2024 **Health Plan Benefits** at a Glance

HumanaChoice SNP-DE H5216-206 (PPO D-SNP) Georgia

Plan Costs	Without Medicare & State Cost-Share Protection	With Medicare & State Cost-Share Protection
Monthly plan premium	$44.20	$0
Annual out-of-pocket maximum	$8,850 in-network $8,850 combined in and out-of-network If you are eligible for Medicare cost-sharing assistance under the Georgia Department of Community Health (DCH)(Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,850 in-network $8,850 combined in and out-of-network If you are eligible for Medicare cost-sharing assistance under the Georgia Department of Community Health (DCH)(Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

	In-Network Without Medicare & State Cost-Share Protection	Out-of-Network Without Medicare & State Cost-Share Protection	In-Network With Medicare & State Cost-Share Protection
Doctor Office Visits			
Primary care provider (PCP)	$0 copay	$0 copay	$0 copay
Specialist	$15 copay	$0 or $15 copay	$0 copay
Preventive Care			
Including: Medicare covered screenings	Covered at no cost	Preventive screenings may have a cost share when you see an out-of-network provider.	$0 copay
Telehealth Services (in addition to Original Medicare)			
Primary care provider (PCP)	$0 copay	Not covered	$0 copay
Specialist	$15 copay	Not covered	$0 copay
Urgent care services	$50 copay	Not covered	$0 copay
Substance abuse or behavioral health services	$0 copay	Not covered	$0 copay

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Inpatient Care			
Acute inpatient hospital care	$325 copay per day for days 1-6 $0 copay per day for days 7-90	$0 or $325 copay per day for days 1-6 $0 copay per day for days 7-90	$0 copay
Lab Services			
Lab tests from lab facility	$0 copay	$0 copay	$0 copay
Lab tests from outpatient hospital facility	$50 copay	$0 or $50 copay	$0 copay
Outpatient Care			
Outpatient surgery at ambulatory surgical center	$380 copay	$0 or $380 copay	$0 copay
Physical therapy at therapy facility	$25 copay	$0 or $25 copay	$0 copay
X-rays at outpatient hospital facility	$125 copay	$0 or $125 copay	$0 copay
Diagnostic testing at outpatient hospital facility	$120 copay	$0 or $120 copay	$0 copay
Mental Health Services			
Inpatient psychiatric hospital Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	$587 copay per day for days 1-3 $0 copay per day for days 4-90	$0 or $587 copay per day for days 1-3 $0 copay per day for days 4-90	$0 copay
Specialist's office	$45 copay	$0 or $45 copay	$0 copay
Outpatient hospital	$100 copay	$0 or $100 copay	$0 copay
Partial hospitalization	$70 copay	$0 or $70 copay	$0 copay
Emergency Services			
Urgently needed services at an urgent care center	$50 copay	$0 or $50 copay	$0 copay

Emergency Services (continued)			
Ambulance services	$300 copay per date of service	$0 or $300 copay per date of service	$0 copay
Emergency room	$100 copay	$0 or $100 copay	$0 copay
Additional Benefits & Programs			
Healthy Options Allowance	**$75** monthly allowance on a prepaid card to use for essentials you need to support your health. This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.). Allowance amount cannot be combined with other allowances which may be on the Card. Unused funds will roll over to the next month and expire at the end of the plan year.		
Mandatory supplemental dental benefit DEN289	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Mandatory supplemental vision benefit VIS782	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Mandatory supplemental hearing benefit HER945	Included - cost share may apply. Please refer to the Summary of Benefits for additional details.		
Transportation	**$0** copay for plan approved location up to 36 one-way trip(s) per year. This benefit is not to exceed 75 miles per trip.		
NationsMarket® Fresh, Prepared meal program	Included		
Personal Home Care	Included		
SilverSneakers® fitness program	Included		

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2024 **Prescription Drug Benefits** at a Glance

HumanaChoice SNP-DE H5216-206 (PPO D-SNP) Georgia

Plan Highlights	
$0 Rx Copay Benefit	If you receive "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary for the entire calendar year.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

If you do not receive "Extra Help" refer to Chapter 6 of the Evidence of Coverage for more details on the prescription drug benefit.

To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

Some drugs are limited to a 30-day supply

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711).

If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. to 8 p.m. seven days a week from Oct. 1, 2023 – Mar. 31, 2024 and Monday - Friday the rest of the year.

Humana is a Coordinated Care (PPO D-SNP) plan with a Medicare contract and a contract with the Georgia Department of Community Health (DCH)(Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

Your provider may choose to submit to the Georgia Department of Community Health (DCH)(Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. Providers are required by federal regulation to accept HumanaChoice SNP-DE H5216-206 (PPO D-SNP) primary payment and the Georgia Department of Community Health (DCH)(Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the Georgia Department of Community Health (DCH)(Medicaid), HumanaChoice SNP-DE H5216-206 (PPO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call Customer Care at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Customer Care or Medicare can ask your provider to stop billing you and refund any payment you have made.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth. Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

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

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Get all your health plan details at
Humana.com/Benefits

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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