important medications. **Together, we are so much more.**℠

Here's a tip: You may pay less for covered Part D medications if you use a preferred pharmacy.

Connecting you to the right resources.

This guide is a summary of what we cover and what you pay from **January 1, 2026, to December 31, 2026**. But it doesn't list every service, limitation or exclusion.

Here's how to find more details.

Shop and compare plans or enroll at **HealthSpring.com/Part-D**.

Learn more about eligibility and Medicare at **HealthSpringMedicare.com**.

Review plan benefits and download the **Evidence of Coverage (EOC)** at **HealthSpring.com/Resources**, then select **Find Plan Documents**. You can also call us to request the EOC by mail.

Scan each code with a smart phone camera for easy access.

True health partnership is part of the plan.

Questions?
Our Licensed Insurance Agents are here to help.

Call **1-877-534-0199 (TTY 711)**, 8 a.m. to 8 p.m. local time.

October – March:
7 days a week
April – September:
Monday – Friday.

Messaging service used during weekends, after hours and holidays.

Plans to Fit Your Life.

It's important to choose a Medicare Prescription Drug plan that supports your needs. And we understand that affordability, flexibility and convenience matter.

In 2026, you can choose from two plan options.

HealthSpring Assurance Rx plan highlights

Affordability meets convenience, with benefits such as:

- **Basic coverage on commonly used drugs.**
- **$0 or low cost-shares for many generic medications.**
- **Standard deductible.**

Tip: If you qualify for Extra Help, the Assurance plan helps lower your monthly premium, deductible and prescription costs.

HealthSpring Extra Rx plan highlights

More coverage and options, with benefits such as:

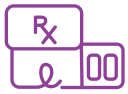
- **Flexible benefits with additional covered products.**
- **$0 copay for many generic medications.**
- **$0 deductible for Tiers 1 and 2 drugs.**
- **Supplemental benefits, including select vitamins, sildenafil and Renova®.**

No matter which plan you choose, you'll enjoy the benefits that spring from a true health partnership.

- A dedicated support team.
- Over **60,000** in-network pharmacies made up of large and regional chains and independent pharmacies.
- Convenient Home Delivery pharmacy options.
- Tools and resources to make the most of your plan.

Making It Easier to Get Your Medications.

At HealthSpring, we know how important it is for you to get your medications and take them as prescribed. That's why we offer meaningful benefits that put your needs first.



Convenience

HealthSpring has over **60,000** network pharmacies. Preferred pharmacy options include Walmart and Walgreens locations nationwide, plus many regional chains and independent pharmacies.

Prescription Home Delivery

Get your medications delivered with free shipping. Enjoy additional benefits, such as:

- A 90-day supply with preferred cost-sharing.
- Automatic refill options.
- Convenient payment options over 90 days.
- 24-hour access to pharmacists.
- Special handling, like refrigeration, if needed.

Comprehensive coverage

We cover over **3,000** medications commonly used among Medicare members including medications for blood pressure, heart health, diabetes, cholesterol, pain, arthritis and more.

Savings

Keep more of your money with **$0 to low cost-shares** for Tier 1 drugs. Our licensed insurance agents can help you find additional savings.

Helping you save is what we do.

To learn more about our pharmacy network or find out if your medications are covered, visit **HealthSpring.com/Part-D**, or call **1-877-534-0199**.

Plan Options Made Easy.

Refer to the **Premiums and cost-sharing** tables on **page 6** to find specific costs by state.

The table has ranges for the costs that vary by region.

	Assurance			Extra		
Monthly plan premium	$0–$153			$50–$92		
Annual deductible	$615 (All tiers)			$0 (Tiers 1 & 2), $615 (Tiers 3-5)		
Initial Coverage	Preferred pharmacies	Standard pharmacies	Preferred Home Delivery	Preferred pharmacies	Standard pharmacies	Preferred Home Delivery
	30 days	30 days	90 days	30 days	30 days	90 days
Tier 1: Preferred Generic	$0 or 5%	$4 or 10%	$0 or 5%	$0	$6	$0
Tier 2: Generic	$2 or 10%	$11–$12 or 14%–15%	$2 or 10%	$5	$11–$13	$3
Tier 3: Preferred Brand	20%–25%	21%–25%	20%–25%	16%–17%	17%–22%	16%–17%
Tier 4: Non-Preferred Drugs	27%–34%	29%–40%	27%–34%	29%–33%	30%–35%	29%–33%
Tier 5: Specialty Tier	25%	25%	N/A	25%	25%	N/A
Catastrophic Coverage	You will pay $0 for covered Part D drugs once your total out-of-pocket costs reach $2,100.					

For insulins that are covered by our plans, you will pay no more than **$35** for each one month supply. Additionally, you will pay **$0** for each covered adult vaccine.

Do you get Extra Help? You may qualify for a $0 or reduced premium, low copays and a lower deductible.

For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **1-800-222-6700 (TTY 711)** or consult the online pharmacy directory at **HealthSpring.com/Resources**.

2026 HealthSpring Assurance Rx (PDP)

Premiums and cost-sharing

Annual deductible $615 (All tiers)

Note: If you receive Extra Help Low Income Subsidy (LIS), some of your benefits may be different, like a $0 or reduced monthly premium, lower yearly deductible, and low drug copays.

Regional states	Premium	Preferred pharmacies, 30-day supply (retail)**				
		T1	T2	T3	T4	T5
Alabama, Tennessee	$87.20	$0	$2	22%	32%	25%
Central NE (CT, MA, RI, VT)	$139.30	$0	$2	21%	31%	25%
Idaho, Utah	$128.60	$0	$2	21%	30%	25%
Indiana, Kentucky	$117.80	$0	$2	20%	30%	25%
Mid-Atlantic (DE, DC, MD)	$32.60	$0	$2	22%	30%	25%
Northern NE (NH,ME)	$0.00	5%	10%	25%	30%	25%
Oregon, Washington	$0.00	5%	10%	24%	30%	25%
Pennsylvania, West Virginia	$74.00	$0	$2	21%	31%	25%
Upper Midwest and N. Plains*	$125.90	$0	$2	21%	30%	25%
Alaska	$0.00	5%	10%	25%	29%	25%
Arizona	$0.00	5%	10%	25%	29%	25%
Arkansas	$0.00	5%	10%	25%	29%	25%
California	$0.00	5%	10%	25%	29%	25%
Colorado	$61.70	$0	$2	20%	30%	25%
Georgia	$149.30	$0	$2	21%	31%	25%
Illinois	$104.20	$0	$2	21%	32%	25%
Kansas	$6.70	5%	10%	25%	31%	25%
Louisiana	$48.40	$0	$2	20%	30%	25%
Michigan	$0.00	5%	10%	25%	30%	25%
Mississippi	$59.70	$0	$2	21%	30%	25%
Missouri	$74.30	$0	$2	20%	30%	25%
Nevada	$95.60	$0	$2	20%	30%	25%
New Jersey	$109.30	$0	$2	20%	27%	25%
New Mexico	$0.00	5%	10%	25%	29%	25%
New York	$35.70	5%	10%	25%	29%	25%
North Carolina	$110.40	$0	$2	22%	32%	25%
Ohio	$109.50	$0	$2	21%	33%	25%
Oklahoma	$126.50	$0	$2	20%	29%	25%
Puerto Rico	$65.70	$0	$2	22%	34%	25%
South Carolina	$152.50	$0	$2	21%	31%	25%
Texas	$111.40	$0	$2	21%	31%	25%
Virginia	$133.80	$0	$2	22%	31%	25%
Wisconsin	$0.00	5%	10%	25%	30%	25%

*IA, MN, MT, ND, NE, SD and WY are associated with the regional states of the Upper Midwest and N. Plains.
**60-day and 90-day copays are two times and three times the 30-day copays.

2026 HealthSpring Assurance Rx (PDP)

Annual deductible $615 (All tiers)

Premiums and cost-sharing

Note: If you receive Extra Help Low Income Subsidy (LIS), some of your benefits may be different, like a $0 or reduced monthly premium, lower yearly deductible, and low drug copays.

Standard pharmacies, 30-day supply (retail)**					Preferred 90-day supply (mail order)***			
T1	T2	T3	T4	T5	T1	T2	T3	T4
$4	$11	23%	34%	25%	$0	$2	22%	32%
$4	$12	23%	33%	25%	$0	$2	21%	31%
$4	$11	22%	31%	25%	$0	$2	21%	30%
$4	$12	22%	33%	25%	$0	$2	20%	30%
$4	$12	23%	32%	25%	$0	$2	22%	30%
10%	15%	25%	30%	25%	5%	10%	25%	30%
10%	15%	25%	31%	25%	5%	10%	24%	30%
$4	$11	23%	32%	25%	$0	$2	21%	31%
$4	$12	23%	32%	25%	$0	$2	21%	30%
10%	15%	25%	29%	25%	5%	10%	25%	29%
10%	15%	25%	30%	25%	5%	10%	25%	29%
10%	15%	25%	29%	25%	5%	10%	25%	29%
10%	15%	25%	29%	25%	5%	10%	25%	29%
$4	$12	21%	31%	25%	$0	$2	20%	30%
$4	$12	23%	31%	25%	$0	$2	21%	31%
$4	$12	23%	33%	25%	$0	$2	21%	32%
10%	15%	25%	31%	25%	5%	10%	25%	31%
$4	$11	21%	31%	25%	$0	$2	20%	30%
10%	15%	25%	31%	25%	5%	10%	25%	30%
$4	$11	22%	31%	25%	$0	$2	21%	30%
$4	$12	21%	32%	25%	$0	$2	20%	30%
$4	$12	22%	30%	25%	$0	$2	20%	30%
$4	$12	21%	30%	25%	$0	$2	20%	27%
10%	15%	25%	30%	25%	5%	10%	25%	29%
10%	15%	25%	29%	25%	5%	10%	25%	29%
$4	$11	23%	33%	25%	$0	$2	22%	32%
$4	$12	23%	34%	25%	$0	$2	21%	33%
$4	$12	22%	30%	25%	$0	$2	20%	29%
$4	$12	23%	40%	25%	$0	$2	22%	34%
$4	$12	23%	31%	25%	$0	$2	21%	31%
$4	$11	22%	32%	25%	$0	$2	21%	31%
$4	$12	23%	33%	25%	$0	$2	22%	31%
10%	14%	25%	31%	25%	5%	10%	25%	30%

***Tier 5 is limited to a 30-day supply. Refer to 30-day retail cost-sharing.

Long-term care (LTC) and home infusion pharmacies use the standard pharmacy cost-sharing. For LTC, you can get up to a 31-day supply. At an out-of-network pharmacy, you will pay the in-network pharmacy copay or percentage of the cost plus the amount the out-of-network pharmacy billed; charges are higher than our typical standard retail pharmacy-billed charges.

2026 HealthSpring Extra Rx (PDP)

Premiums and cost-sharing

Note: If you receive Extra Help Low Income Subsidy (LIS), some of your benefits may be different, like a reduced monthly premium, lower yearly deductible, and low drug copays.

Annual deductible
$0 (Tiers 1, 2)
$615 (Tiers 3–5)

Regional states	Premium	Preferred pharmacies, 30-day supply (retail)**				
		T1	T2	T3	T4	T5
Alabama, Tennessee	**$77.50**	$0	$5	17%	31%	25%
Idaho, Utah	**$56.30**	$0	$5	17%	31%	25%
Indiana, Kentucky	**$78.20**	$0	$5	17%	30%	25%
Mid-Atlantic (DE, DC, MD)	**$66.60**	$0	$5	17%	32%	25%
Oregon, Washington	**$50.00**	$0	$5	16%	30%	25%
Pennsylvania, West Virginia	**$62.60**	$0	$5	17%	31%	25%
Upper Midwest and N. Plains*	**$66.50**	$0	$5	17%	31%	25%
Arizona	**$66.40**	$0	$5	17%	31%	25%
Arkansas	**$54.50**	$0	$5	17%	31%	25%
California	**$70.60**	$0	$5	17%	30%	25%
Colorado	**$70.70**	$0	$5	17%	31%	25%
Georgia	**$71.20**	$0	$5	17%	30%	25%
Illinois	**$66.60**	$0	$5	17%	30%	25%
Louisiana	**$60.60**	$0	$5	17%	30%	25%
Michigan	**$50.40**	$0	$5	17%	32%	25%
Mississippi	**$77.10**	$0	$5	17%	30%	25%
Missouri	**$70.70**	$0	$5	17%	30%	25%
Nevada	**$52.60**	$0	$5	17%	30%	25%
New Jersey	**$59.90**	$0	$5	16%	30%	25%
New York	**$91.60**	$0	$5	17%	29%	25%
North Carolina	**$78.00**	$0	$5	17%	31%	25%
Ohio	**$65.70**	$0	$5	17%	30%	25%
Oklahoma	**$65.40**	$0	$5	17%	30%	25%
Puerto Rico	**$50.00**	$0	$5	17%	31%	25%
South Carolina	**$71.20**	$0	$5	17%	30%	25%
Texas	**$70.00**	$0	$5	17%	30%	25%
Wisconsin	**$56.30**	$0	$5	17%	33%	25%

*IA, MN, MT, ND, NE, SD and WY are associated with the regional states of the Upper Midwest and N. Plains.
**60-day and 90-day copays are two times and three times the 30-day copays.

2026 HealthSpring Extra Rx (PDP)

Premiums and cost-sharing

Note: If you receive Extra Help Low Income Subsidy (LIS), some of your benefits may be different, like a reduced monthly premium, lower yearly deductible, and low drug copays.

Annual deductible
$0 (Tiers 1, 2)
$615 (Tiers 3–5)

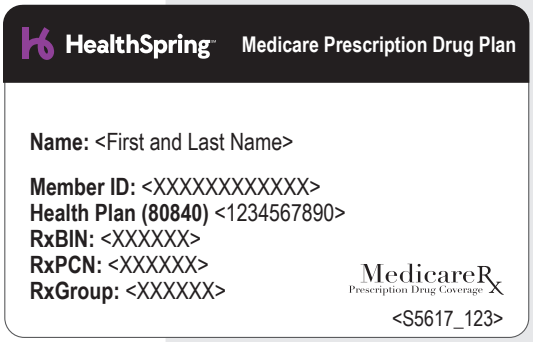
Standard pharmacies, 30-day supply (retail)**					Preferred 90-day supply (mail order)***			
T1	T2	T3	T4	T5	T1	T2	T3	T4
$6	$12	19%	33%	25%	$0	$3	17%	31%
$6	$11	20%	32%	25%	$0	$3	17%	31%
$6	$11	20%	30%	25%	$0	$3	17%	30%
$6	$12	20%	34%	25%	$0	$3	17%	32%
$6	$11	20%	31%	25%	$0	$3	16%	30%
$6	$11	20%	32%	25%	$0	$3	17%	31%
$6	$12	20%	32%	25%	$0	$3	17%	31%
$6	$12	20%	32%	25%	$0	$3	17%	31%
$6	$12	21%	35%	25%	$0	$3	17%	31%
$6	$11	19%	30%	25%	$0	$3	17%	30%
$6	$12	20%	32%	25%	$0	$3	17%	31%
$6	$11	20%	32%	25%	$0	$3	17%	30%
$6	$12	22%	32%	25%	$0	$3	17%	30%
$6	$12	20%	31%	25%	$0	$3	17%	30%
$6	$12	20%	33%	25%	$0	$3	17%	32%
$6	$11	19%	30%	25%	$0	$3	17%	30%
$6	$12	20%	32%	25%	$0	$3	17%	30%
$6	$12	20%	33%	25%	$0	$3	17%	30%
$6	$11	17%	30%	25%	$0	$3	16%	30%
$6	$11	17%	30%	25%	$0	$3	17%	29%
$6	$12	20%	32%	25%	$0	$3	17%	31%
$6	$12	19%	32%	25%	$0	$3	17%	30%
$6	$12	20%	33%	25%	$0	$3	17%	30%
$6	$12	21%	33%	25%	$0	$3	17%	31%
$6	$12	19%	30%	25%	$0	$3	17%	30%
$6	$12	20%	32%	25%	$0	$3	17%	30%
$6	$13	20%	34%	25%	$0	$3	17%	33%

***Tier 5 is limited to a 30-day supply. Refer to 30-day retail cost-sharing.

Long-term care (LTC) and home infusion pharmacies use the standard pharmacy cost-sharing. For LTC, you can get up to a 31-day supply. At an out-of-network pharmacy, you will pay the in-network pharmacy copay or percentage of the cost plus the amount the out-of-network pharmacy billed; charges are higher than our typical standard retail pharmacy-billed charges.

Ready to Enroll?

Once you choose your plan and enroll, you'll receive the following materials in the mail.



- **Confirmation.** This confirms Medicare has approved your enrollment.
- **HealthSpring Rx ID card.** This is the card you'll show at the pharmacy when you start using your plan.
- **Welcome package.** This includes helpful resources to help you start using your HealthSpring plan.

Questions? We've got answers.

Here are just some of the ways you can get in touch with us or learn more about our plans:

Our Licensed Insurance Agents are here to help.

- Already a member? Call **1-800-222-6700 (TTY 711)**.
- Not yet a member? Call **1-877-534-0199 (TTY 711)**.

8 a.m. to 8 p.m. local time.
October – March: 7 days a week. April – September: Monday – Friday.
Messaging service used during weekends, after hours and holidays.

Visit us online to learn more.

- General questions? Visit **HealthSpring.com/Part-D**.
- Already a member of the plan? Visit **HealthSpring.com/Resources**.

A True Health Partnership Can Start Today.

Ready to choose your Medicare Prescription Drug plan?

- Check out the pre-enrollment checklist.
- Review plan coverage, costs and rules.
- Reach out to us with any questions.

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Agent Enrollment Checklist

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Agent checklist for submitting PDP paper applications

When submitting applications, electronic submissions are preferred. However, we realize that a paper application is necessary in some cases. When you must submit a paper application, please be sure to follow the instructions below. **Remember, you must retain a paper application for 10 years after submission.** If you have any questions, please contact the Agent Resource Center (ARC) team at **1-866-442-7516**.

Part I

Before meeting with the customer/prospect, you must be in good standing with HealthSpring (i.e., are active, licensed and appointed per state law and have successfully completed all HealthSpring certification requirements).

Part II

While meeting with a customer/prospect, please be sure to complete the following fields legibly and accurately to avoid delays in application processing.

- ☐ Select the appropriate PDP.
- ☐ Complete the appropriate election period section. If an SEP, be sure to include the SEP date as applicable.
- ☐ Enter application date and requested coverage date.
- ☐ Enter beneficiary's full name, birth date and gender.
- ☐ Enter beneficiary's Medicare Beneficiary Identifier (MBI).
- ☐ Enter beneficiary's address (no PO Boxes allowed).
- ☐ Get an authorized signature of either the beneficiary or an authorized representative.
- ☐ When completing an electronic application, enter the beneficiary's email address, and HealthSpring will send them their enrollment materials electronically.

Part III

When submitting the paper application, please remember the following:

- ☐ Applications must be submitted within 24 hours of receipt.
- ☐ Applications can be submitted via:
  - The ConnectureDRX platform, which can be accessed through **HealthSpringforBrokers.com**
  - Fax to **1-800-735-1469**
  - Mail to HealthSpring: **PO Box 269005, Weston, FL 33326-9927**

Visit **HealthSpring Producers' University** for more information about the ConnectureDRx enrollment tool.

Pre-enrollment checklist

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Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a Licensed Insurance Agent at **1-877-534-0199 (TTY 711)**, 7 days a week, 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call during weekends from April 1 to September 30.

Understanding the benefits

- ☐ Review the *Evidence of Coverage (EOC)*, which provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **HealthSpring.com/resources** or call **1-877-534-0199 (TTY 711)** to view a copy of the EOC.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the prescription drug list to make sure your drugs are covered.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2027.
- ☐ **Effect on current coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Part D coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Part D coverage starts. Please contact TRICARE for more information.

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OMB No. 0938-1378
Expires: 12/31/2026

2026 Medicare Prescription Drug Plan Individual Enrollment Form

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either or both:

- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)

When do I use this form?

You can join a plan:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent residence street address (P.O. Box is not allowed unless you are experiencing homelessness) and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional; you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- We will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to
HealthSpring Medicare Prescription Drug Plans
P.O. Box 269005
Weston, FL 33326-9927

Or fax it to this number: **1-800-735-1469**.

Once we process your request to enroll, we will contact you.

Call HealthSpring at **1-877-534-0199**.
TTY users can call 711.

How do I get help with this form?

Or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call 1-877-486-2048.

En español: Llame a HealthSpring al **1-877-534-0199**/ TTY 711 o a Medicare gratis al **1-800-633-4227** y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a P.O. Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

To enroll in a HealthSpring Medicare Prescription Drug Plan, please provide the following information:

Please check which plan you want to enroll in:	☐ **HealthSpring Extra Rx (PDP)** ☐ **HealthSpring Assurance Rx (PDP)**		
LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (__ __ / __ __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Phone numbers to contact you: Primary number (__ __ __) __ __ __ - __ __ __ __ ☐ Home ☐ Cell Alternate number (optional) (__ __ __) __ __ __ - __ __ __ __ ☐ Home ☐ Cell

By providing my phone number, I agree to receive calls, texts or emails from Health Care Service Corporation, its subsidiaries and affiliates regarding the administration of my HealthSpring plan benefits and services. Calls may be autodialed or prerecorded. You can opt out at any time.

To receive email communications provide your email address below. To update your communication preferences visit **myHealthSpring.com**

Your Email Address (optional):

Permanent Residence Street Address (P.O. Box is not allowed unless you are experiencing homelessness):

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact (optional):	Phone Number:	Relationship to You:

Please provide your Medicare insurance information:

Medicare number: _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthSpring Medicare Prescription Drug Plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and sign below

- I must keep Hospital (Part A) or Medical (Part B) to stay in HealthSpring Medicare Prescription Drug Plan.
- By joining this Medicare Prescription Drug Plan, I acknowledge that HealthSpring will share my information with Medicare, who may use it to track my enrollment, to make payments, and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that I can be enrolled in only one MA or Part D plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- HealthSpring Medicare Prescription Drug Plan serves a specific service area. If I move out of the area that HealthSpring Medicare Prescription Drug Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use HealthSpring Medicare Prescription Plan network pharmacies.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

By providing my phone number and signing below, I agree to receive calls and texts from Health Care Service Corporation (HCSC), its subsidiaries, affiliates and brokers regarding additional HealthSpring products or services. I acknowledge these calls may be autodialed or prerecorded and use an artificial or prerecorded voice. I agree that HCSC may use the information provided or obtained in connection with this application, or insurance coverage provided by HCSC including my personal information, to offer me additional products and services or to send related marketing communications regarding HealthSpring products. I acknowledge that I am not required to provide consent to receive these communications as a condition of applying for coverage. If I choose not to receive marketing communications, I will indicate that by checking the box below or I can withdraw my consent at any time by contacting HealthSpring.

☐ I do not consent to receive marketing communications at the phone number provided.

Signature:	**Today's date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (__ __ __) __ __ __ - __ __ __ __

Relationship to Enrollee _____

Special Enrollment Period
Skip this section if you are enrolling between October 15 – December 7

Please complete – if you are enrolling outside of October 15 – December 7.

Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I have Medicare and Medicaid, or I get Extra Help paying for Medicare drug costs. I want to switch to a different Medicare drug plan.
- ☐ I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly received, had a change, or lost Extra Help) on (insert date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly received, had a change, or lost Medicaid) on (insert date) _____.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (January 1 – March 31)
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact HealthSpring Medicare Prescription Drug Plan at **1-877-534-0199 (TTY 711)** to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30.

Section 2 – All fields that follow below are optional

Answering these questions is your choice. You can't be denied coverage because you didn't fill them out.

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact HealthSpring Medicare Prescription Drug Plan at **1-877-534-0199** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. Our automated phone system may answer your call during weekends from April 1 – September 30. TTY users can call 711.

Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to HealthSpring Medicare Prescription Drug Plan.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check. (Depending on the date your enrollment is processed, you may receive a premium invoice for the first month you are enrolled. If Social Security/Railroad Retirement Board accepts your request for deduction, the deduction from your benefit check may take several months to take effect. Therefore, your first deduction may include the premiums for several months. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

After Medicare has approved your enrollment, you will have additional payment options to choose from. Visit **HealthSpring.com/pay-my-premium** for online payment options and details.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual helping an enrollee fill out this form (for example: SHIP counselor, family member, or other third party).

Name: _____ Signature: _____

Relationship to enrollee: _____

Producer Use Only:

The person that is discussing plan options with you is either employed by or contracted directly or indirectly with HealthSpring. The person may be compensated based on your enrollment in a plan.

Requested Effective Date: _____

☐ IEP ☐ AEP ☐ SEP (See Special Enrollment Period Section)

Name of Plan Representative/Agent/Broker: _____

Producer Last Name: _____ Producer First Name: _____

National Producer Number: _____

Producer Agency: _____

Producer must provide how the enrollment was completed:

☐ Face-to-face meeting ☐ Walk-in ☐ Sales event ☐ Through mail ☐ Telephone

Producer Signature: _____

Producer Phone: (__ __ __) __ __ __ - __ __ __ __ Producer E-mail: _____

Producer needs to provide Effective Date requested, IEP, AEP, or SEP information above. Please be sure to sign the form and provide your National Producer Number.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Scope of Appointment Confirmation Form

FORM TO BE COMPLETED BY LICENSED INSURANCE AGENT AT LEAST 48 HOURS PRIOR TO APPOINTMENT.

The Centers for Medicare & Medicaid Services (CMS) requires Licensed Insurance Agents to document the scope of a marketing appointment at least **48 hours prior** to any personal marketing meeting to ensure understanding of what will be discussed between the Licensed Insurance Agent and the Medicare beneficiary (you or your authorized representative).

A Scope of Appointment Form is required for each beneficiary, and a new form is required if you request information regarding a different plan type than originally agreed upon. All information provided on this form is confidential and should be completed by your Licensed Insurance Agent at least **48 hours prior** to your appointment unless an exception applies.

- ☐ Medicare Advantage Plans (Part C)
- ☐ Medicare Supplement (Medigap) Plans
- ☐ Standalone Prescription Drug Plans (PDPs)
- ☐ Dental/Vision/Hearing Plans
- ☐ Cancer/Heart Attack/Stroke Plans
- ☐ Hospital Indemnity Plans

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in a Medicare plan.

Name: _____ Relationship/POA: _____

Signature: _____ Date: _____

All sections to be completed by Agent.	
Agent Name/Writing ID	**Beneficiary Name**
Agent Phone	**Beneficiary Phone (optional)**
Agent Signature	**Beneficiary Address (optional)**
Date Appointment Completed	**Initial Method of Contact (optional)**

Agents: If you have any questions about the SOA guidelines and/or process, please speak with your manager or a HealthSpring Broker Manager, or contact our Agent Resource Center (ARC) at **1-866-442-7516** or **ARCMAPD@HealthSpring.com**.

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

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

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

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HealthSpring℠

Together, we are so much more.℠

You Have Choices; We Can Help

HealthSpring

We're here to help.

Call **1-877-534-0199 (TTY 711)**
7 days a week, 8 a.m. to 8 p.m. local time

Our automated phone system may answer your call during weekends from April 1 – September 30.

Mail **HealthSpring**
PO Box 269055
Weston, FL 33326-9927

Visit **HealthSpringMedicare.com**