2025

Summary of Benefits

Humana Dual Select H5216-206 (PPO D-SNP)

Georgia

Select Counties in Georgia

Our service area includes the following county/counties in Georgia: Atkinson, Bacon, Baker, Baldwin, Banks, Barrow, Bartow, Ben Hill, Berrien, Bibb, Brooks, Bryan, Bulloch, Burke, Butts, Calhoun, Camden, Carroll, Catoosa, Charlton, Chatham, Chattahoochee, Chattooga, Cherokee, Clarke, Clay, Clayton, Clinch, Cobb, Coffee, Colquitt, Columbia, Cook, Coweta, Crawford, Crisp, Dade, Dawson, Decatur, DeKalb, Dodge, Dooly, Dougherty, Douglas, Early, Effingham, Elbert, Emanuel, Fannin, Fayette, Floyd, Forsyth, Franklin, Fulton, Gilmer, Glascock, Glynn, Gordon, Grady, Greene, Gwinnett, Habersham, Hall, Hancock, Haralson, Harris, Hart, Heard, Henry, Houston, Irwin, Jackson, Jasper, Jeff Davis, Jefferson, Jenkins, Johnson, Jones, Lamar, Lanier, Laurens, Lee, Liberty, Lincoln, Long, Lowndes, Lumpkin, Macon, Madison, Marion, McDuffie, McIntosh, Meriwether, Miller, Mitchell, Monroe, Morgan, Murray, Muscogee, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pierce, Pike, Polk, Pulaski, Putnam, Quitman, Randolph, Richmond, Rockdale, Schley, Screven, Seminole, Spalding, Stephens, Stewart, Sumter, Talbot, Taliaferro, Tattnall, Taylor, Terrell, Thomas, Tift, Toombs, Towns, Treutlen, Troup, Turner, Twiggs, Union, Upson, Walker, Walton, Ware, Warren, Washington, Wayne, Webster, Wheeler, White, Whitfield, Wilcox, Wilkes, Wilkinson, Worth.

Pre-Enrollment Checklist

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 customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part A/ Part B premiums may be paid for by Georgia Department of Community Health (DCH) (Medicaid).
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2026.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll FBDE, QI, QMB, QMB+, SLMB, SLMB+.

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Let's talk about Humana Dual Select H5216-206 (PPO D-SNP)

Find out more about the Humana Dual Select H5216-206 (PPO D-SNP) plan – including the health and drug services it covers – in this easy-to-use guide.

Humana Dual Select H5216-206 (PPO D-SNP) is a Coordinated Care plan LPPO with a Medicare contract and a contract with Georgia Department of Community Health (DCH) (Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **Humana.com/PlanDocuments**.

As a member, it's a good idea to select a doctor as your Primary Care Provider(PCP). Humana Dual Select H5216-206 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers.

You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in Humana Dual Select H5216-206 (PPO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from Georgia Department of Community Health (DCH) (Medicaid).

Humana Dual Select H5216-206 (PPO D-SNP) may enroll FBDE, QI, QMB, QMB+, SLMB, SLMB+.

Full Benefit Dual Eligible (FBDE): May help pay Medicare Part A and/or Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Qualifying Individual (QI): Helps pay Part B premiums.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name

Humana Dual Select H5216-206 (PPO D-SNP)

More about Humana Dual Select H5216-206 (PPO D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Benefit Comparison chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the Georgia Department of Community Health (DCH) (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. Your services are paid first by Humana and then by Medicaid.

How to reach us

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or Georgia Department of Community Health (DCH) (Medicaid) for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 – March 31:
Call 7 days a week from 8 a.m. – 8 p.m.

April 1 – September 30:
Call Monday - Friday, 8 a.m. – 8 p.m.

Or visit our website: **Humana.com/Medicare**

Medicaid benefits last validated on 07/01/2024 and are subject to change. For the most current Georgia Medicaid coverage information, please visit Georgia Department of Community Health (DCH) (Medicaid) website at **http://www.dch.georgia.gov/** or call the Medicaid Hotline at 1-800-436-7442 (toll free) .

A healthy partnership

Get more from this plan – with extra services and resources provided by Humana!

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** or up to **$40** depending on your level of "Extra Help." You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by Georgia Department of Community Health (DCH) (Medicaid) Program.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$3** but by no more than Original Medicare's Part B Premium for 2025.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$590** deductible
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$9,350** in-network **$9,350** combined in- and out-of-network If you are eligible for Medicare cost-sharing assistance under 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.

Medical Benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$0** or **$399** copay per day for days 1-6 **$0** copay per day for days 7-90	**$0** or **$399** copay per day for days 1-6 **$0** copay per day for days 7-90
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Diagnostic mammography	**$0** copay	**$0** copay
Surgery services	**$0** or **$450** copay	**$0** or **$450** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Surgery services	**$0** or **$400** copay	**$0** or **$400** copay
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**$0** copay
• Telehealth	**$0** copay	**Not Covered**

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Specialist		
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
• Telehealth	**$0** or **$25** copay	**Not Covered**
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: • **Abdominal aortic aneurysm screening** • **Alcohol misuse screening & counseling** • **Annual Wellness Visit (AWV)** • **Bone mass measurement** • **Breast cancer screening (mammogram)** • **Cardiovascular disease risk reduction visit** • **Cardiovascular disease screenings** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Depression screening** • **Diabetes screening** • **Diabetes self-management training** • **Glaucoma screening** • **HIV screening** • **Immunizations** • **Lung cancer screening** • **Medical nutrition therapy** • **Medicare Diabetes Prevention Program (MDPP)** • **Obesity screening and therapy** • **Prostate cancer screening exams** • **Routine physical Exam** • **Sexually transmitted infections (STIs) screening and counseling**	**$0** copay	**$0** copay

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
• **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** • **"Welcome to Medicare" preventive visit** Any additional preventive services approved by Medicare during the contract year will be covered.		
EMERGENCY CARE		
Emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$0** or **$110** copay	**$0** or **$110** copay
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
• **Telehealth** • **Urgent care center** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** or **$45** copay **$0** or **$45** copay	**Not Covered** **$0** or **$45** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$0** or **$200** copay	**$0** or **$200** copay
• Outpatient hospital	**$0** or **$325** copay	**$0** or **$325** copay
• PCP's office	**$0** or **$200** copay	**$0** or **$200** copay
• Specialist's office	**$0** or **$200** copay	**$0** or **$200** copay

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$0** or **$50** copay	**$0** or **$50** copay
• Outpatient hospital	**$0** or **$130** copay	**$0** or **$130** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
• Urgent care center	**$0** or **$45** copay	**$0** or **$45** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Outpatient hospital	**$0** or **$120** copay	**$0** or **$120** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
• Urgent care center	**$0** or **$45** copay	**$0** or **$45** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** copay
• Outpatient hospital	**$0** or **$50** copay	**$0** or **$50** copay
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** or **$45** copay	**$0** or **$45** copay
Nuclear medicine and services		
• Freestanding radiological facility	**$0** or **$325** copay	**$0** or **$325** copay
• Outpatient hospital	**$0** or **$325** copay	**$0** or **$325** copay
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Outpatient hospital	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
HEARING SERVICES		
Medicare-covered hearing	**$0** or **$25** copay	**$0** or **$25** copay
Mandatory supplemental hearing benefit	**HER945** • **$0** copay for routine hearing exams up to 1 per year. • **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for Premium and Advanced aids for an additional $50 per aid **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).**	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
DENTAL SERVICES		
Medicare-covered dental	**$0** or **$25** copay	**$0** or **$25** copay
Mandatory supplemental dental benefit Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and	**DEN243** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic,	**DEN243** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic,

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	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**. In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance	complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.	complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$1,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. • Benefits received out-of-network are subject to

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	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information in your Evidence of Coverage or visit **Humana.com** for information on requesting reimbursement. When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing. HumanaDental: Find a dentist in the nationwide HumanaDental Medicare network at **Humana.com** > Find Care.		any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered vision services The provider locator for Medicare-covered vision can be found at **Humana.com** > Find Care.	**$0** or **$25** copay	**$0** or **$25** copay
Mandatory supplemental vision benefit The mandatory supplemental vision benefits are provided through the Humana Medicare Insight Network. The provider	**VIS694** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam.	**VIS694** • **$0** copay for routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for routine exam.

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	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
locator can be found at **Humana.com** > Find Care.	• **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • OR • **$100** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Maximum benefit coverage amounts cannot be combined. PLUS providers are part of the Humana Medicare Insight Network and are indicated in the provider locator search results.	• **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. • Maximum benefit coverage amounts cannot be combined.
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** or **$399** copay per day for days 1-5 **$0** copay per day for days 6-90	**$0** or **$399** copay per day for days 1-5 **$0** copay per day for days 6-90
Mental health therapy visits		
• Outpatient hospital	**$0** or **$100** copay	**$0** or **$100** copay
• Partial hospitalization	**$0** or **$80** copay	**$0** or **$80** copay
• Specialist's office	**$0** or **$45** copay	**$0** or **$45** copay

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Medical Benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Outpatient substance abuse services		
• Outpatient hospital	**$0** or **$100** copay	**$0** or **$100** copay
• Partial hospitalization	**$0** or **$80** copay	**$0** or **$80** copay
• Specialist's office	**$0** or **$45** copay	**$0** or **$45** copay
• Telehealth	**$0** or **$45** copay	**Not Covered**
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$0** or **$214** copay per day for days 21-100	**$0** copay per day for days 1-20 **$0** or **$214** copay per day for days 21-100
AMBULANCE		
	$0 or **$315** copay per date of service	**$0** or **$315** copay per date of service
TRANSPORTATION		
	Not Covered	
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance.		
Allergy shots and serum		
• PCP's office	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs		
• Outpatient hospital	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Other Part B drugs		
• Outpatient hospital	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Pharmacy	**$0** copay	**$0** copay
• Specialist's office	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Part B Insulin		
• Outpatient hospital	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Pharmacy	**$0** copay	**$0** copay
• Specialist's office	**$0** or **20%** of the cost	**$0** or **20%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.		

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Prescription Drug Benefits

PLAN HIGHLIGHTS

"Extra Help"	Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, please refer to the "Extra Help" section below to view your deductible and initial coverage stage cost shares.
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$590** deductible. You pay the full cost of your drugs until you reach **$590**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Drugs	25%	25%	25%	25%

To find which pharmacies are available in our network, go to **Humana.com/pharmacyfinder**.
*Some drugs are limited to a 30-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Insulins	$35	$105	$35	$105

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

*Some drugs are limited to a 30-day supply.

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional benefits

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Acupuncture services (Medicare-covered)	**$0** or **$25** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$0** or **$25** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Chiropractic services (Medicare-covered)	**$0** or **$15** copay	**$0** or **$15** copay
Podiatry services (Medicare-covered)	**$0** or **$25** copay	**$0** or **$25** copay

Additional benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Pharmacy	**$0** copay	**$0** copay
Diabetic monitoring supplies		
• Diabetic supplier	**$0** or **20%** of the cost	**$0** or **20%** of the cost
• Network retail pharmacy	**$0** copay	**$0** copay
• Preferred diabetic supplier	**$0** copay	**Not Covered**
Durable medical equipment (DME)	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Medical supplies at medical supplier	**$0** or **20%** of the cost	**$0** or **20%** of the cost
Prosthetic devices and related supplies	**$0** or **20%** of the cost	**$0** or **20%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services		
• Outpatient hospital	**$0** or **$25** copay	**$0** or **$25** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$0** or **$25** copay	**$0** or **$25** copay
• Outpatient hospital	**$0** or **$25** copay	**$0** or **$25** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$0** or **$25** copay	**$0** or **$25** copay
• Outpatient hospital	**$0** or **$25** copay	**$0** or **$25** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
Pulmonary rehabilitation services		
• Outpatient hospital	**$0** or **$25** copay	**$0** or **$25** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay
Speech therapy		
• Comprehensive outpatient rehab facility	**$0** or **$25** copay .	**$0** or **$25** copay
• Outpatient hospital	**$0** or **$25** copay	**$0** or **$25** copay
• Specialist's office	**$0** or **$25** copay	**$0** or **$25** copay

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Additional benefits (cont.)

	IN-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN	OUT-OF-NETWORK WHAT YOU PAY ON THIS HUMANA PLAN
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$0** or **$20** copay	**$0** or **$20** copay
• Specialist's office	**$0** or **$20** copay	**$0** or **$20** copay

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Dual Select H5216-206 (PPO D-SNP). For each benefit listed below, you can see what Georgia Department of Community Health (DCH) (Medicaid) covers and what this plan covers.

All Medicaid benefits are subject to Georgia Department of Community Health (DCH) (Medicaid) eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact Georgia Department of Community Health (DCH) (Medicaid) at 1-800-436-7442 (toll free).

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Covered	Covered
Diagnostic services, labs, and imaging	Covered	Covered
Doctor visits	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital	Covered	Covered
Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Inpatient mental health services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Medicare Part B drugs	Covered	Covered
Mental health services	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Preventive care	Covered	Covered
Skilled nursing facility	Covered	Covered
Transportation	Covered	Not Covered
Urgently needed services	Covered	Covered

More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/PlanDocuments** to view a copy of the EOC or call **1-800-833-2364**.

Travel Coverage
The PPO national network gives you in-network coverage across the country, so you can see any doctor who accepts the plan terms and conditions. You'll be able to travel with ease or split your time between locations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Humana Well Dine® Meal Program
$0 copayment for Humana Well Dine® meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Rewards and Incentives - Go365® by Humana
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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Multi-Language Insert

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 1-877-320-1235 (TTY: 711). Someone who speaks English 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235（听障专线：711）。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 1-877-320-1235（聽障專線：711）。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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と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をご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25) Form Approved OMB# 0938-1421

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Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **Humana.com/Find-Care** or call us at the number listed at the beginning of this booklet and we will send you one. Many doctor listings include a Care Highlight® rating. These ratings in clinical quality and cost-efficiency can help you make informed choices about your healthcare. Ratings only appear when we have enough information to measure a doctor's clinical quality and cost-efficiency. Learn more at **Humana.com/CareHighlight**.

You can see this plan's **Drug Guide** at our website at **Humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

Clinical quality and cost-efficiency ratings are available in all states except Alaska. Ratings are not available for all physicians. Care Highlight is intended for informational purposes only. Members have access to all physicians in the Humana network, regardless of whether or not the physician has a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Humana Dual Select H5216-206 (PPO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of Humana Dual Select H5216-206 (PPO D-SNP) Model of Care.

If you get Medicare cost-share assistance, Humana Dual Select 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 billed or asked to pay an in-network 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 us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

Your provider may choose to submit to Georgia Department of Community Health (DCH) (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are cost-share protected, providers are required by federal regulation to accept Humana Dual Select H5216-206 (PPO D-SNP) primary payment and 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.

Find out **more** *(Continued)*

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 this plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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.

The Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B.

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More information is just a click away.

Visit **Humana.com/PlanDocuments** to see additional details about this plan, including benefits and costs.

If you'd like a printed Evidence of Coverage, Provider Directory, or Drug Guide mailed to you, you can request one online at the website above, or call **1-800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage," "Drug Guide" or "Provider Directory."

Activate your secure MyHumana account.

Your online MyHumana account is an important part of your Humana membership. Use it to view this plan's details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **Humana.com/Member/ManageYourAccount** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

Receiving information about other insurance products

As a Humana member, we may call you to offer other insurance-related products. You can opt out of any future calls using the Customer Care number on the back of your ID card.

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Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

Important information about this plan

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