

# 2022 Health Plan Benefits at a Glance

HumanaChoice SNP-DE H5216-205 (PPO D-SNP) Georgia

Plan Costs	In-Network	Out-of-Network
Monthly plan premium	\$0	
Medical deductible	\$0	\$0
Part B deductible	\$0	\$0
Annual out-of-pocket maximum	\$0	\$0
<b>Doctor Office Visits</b>		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialist	\$0 copay	\$0 copay
<b>Preventive Care</b>		
Including: Medicare covered screenings	Covered at no cost	Covered at no cost
<b>Telehealth Services (in addition to Original Medicare)</b>		
Primary care provider (PCP)	\$0 copay	Not covered
Specialist	\$0 copay	Not covered
Urgent care services	\$0 copay	Not covered
Substance abuse or behavioral health services	\$0 copay	Not covered
<b>Inpatient Care</b>		
Acute inpatient hospital care	\$0 copay	
<b>Lab Services</b>		
Lab tests from lab facility	\$0 copay	\$0 copay
Lab tests from outpatient hospital facility	\$0 copay	\$0 copay
<b>Outpatient Care</b>		
Outpatient surgery at ambulatory surgical center	\$0 copay	\$0 copay
Physical therapy at therapy facility	\$0 copay	\$0 copay
X-rays at outpatient hospital facility	\$0 copay	\$0 copay
Diagnostic testing at outpatient hospital facility	\$0 copay	\$0 copay

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## Mental Health Services

Inpatient psychiatric hospital	\$0 copay	\$0 copay
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Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

Specialist's office	\$0 copay	\$0 copay
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Outpatient hospital	\$0 copay	\$0 copay
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Partial hospitalization	\$0 copay	\$0 copay
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## Emergency Services

Urgently needed services at an urgent care center	\$0 copay	\$0 copay
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Ambulance services	\$0 copay	\$0 copay
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Emergency room	\$0 copay	\$0 copay
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## Additional Benefits & Programs

Healthy Foods Card	<b>\$50</b> automatically loaded every month to spend at participating retailers toward the purchase of approved healthy foods.
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Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance	A needs based benefit included for chronically ill members who meet eligibility criteria, and are participating in care management. Please refer to the Summary of Benefits for additional details.
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Routine dental services DEN189	Included
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Routine vision services VIS783	Included
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Transportation services	<b>\$0</b> copay for plan approved location up to 36 one-way trip(s) per year. This benefit is not to exceed 75 miles per trip.
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Over-the-Counter (OTC) card	<b>\$100</b> maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers.
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SilverSneakers® fitness program	Included
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Personal Emergency Response System	Included
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Humana Well Dine® Meal Program	Included
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Routine hearing services HER953	Included
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# 2022 Prescription Drug Benefits at a Glance

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**Deductible** This plan does not have a deductible.

Depending on the level of Extra Help you receive, you'll pay one of the following cost-share amounts each time you fill your drug.

## Pharmacy options

<b>Preferred cost-sharing</b>	<b>Mail Order:</b> Humana Pharmacy® <b>Retail:</b> To find the preferred cost-share retail pharmacies near you, go to <a href="https://www.humana.com/pharmacyfinder">Humana.com/pharmacyfinder</a>	
<b>Standard cost-sharing</b>	<b>Mail Order:</b> Walmart Mail <b>Retail:</b> All other network retail pharmacies	
For generic drugs (including brand drugs treated as generic), either:	<b>30-day supply</b>	<b>90-day supply*</b>
	\$0 copay; or \$1.35 copay; or \$3.95 copay; or 15% of the cost	\$0 copay; or \$1.35 copay; or \$3.95 copay; or 15% of the cost
For all other drugs, either:	\$0 copay; or \$4 copay; or \$9.85 copay; or 15% of the cost	\$0 copay; or \$4 copay; or \$9.85 copay; or 15% of the cost

You can get more out of your plan by doing the following:

- **Use preferred cost-sharing pharmacies.** You will always pay **\$0** for Tier 1 drugs on this plan at a Preferred Cost-Sharing Retail or Preferred Cost-Sharing Mail Order Pharmacy.
- **Get a 90-day supply of many of the drugs you take all of the time.** You'll get a three-month supply of your drug for the same cost-share as a one-month supply.

Other pharmacies are available in our network.

\*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. - 8 p.m. seven days a week from Oct. 1, 2021 - Mar. 31, 2022 and Monday through 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.

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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.



Get all your health plan details at  
**[Humana.com/Benefits](https://www.humana.com/Benefits)**



## Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.  
If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

### **Auxiliary aids and services, free of charge, are available to you.** **1-877-320-1235 (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.

### **Language assistance services, free of charge, are available to you.** **1-877-320-1235 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'éh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك