



## 2026 Summary of Benefits

PruittHealth Premier D-SNP (HMO D-SNP)

H3291, Plan 002

**This is a summary of drug and health services covered by PruittHealth Premier D-SNP (HMO D-SNP) from January 1 – December 31, 2026.**

PruittHealth Premier D-SNP (HMO D-SNP) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is not a complete description of benefits. Call 1-855-855-0668, TTY should call 711, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at [PruittHealthPremier.com](https://PruittHealthPremier.com), or call Member Services and request the *Evidence of Coverage*.

### **To reach our Member Services Representatives:**

- Toll-free number: 1-855-855-0668, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

### **To join PruittHealth Premier D-SNP (HMO D-SNP), you must:**

- Have both Medicare Part A and Medicare Part B,
- -- *and* -- live in our geographic service area,
- -- *and* -- be a United States citizen or be lawfully present in the United States,
- -- *and* -- meet the special eligibility requirements: Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medicaid.

Our service area includes these counties in Georgia: Baker, Baldwin, Banks, Barrow, Bartow, Ben Hill, Berrien, Bibb, Brooks, Bryan, Burke, Butts, Camden, Carroll, Catoosa, Chatham, Chattooga, Cherokee, Clarke, Clayton, Clinch, Cobb, Colquitt, Columbia, Coweta, Dawson, DeKalb, Dooly, Dougherty, Douglas, Echols, Elbert, Emanuel, Fannin, Fayette, Floyd, Forsyth, Fulton, Glascock, Glynn, Grady, Greene, Gwinnett, Habersham, Hall, Hancock, Haralson, Heard, Henry, Houston, Irwin, Jackson, Jasper, Jefferson, Jenkins, Lincoln, Long, Lowndes, Lumpkin, Madison, McDuffie, McIntosh, Meriwether, Mitchell, Monroe, Morgan, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pike, Polk, Pulaski, Richmond, Rockdale, Schley, Screven, Spalding, Stephens, Taliaferro, Thomas, Toombs, Turner, Twiggs, Walker, Walton, Warren, Washington, Webster, Wilkes, Wilkinson, and Worth.

PruittHealth Premier D-SNP (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [PruittHealthPremier.com](http://PruittHealthPremier.com). If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in braille and in large print.

Premium, copayments, coinsurance, and deductibles may vary based on the level of “Extra Help” you receive. Please contact the plan for further details.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2026* handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Medical Benefits

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<b>Monthly plan premium</b> <i>(includes both medical and drug coverage)</i>	\$0 You must continue to pay your Medicare Part B premium. Your premium may be higher depending on your level of Extra Help.	\$24.80 You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	\$0 deductible	You pay the 2026 Original Medicare cost-sharing amounts. The Part A deductible is \$1,736. The Part B deductible is \$283.
<b>Maximum out-of-pocket amount</b> <i>(does not include Part D prescription drugs)</i>	\$9,250 for in-network services	\$9,250 for in-network services
<b>Inpatient hospital coverage</b>	\$0 copayment for each Medicare-covered stay \$0 per day for each lifetime reserve day (up to 60 days over your lifetime)  <i>Prior authorization is required.</i>	You pay the 2026 Original Medicare cost-sharing amounts.  You pay a \$1,736 deductible for each Medicare-covered stay \$0 copayment per day for days 1-60 \$434 copayment per day for days 61-90 \$868 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)  <i>Prior authorization is required.</i>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<b>Outpatient hospital coverage</b> Outpatient hospital services  Outpatient hospital observation services	0% coinsurance  <i>Prior authorization is required.</i>  \$0 copayment  <i>Prior authorization is required.</i>	20% coinsurance  <i>Prior authorization is required.</i>  \$100 copayment  <i>Prior authorization is required.</i>
<b>Ambulatory Surgical Center (ASC) services</b>	0% coinsurance  <i>Prior authorization is required.</i>	20% coinsurance  <i>Prior authorization is required.</i>
<b>Doctor visits</b> Primary care providers  Specialists	\$0 copayment  \$0 copayment	\$0 copayment  \$10 copayment
<b>Preventive care (e.g., flu vaccine, diabetic screenings)</b>	\$0 copayment	\$0 copayment
<b>Emergency care</b>	\$0 copayment	\$90 copayment  You do not pay this amount if you are admitted to the hospital within 3 days.
<b>Urgently needed services</b>	\$0 copayment per visit	\$35 copayment per visit  You do not pay this amount if you are admitted to the hospital within 3 days.

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<b>Diagnostic services/labs/imaging</b>		
Diagnostic tests and procedures	0% coinsurance  <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i>	20% coinsurance  <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i>
Diagnostic radiology services (e.g., MRI, CAT scan)	0% coinsurance  <i>Prior authorization is required except for ultrasounds.</i>	20% coinsurance  <i>Prior authorization is required except for ultrasounds.</i>
Lab services	\$0 copayment  <i>Prior authorization is required only for genetic testing.</i>	\$0 copayment  <i>Prior authorization is required only for genetic testing.</i>
Outpatient x-rays	0% coinsurance	20% coinsurance
Therapeutic radiology	0% coinsurance  <i>Prior authorization is required.</i>	20% coinsurance  <i>Prior authorization is required.</i>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<b>Hearing services (Medicare-covered)</b>		
Medicare-covered services	0% coinsurance	20% coinsurance
<b>Hearing services (Supplemental)</b>		
Routine hearing exam	\$0 copayment Limit 1 every year	\$0 copayment Limit 1 every year
Fitting/evaluation(s) for hearing aids	\$0 copayment Unlimited visits	\$0 copayment Unlimited visits
Hearing aids	\$4,620 every year for both ears combined	\$4,620 every year for both ears combined
	Benefit is administered by NationsBenefits.	Benefit is administered by NationsBenefits.

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<p><b>Dental services (Medicare-covered)</b></p> <p>Medicare-covered services</p> <p><b>Dental services (Supplemental)</b></p> <p>Preventive and comprehensive services</p>	<p>0% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$4,200 every year for preventive and comprehensive services</p> <p>All services must be provided by <b>Liberty Dental</b>. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at <a href="http://libertydentalplan.com/pruitthealthpremier">libertydentalplan.com/pruitthealthpremier</a>.</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$4,200 every year for preventive and comprehensive services</p> <p>All services must be provided by <b>Liberty Dental</b>. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at <a href="http://libertydentalplan.com/pruitthealthpremier">libertydentalplan.com/pruitthealthpremier</a>.</p>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<b>Vision services (Medicare-covered)</b>		
Exam to diagnose and treat diseases and conditions of the eye	0% coinsurance	20% coinsurance
For people with diabetes, screening for diabetic retinopathy is covered once per year	0% coinsurance	20% coinsurance
Eyewear after cataract surgery	\$0 copayment	\$0 copayment
Glaucoma screening	\$0 copayment	\$0 copayment
<b>Vision services (Supplemental)</b>		
Routine eye exam	\$0 copayment Limit 1 every year	\$0 copayment Limit 1 visit every year
Additional routine eyewear	Up to a \$500 credit every year for lenses, frames, contacts, or eyewear upgrades  Members may pay for eyewear using their preloaded Healthy Living Flex Card – allowance is separate	Up to a \$500 credit every year for lenses, frames, contacts, or eyewear upgrades  Members may pay for eyewear using their preloaded Healthy Living Flex Card – allowance is separate

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<p><b>Mental health services</b></p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>\$0 copayment for each Medicare-covered stay</p> <p>\$0 per day for each lifetime reserve day (up to 60 days over your lifetime)</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment</p> <p>\$0 copayment</p>	<p>You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>You pay a \$1,736 deductible for each Medicare-covered stay</p> <p>\$0 copayment per day for days 1-60</p> <p>\$434 copayment per day for days 61-90</p> <p>\$868 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)</p> <p><i>Prior authorization is required.</i></p> <p>\$40 copayment</p> <p>\$40 copayment</p>
<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>\$0 copayment for each Medicare-covered stay</p> <p><i>Prior authorization is required.</i></p>	<p>You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20</p> <p>\$217 copayment per day for days 21-100</p> <p><i>Prior authorization is required.</i></p>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<b>Physical therapy</b>	0% coinsurance  <i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i>	20% coinsurance  <i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i>
<b>Ambulance</b>  Ground ambulance  Air ambulance	0% coinsurance  0% coinsurance	20% coinsurance  20% coinsurance
<b>Transportation</b> <i>(non-emergency)</i> <ul style="list-style-type: none"><li>• Plan approved health-related location</li><li>• Non-medical needs*</li></ul>	\$0 copayment Limit 80 one-way trips every year to plan approved health-related locations (for members that qualify, up to 30 of these one-way trips may be used for non-medical trips*) Each non-medical ride is limited to 30 miles  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.	\$0 copayment Limit 80 one-way trips every year to plan approved health-related locations (for members that qualify, up to 30 of these one-way trips may be used for non-medical trips*) Each non-medical ride is limited to 30 miles  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<p><b>Medicare Part B prescription drugs</b></p> <p>Chemotherapy/Radiation drugs</p> <p>Other Part B drugs</p>	<p>0%-20% coinsurance Cost-sharing is dependent on the drug administered.</p> <p><i>Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.</i></p> <p>0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum</p> <p><i>Prior authorization is required.</i></p>	<p>0%-20% coinsurance Cost-sharing is dependent on the drug administered.</p> <p><i>Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.</i></p> <p>0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum</p> <p><i>Prior authorization is required.</i></p>

## Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
<b>Prescription drug deductible</b>	\$0 Your deductible may be higher (up to \$615) if you do not qualify for Extra Help.		
<b>Initial coverage</b>	You stay in the Initial Coverage stage until your total out-of-pocket costs reach \$2,100. You then move on to the Catastrophic Coverage Stage.		
<b>Drug coverage</b>	<b>Standard retail cost sharing</b> (in-network) (up to a 30-day supply)	<b>Mail-order cost sharing</b> (up to a 90-day supply)	<b>Long-term care (LTC) cost sharing</b> (up to a 31-day supply)
<b>Cost-sharing for covered drugs</b>	You pay a \$0, \$1.60, \$4.90, \$5.10, or \$12.65 copayment for covered drugs depending on your level of Low-Income Subsidy (LIS) also known as Extra Help. If you do not receive Extra Help, you will pay a 25% coinsurance for covered drugs.		
<b>Catastrophic coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, you pay nothing for your covered Part D prescription drugs.		

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

## Additional Benefits

Benefit category	Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**	Your plan benefits with SLMB and QI cost-share assistance
<b>Diabetic monitoring supplies</b>	\$0 copayment	\$0 copayment
<b>Dialysis services</b>	0% coinsurance	20% coinsurance
<b>Durable Medical Equipment (DME)</b>	0% coinsurance <i>Prior authorization is required.</i>	20% coinsurance <i>Prior authorization is required.</i>
<b>Healthy Living Flex Card</b> <ul style="list-style-type: none"> <li>• Fitness</li> <li>• General supports for living*</li> <li>• Groceries*</li> <li>• Meals*</li> <li>• Over-The-Counter (OTC) items</li> </ul>	<p>\$250 every month to spend towards Fitness, General Supports For Living (utilities, rent, or mortgage), Groceries, Meals (post-discharge, to prevent exacerbation of chronic condition, or if your condition requires you to remain at home for a period of time), and OTC Items.</p> <p>Benefit is administered by NationsBenefits</p> <p>*Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.</p>	<p>\$250 every month to spend towards Fitness, General Supports For Living (utilities, rent, or mortgage), Groceries, Meals (post-discharge, to prevent exacerbation of chronic condition, or if your condition requires you to remain at home for a period of time), and OTC Items.</p> <p>Benefit is administered by NationsBenefits</p> <p>*Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.</p>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<b>In-home support services (Support with daily tasks)</b>	<p>\$0 copayment Limited to 85 hours annually</p> <p>Members have access to an In-Home Support Services benefit that may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting. This may also include general tasks such as errands, accompaniment to appointments, technology assistance, and setting appointments.</p>	<p>\$0 copayment Limited to 85 hours annually</p> <p>Members have access to an In-Home Support Services benefit that may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting. This may also include general tasks such as errands, accompaniment to appointments, technology assistance, and setting appointments.</p>
<b>Meals</b>	<p>\$0 copayment</p> <p>The Plan provides up to 2 meals per day for 14 days following a hospital or SNF stay (this benefit is limited up to 4 times per calendar year).</p>	<p>\$0 copayment</p> <p>The Plan provides up to 2 meals per day for 14 days following a hospital or SNF stay (this benefit is limited up to 4 times per calendar year).</p>
<b>Occupational therapy</b>	<p>0% coinsurance</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>	<p>20% coinsurance</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>
<b>Personal Emergency Response System (PERS)</b>	<p>\$0 copayment</p> <p>Life Alert button available to all members upon enrollment.</p>	<p>\$0 copayment</p> <p>Life Alert button available to all members upon enrollment.</p>

<b>Benefit category</b>	<b>Your plan benefits with full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)**</b>	<b>Your plan benefits with SLMB and QI cost-share assistance</b>
<p><b>Podiatry services (Foot care)</b></p> <p>Medicare-covered services</p> <p>Routine foot care</p>	<p>0% coinsurance</p> <p>\$0 copayment</p> <p>Limit 6 visits every year</p>	<p>20% coinsurance</p> <p>\$0 copayment</p> <p>Limit 6 visits every year</p>
<p><b>Speech therapy</b></p>	<p>0% coinsurance</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>	<p>20% coinsurance</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>
<p><b>Telemonitoring services (Remote Patient Monitoring – RPM)</b></p>	<p>\$0 copayment</p> <p>Members will have access to remote patient monitoring (RPM) devices including blood pressure, cuff, weight scale, glucometer, and pulse oximeter, as appropriate.</p>	<p>\$0 copayment</p> <p>Members will have access to remote patient monitoring (RPM) devices including blood pressure, cuff, weight scale, glucometer, and pulse oximeter, as appropriate.</p>

\*\* Your costs may be higher if your Medicaid does not cover cost-sharing for Medicare-covered services.

\*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. Special supplemental benefits for the chronically ill (SSBCI) are only available to members with certain chronic conditions. You may be eligible if you have one of the following conditions:

- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic alcohol use disorder and other substance use disorders (SUDs)
- Chronic and disabling mental health conditions
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease (CKD)
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and Immunosuppressive disorders
- Neurologic disorders
- Osteoporosis
- Overweight, obesity, and metabolic syndrome
- Post-organ transplantation
- Severe hematologic disorders
- Stroke

## Georgia Medicaid and PruittHealth Premier D-SNP (HMO D-SNP)

PruittHealth Premier D-SNP (HMO D-SNP) enrolls individuals with different levels of Medicaid benefits. This means that, depending on your level of Medicaid benefits, some or all of the out-of-pocket costs for PruittHealth Premier D-SNP (HMO D-SNP) could be covered by Medicaid. For more information on your level of Medicaid and the benefits to which you are entitled contact: Georgia Department of Community Health: 1-404-656-4507.

### You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayment amounts.
- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayments amount only.
- **Qualifying Individual (QI):** Medicaid pays your part B premium only.
- **Specified Low-Income Medicare Beneficiary (SLMB+):** You get full Medicaid benefits, and Medicaid pays your Part B premium.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid pays your Part B premium only.
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits.

Eligibility Level	QMB+	QMB	QI	SLMB+	SLMB	FBDE
Part A Premium	X	X				
Part B Premium	X	X	X	X	X	
Medicare deductibles, copays, coinsurance	X	X				
Full Medicaid Benefits	X			X		X

## **Cost-sharing protections an individual is entitled to under Title XIX (Medicaid)**

PruittHealth Premier D-SNP (HMO D-SNP) is prohibited from imposing cost-sharing requirements on Dual Eligible enrollees that would exceed the amounts permitted under the State Medicaid plan if the enrollee were not enrolled in our plan.

Our contracts with network providers include language that ensures providers accept the Medicare fee schedule plus enrollee cost sharing as payment in full. Under PruittHealth Premier D-SNP (HMO D-SNP), providers may only collect enrollee cost sharing as specified by the Health Plan and in alignment with Medicare and Georgia Medicaid guidelines.

## **Medicaid Benefits**

As a member of the plan, your services are paid first by Medicare through PruittHealth Premier D-SNP (HMO D-SNP), and then by Medicaid. Below, you can see what Georgia Department of Community Health covers as the Medicaid agency, and what our plan covers for you. If a benefit is exhausted or not covered by Medicare, your Medicaid may provide coverage, though it depends on the type of Medicaid you have.

Once you are a member of the plan, no matter what type of Medicaid you have, PruittHealth Premier D-SNP (HMO D-SNP) will cover the benefits described in the Medical Benefits section of the Summary of Benefits document.

<b>Benefit category</b>	<b>PruittHealth Premier D-SNP (HMO D-SNP)</b>	<b>Medicaid</b>
<b>Additional Dental Services</b>	Covered	Covered if Medically Appropriate up to age 21
<b>Additional Foot Care</b>	Covered	Covered
<b>Additional Vision Services</b>	Covered	Not Covered
<b>Ambulance</b>	Covered	Not Covered
<b>Chiropractic Care</b>	Covered	Covered
<b>Dental Services</b>	Covered	Covered
<b>Diabetes Supplies and Services</b>	Covered	Covered if Medically Appropriate up to age 21
<b>Diagnostic Tests, Lab and Radiology Services and X-Rays</b>	Covered	Covered
<b>Doctor Office Visits</b>	Covered	Covered
<b>Durable Medical Equipment</b>	Covered	Covered
<b>Emergency Care</b>	Covered	Covered

<b>Benefit category</b>	<b>PruittHealth Premier D-SNP (HMO D-SNP)</b>	<b>Medicaid</b>
<b>Foot Care</b>	Covered	Covered
<b>Hearing Services</b>	Covered	Covered
<b>Home Health Care</b>	Covered	Covered
<b>Hospice</b>	Covered	Covered
<b>Inpatient Hospital Care</b>	Covered	Covered
<b>Inpatient Mental Health Care</b>	Covered	Covered
<b>Intermediate Care Facilities</b>	Covered	Covered
<b>Mental Health Care</b>	Covered	Covered
<b>Outpatient Hospital Services</b>	Covered	Covered
<b>Over the Counter Items</b>	Covered	Not Covered
<b>Preventive Care</b>	Covered	Covered
<b>Prosthetic Devices</b>	Covered	Covered
<b>Renal Dialysis</b>	Covered	Covered
<b>Skilled Nursing Facility</b>	Covered	Covered
<b>Transportation (Non-Emergency)</b>	Covered	Covered
<b>Urgent Care</b>	Covered	Covered
<b>Vision Services</b>	Covered	Covered

The following is a list of Home and Community Based Services (HCBS) waiver benefits provided under Georgia Medicaid. Whether you receive them is based upon your level of Medicaid:

- Medicare premiums, deductibles and coinsurance
- Non-emergency transportation (to get to and from medical appointments)
- 24 hour medical access
- Skilled nursing services
- Adult day health/adult day care
- Alternative living services/assisted living services (does not include room and board costs)
- Emergency response system

- Home delivered meals
- Home delivered services
- Personal support services – house cleaning, shopping, laundry, assistance with activities of daily living, such as eating, dressing, moving about, etc.
- Respite care- both in-home and out-of-home

This document is a summary description of the benefits and cost-sharing protections that are covered under this D-SNP. Benefits provided by PruittHealth Premier D-SNP (HMO D-SNP) are also summarized above. For a full listing of the benefits see the *Evidence of Coverage* at [PruittHealthPremier.com](http://PruittHealthPremier.com).

PruittHealth Premier D-SNP (HMO D-SNP) has a contract with Georgia Medicaid to coordinate your Medicare and Medicaid services. Your Medicaid services are still provided through Georgia Medicaid, but PruittHealth Premier D-SNP (HMO D-SNP) will help in ensuring that all of your healthcare services work together.

PruittHealth Premier D-SNP (HMO D-SNP) ensures that members continue to have all of the cost sharing protections under both Medicare and Medicaid.