



# 2024 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) January 1, 2024 - December 31, 2024.**

PruittHealth Premier D-SNP (HMO D-SNP) is a Medicare Advantage HMO D-SNP Plan (HMO stands for Health Maintenance Organization) (D-SNP stands for Dual-Eligible Special Needs Plan) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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://www.PruittHealthPremier.com), or call Member Services and request the *Evidence of Coverage*.

#### **To Reach Our Member Services Representatives:**

- Toll Free 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:**

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- you are a United States citizen or are lawfully present in the United States,

- -- *and* -- you meet the eligibility requirements described below.

### **Special eligibility requirements for our plan**

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 plans and service areas:

H3291002000 PruittHealth Premier D-SNP (HMO D-SNP) includes these counties in Georgia: Banks, Barrow, Bibb, Clarke, DeKalb, Elbert, Forsyth, Fulton, Greene, Gwinnett, Hall, Henry, Houston, Jackson, Jasper, Madison, Monroe, Morgan, Oconee, Oglethorpe, Spalding, and Walton.

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](https://www.pruithhealth.com). If you use providers that are not in our network, the plan may not pay for these services.

This document is available for free in Spanish. (Este documento está disponible de forma gratuita en español).

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 current “**Medicare & You 2024**” handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Monthly Plan Premium</b> ( <i>includes both medical and drugs</i> )	\$44.20 You must continue to pay your Medicare Part B premium.	\$44.20 You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	The Part B deductible is \$240. For the Part A deductible, you pay the 2024 Original Medicare cost-sharing amounts for Inpatient Hospital or Mental Health for inpatient visits. \$1,632 deductible	The Part B deductible is \$240. For the Part A deductible, you pay the 2024 Original Medicare cost-sharing amounts for Inpatient Hospital or Mental Health for inpatient visits. \$1,632 deductible
<b>Maximum out-of-pocket amount</b> (does not include Part D Prescription drugs)	\$8,850	\$8,850
<b>Inpatient Hospital coverage</b>	\$0 copayment for each Medicare-covered hospital stay. \$0 copayment for an additional 60 lifetime reserve days. <i>Prior authorization is required.</i>	You pay the 2024 Original Medicare cost-sharing amounts. \$1,632 deductible; \$0 copayment each day for days 1 to 60; \$408 copayment each day for days 61 to 90; \$816 copayment each day for days 91 to 150 (lifetime reserve days) <i>Prior authorization is required.</i>
<b>Outpatient Hospital coverage</b>		
Outpatient hospital services	0% coinsurance <i>Prior authorization is required.</i>	20% coinsurance <i>Prior authorization is required.</i>
Outpatient hospital observation services	\$0 copayment per stay <i>Prior authorization is required.</i>	\$100 copayment per stay <i>Prior authorization is required.</i>
<b>Ambulatory Surgical Center (ASC)</b>	0% coinsurance <i>Prior authorization is required.</i>	20% coinsurance <i>Prior authorization is required.</i>

	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Doctor Visits</b> Primary Care Providers Specialists	\$0 copayment 0% coinsurance	\$0 copayment 20% coinsurance
<b>Preventive Care (e.g., flu vaccine, diabetic screenings)</b>	You pay nothing.	You pay nothing.
<b>Emergency care</b>	\$0 copayment	\$90 copayment Copayment is waived if you are admitted to a hospital within 3 days.
<b>Urgently needed services</b>	0% coinsurance	20% coinsurance Up to a maximum of \$55 per visit Coinsurance is waived if you are admitted to a hospital within 3 days.
<b>Diagnostic Services/Labs/Imaging</b>  Diagnostic tests and procedures  Diagnostic radiology services (e.g. MRI, CAT Scan)  Lab services	0% coinsurance <i>No Authorization required when services are rendered in a Nursing Facility or Physician Office.</i>  0% coinsurance <i>Ultrasounds do not require authorization.</i>  \$0 copayment <i>No authorization required for lab services rendered in any place of service. Authorization required for genetic testing only.</i>	20% coinsurance <i>No Authorization required when services are rendered in a Nursing Facility or Physician Office.</i>  20% coinsurance <i>Ultrasounds do not require authorization.</i>  \$0 copayment <i>No authorization required for lab services rendered in any place of service. Authorization required for genetic testing only.</i>

	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<p>Outpatient X-rays</p> <p>Therapeutic Radiology</p>	<p>0% coinsurance <i>X-rays do not require authorization when service is rendered in a nursing facility, physician's office or hospital.</i></p> <p>0% coinsurance <i>Prior authorization is required.</i></p>	<p>20% coinsurance <i>X-rays do not require authorization when service is rendered in a nursing facility, physician's office or hospital.</i></p> <p>20% coinsurance <i>Prior authorization is required.</i></p>
<p><b>Hearing services</b></p> <p>Hearing exam</p> <p><i>Supplemental benefits</i> Routine hearing exam</p> <p>Fitting-evaluation(s) for hearing aids</p> <p><b>Hearing aids</b></p>	<p>0% coinsurance for each Medicare-covered service.</p> <p>\$0 copayment Limited to 1 visit every year</p> <p>\$0 copayment</p> <p>Up to a \$2,550 credit for both ears combined every year for hearing aids.</p>	<p>20% coinsurance for each Medicare-covered service.</p> <p>\$0 copayment Limited to 1 visit(s) every year</p> <p>\$0 copayment</p> <p>Up to a \$2,550 credit for both ears combined every year for hearing aids.</p>
<p><b>Dental services</b></p> <p>Medicare-covered dental</p> <p><i>Supplemental benefits</i> Preventive and comprehensive services</p>	<p>0% coinsurance for each Medicare-covered service. <i>Prior authorization is only required for Medicare-covered comprehensive dental services.</i></p> <p>1 oral exam(s); 1 cleaning(s); 1 Fluoride treatment every six months. Dental X-rays limitations are included in the <i>Evidence of Coverage</i>.</p>	<p>20% coinsurance for each Medicare-covered service. <i>Prior authorization is only required for Medicare-covered comprehensive dental services.</i></p> <p>1 oral exam(s); 1 cleaning(s); 1 Fluoride treatment every six months. Dental X-rays limitations are included in the <i>Evidence of Coverage</i>.</p>

	<p><b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b></p>	<p><b>What you pay: With SLMB and QI cost-share assistance</b></p>
	<p>\$4,200 every year for use to access (non-Medicare and/or non-Medicaid covered services) supplemental preventive and comprehensive dental services combined. All services must be provided by <b>Liberty Dental</b>.</p> <p>Our plan partners with Liberty Dental to provide your dental benefits. To locate a network provider or to review Liberty Dental Plan's Clinical Guidelines, you may call Member Services at 1-866-544-1942 or search the Liberty Dental online provider directory at <a href="http://libertydentalplan.com/pruitthealthpremier">libertydentalplan.com/pruitthealthpremier</a>. If you choose to use a provider outside of the network, the services you receive will not be covered. Additional Limitations and Exclusions may be found in the <i>Evidence of Coverage</i>.</p>	<p>\$4,200 every year for use to access (non-Medicare and/or Medicaid covered services) supplemental preventive and comprehensive dental services combined. All services must be provided by <b>Liberty Dental</b>.</p> <p>Our plan partners with Liberty Dental to provide your dental benefits. To locate a network provider or to review Liberty Dental Plan's Clinical Guidelines, you may call Member Services at 1-866-544-1942 or search the Liberty Dental online provider directory at <a href="http://libertydentalplan.com/pruitthealthpremier">libertydentalplan.com/pruitthealthpremier</a>. If you choose to use a provider outside of the network, the services you receive will not be covered. Additional Limitations and Exclusions may be found in the <i>Evidence of Coverage</i>.</p>

	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<p><b>Vision care</b></p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year.</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p> <p><i>Supplemental benefits</i></p> <p>Routine eye exam</p> <p><b>Additional routine eyewear</b></p> <ul style="list-style-type: none"> <li>○ Contact lenses</li> <li>○ Eyeglass lenses</li> <li>○ Eyeglass frames</li> <li>○ Eyeglasses (lenses and frames)</li> <li>○ Upgrades</li> </ul>	<p>0% coinsurance for each Medicare-covered service.</p> <p>0% coinsurance for each Medicare-covered service.</p> <p>\$0 copayment</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>You pay \$0 copayment for 1 routine eye exam visit every year.</p> <p>Up to a \$500 combined credit every year.</p> <p>Members may pay for eyewear using their preloaded flex card.</p>	<p>20% coinsurance for each Medicare-covered service.</p> <p>20% coinsurance for each Medicare-covered service.</p> <p>\$0 copayment</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>You pay \$0 copayment for 1 routine eye exam visit every year.</p> <p>Up to a \$500 combined credit every year</p> <p>Members may pay for eyewear using their preloaded flex card.</p>

	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Mental Health Services</b>		
Inpatient visit	\$0 copayment for each Medicare-covered hospital stay. \$0 copayment for an additional 60 lifetime reserve days. <i>Prior authorization is required.</i>	You pay the 2024 Original Medicare cost-sharing amounts. \$1,632 deductible; \$0 copayment each day for days 1 to 60; \$408 copayment each day for days 61 to 90; \$816 copayment each day for days 91 to 150 (lifetime reserve days) <i>Prior authorization is required.</i>
Outpatient group therapy visit	0% coinsurance	20% coinsurance
Outpatient individual therapy visit	0% coinsurance	20% coinsurance
<b>Skilled nursing facility (SNF) care</b>	You pay a \$0 copayment for Medicare-covered Skilled Nursing Facility stays. <i>Prior authorization is required.</i>	You pay the 2024 Original Medicare cost-sharing amounts. \$0 copayment each day for days 1 to 20 for each Medicare-covered skilled nursing facility stay. \$204 copayment each day for days 21 to 100 for each Medicare-covered skilled nursing facility stay. <i>Prior authorization is required.</i>
<b>Physical Therapy</b>	0% coinsurance <i>Authorization is not required when the service is provided in PruittHealth Skilled Nursing Facilities.</i>	20% coinsurance <i>Prior authorization is not required when service is provided in PruittHealth Skilled Nursing Facilities.</i>
<b>Ambulance services</b>		
Ground Ambulance	0% coinsurance	20% coinsurance



	<b>What you pay: With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
Air Ambulance	0% coinsurance	20% coinsurance
<b>Transportation (Non-Emergency)</b>	\$0 copayment Routine transportation for up to 64 trips every year. A trip is considered one-way transportation by taxi, bus/subway, van, medical transport, or rideshare services to a plan approved health-related location.	\$0 copayment Routine transportation for up to 64 trips every year. A trip is considered one-way transportation by taxi, bus/subway, van, medical transport, or rideshare services to a plan approved health-related location.
<b>Medicare Part B prescription drugs</b>		
Chemotherapy/ Radiation drugs	0 - 20% coinsurance <i>For chemotherapy, authorization is required for the initial drug approval only.</i>	0 - 20% coinsurance <i>For chemotherapy, authorization is required for the initial drug approval only.</i>
Other Part B drugs	0 - 20% coinsurance <i>Prior authorization is required for some medications.</i>	0 - 20% coinsurance <i>Prior authorization is required for some medications.</i>

<b>PruittHealth Premier D-SNP (HMO D-SNP)</b>		
<b>Outpatient Prescription Drugs</b>		
	<b>Standard retail cost-sharing (in-network) (up to a 30-day supply)</b>	<b>Long-term care (LTC) cost-sharing (up to a 31-day supply)</b>
<b>Deductible</b>	\$545 for all Part D prescription drugs.	
<b>Cost- Sharing for Covered Drugs</b>	25% coinsurance	25% coinsurance

PruittHealth Premier D-SNP (HMO D-SNP)		
Outpatient Prescription Drugs		
	<b>Standard retail cost-sharing</b> (in-network) (up to a 30-day supply)	<b>Long-term care (LTC) cost-sharing</b> (up to a 31-day supply)
<b>Coverage Gap</b>	After your total drug costs (including what our plan has paid and what you have paid) reach \$5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.	
<b>Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$8,000, you pay nothing.	

Cost-sharing may differ based on point-of-service (retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (30-day supply) or long term (90-day supply).

**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

	<b>With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Chiropractic services</b>		
Manual manipulation of the spine to correct subluxation	0% coinsurance for Medicare-covered services. <i>Prior authorization is required.</i>	20% coinsurance for Medicare-covered services. <i>Prior authorization is required.</i>
Routine chiropractic care	20% coinsurance Unlimited visits every year	20% coinsurance Unlimited visits each year

	<b>With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Diabetic monitoring supplies</b>	\$0 copayment	\$0 copayment
<b>Fitness program</b> <ul style="list-style-type: none"> <li>• <b>Memory fitness</b></li> <li>• <b>Physical fitness</b></li> <li>• <b>Gym membership</b></li> </ul>	<p>\$0 copayment Members will receive an annual subscription to BrainHQ. BrainHQ is an online, evidence-based memory fitness program with dozens of exercises that have been shown in studies to help people think faster, focus better, and remember more.</p> <p>Members will receive an annual subscription to an online fitness program with on-demand classes, exercise programs, and stretching.</p> <p>Members also have the option of purchasing a gym membership using the Flex Card. Please see the Flex Card row below.</p>	<p>\$0 copayment Members will receive an annual subscription to BrainHQ. BrainHQ is an online, evidence-based memory fitness program with dozens of exercises that have been shown in studies to help people think faster, focus better, and remember more.</p> <p>Members will receive an annual subscription to an online fitness program with on-demand classes, exercise programs, and stretching.</p> <p>Members also have the option of purchasing a gym membership using the Flex Card. Please see the Flex Card row below.</p>
<b>Flex Card</b> <ul style="list-style-type: none"> <li>• Fitness</li> <li>• Utilities</li> <li>• Groceries</li> <li>• Over-the-Counter Items</li> <li>• Eyewear</li> </ul>	<p>\$0 copayment Members receive \$200 monthly on a Flex Card. The debit card is prepaid by the plan for covered fitness, utilities*, groceries*, and over-the-counter (OTC) items.</p>	<p>\$0 copayment Members receive \$200 monthly on a Flex Card. The debit card is prepaid by the plan for covered fitness, utilities*, groceries*, and over-the-counter (OTC) items.</p>

	<b>With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
	<p>Credits do not carry over to the next month or the following year.</p> <p>Members may access their \$500 eyewear funds using the same preloaded flex card.</p> <p>*Certain benefits (groceries and utilities) are only available to members with certain chronic conditions. See the list of conditions below to find out if you qualify:</p> <ul style="list-style-type: none"> <li>• Chronic alcohol and other drug dependence</li> <li>• Autoimmune disorders</li> <li>• Cancer</li> <li>• Cardiovascular disorders</li> <li>• Chronic heart failure</li> <li>• Dementia</li> <li>• Diabetes</li> <li>• End-stage liver disease</li> <li>• End-stage renal disease (ESRD)</li> <li>• Severe hematologic disorders</li> <li>• HIV/AIDS</li> <li>• Chronic lung disorders</li> <li>• Chronic and disabling mental health conditions</li> <li>• Neurological disorders</li> <li>• Stroke</li> <li>• Osteoarthritis</li> <li>• Hypertension</li> <li>• Hyperlipidemia</li> <li>• Chronic intellectual disabilities</li> <li>• Chronic malnutrition, including failure to thrive</li> </ul>	<p>Credits do not carry over to the next month or the following year.</p> <p>Members may access their \$500 eyewear funds using the same preloaded flex card.</p> <p>*Certain benefits (groceries and utilities) are only available to members with certain chronic conditions. See the list of conditions below to find out if you qualify:</p> <ul style="list-style-type: none"> <li>• Chronic alcohol and other drug dependence</li> <li>• Autoimmune disorders</li> <li>• Cancer</li> <li>• Cardiovascular disorders</li> <li>• Chronic heart failure</li> <li>• Dementia</li> <li>• Diabetes</li> <li>• End-stage liver disease</li> <li>• End-stage renal disease (ESRD)</li> <li>• Severe hematologic disorders</li> <li>• HIV/AIDS</li> <li>• Chronic lung disorders</li> <li>• Chronic and disabling mental health conditions</li> <li>• Neurological disorders</li> <li>• Stroke</li> <li>• Osteoarthritis</li> <li>• Hypertension</li> <li>• Hyperlipidemia</li> <li>• Chronic intellectual disabilities</li> <li>• Chronic malnutrition, including failure to thrive</li> </ul>

	<b>With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Meal benefit</b>	\$0 copayment Limit of 2 meals per day for 14 days for 4 times per calendar year following hospital or SNF stay.	\$0 copayment Limit of 2 meals per day for 14 days for 4 times per calendar year following hospital or SNF stay.
<b>Occupational therapy</b>	0% coinsurance <i>Authorization is not required when service is provided in PruittHealth Skilled Nursing Facilities.</i>	20% coinsurance <i>Authorization is not required when service is provided in PruittHealth Skilled Nursing Facilities.</i>
<b>Personal emergency response system (PERS)</b>	\$0 copayment Life Alert button (Provided by Lifeline) available to all members upon enrollment.	\$0 copayment Life Alert button (Provided by Lifeline) available to all members upon enrollment.
<b>Podiatry services (Foot care)</b> Foot exams and treatment	0% coinsurance for each Medicare-covered service.	20% coinsurance for each Medicare-covered service.
<i>Supplemental Benefit</i> <b>Additional routine foot care</b>	\$0 copayment Limited to 6 visit(s) every year	\$0 copayment Limited to 6 visit(s) every year.

	<b>With full Medicaid cost-sharing assistance (QMB, QMB+, SLMB+, FBDE)</b>	<b>What you pay: With SLMB and QI cost-share assistance</b>
<b>Remote patient monitoring</b>	<p>\$0 copayment</p> <p>Members will have access to remote patient monitoring devices including blood pressure cuff, weight scale, glucometer, pulse oximeter and thermometer, as appropriate. Services will include alert response and outreach from nurse case managers to facilitate responsive symptom management.</p>	<p>\$0 copayment</p> <p>Members will have access to remote patient monitoring devices including blood pressure cuff, weight scale, glucometer, pulse oximeter and thermometer, as appropriate. Services will include alert response and outreach from nurse case managers to facilitate responsive symptom management.</p>
<b>Speech Therapy</b>	<p>0% coinsurance</p> <p><i>Authorization is not required when service is provided in PruittHealth Skilled Nursing Facilities.</i></p>	<p>20% coinsurance</p> <p><i>Authorization is not required when service is provided in PruittHealth Skilled Nursing Facilities.</i></p>

## Georgia Medicaid and PruittHealth Premier

PruittHealth Premier (HMO DSNP) is a Medicare Advantage HMO plan with a Medicare Contract. This plan is a Dual Eligible Special Needs Plan (DSNP) for individuals who have both Medicare and Medicaid.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area and be a United States citizen or lawfully present in the United States.

PruittHealth Premier 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 could be covered by Medicaid. For more information on your level of Medicaid and the benefits you are entitled to 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

**The cost-sharing protections that the individual is entitled to under Title XIX (Medicaid).**

PruittHealth Premier 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 PruittHealth Premier DSNP.

PruittHealth Premier’s 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, 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, 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, through 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 (HMO DSNP) will cover the benefits described in the covered benefits section of the Summary of Benefits document.

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



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

The description of the benefits and cost-sharing protections that are covered under the D-SNP.

Benefits provided by PruittHealth Premier D-SNP are summarized above. For a full listing of the benefits see the Evidence of Coverage at [www.Pruitthealthpremier.com](http://www.Pruitthealthpremier.com).

PruittHealth Premier 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 will help in ensuring all of your healthcare services work together.

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

# Pre-Enrollment Checklist

PruittHealth Premier D-SNP (HMO D-SNP)

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 1-855-855-0668 (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 [PruittHealthPremier.com](https://www.PruittHealthPremier.com) or call 1-855-855-0668 (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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- Effect on Current Coverage.** Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- For D-SNP enrollees only:** 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.

# Pre-Enrollment Checklist

## PruittHealth Premier D-SNP (HMO D-SNP)

PruittHealth Premier is an HMO D-SNP with a Medicare contract. Enrollment in PruittHealth Premier depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat PruittHealth Premier 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.

PruittHealth Premier complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-855-0668 (TTY 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-855-0668 (TTY 711).

## 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 1-855-855-0668. Someone who speaks English/Language 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 1-855-855-0668. 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 1-855-855-0668。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 1-855-855-0668。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 panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-855-0668. 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 1-855-855-0668. 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 quý vị cần thông dịch viên xin gọi 1-855-855-0668 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-855-0668. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-855-0668 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**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 1-855-855-0668. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية لإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول سيقوم شخص ما يتحدث العربية 1-855-855-0668 على مترجم فوري، ليس عليك سوى الاتصال بنا على بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजनाके बारे में आपके ककसी भी प्रश्नके जवाब देनेके किए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करनेके किए, बस हमें 1-855-855-0668 पर फोन करें. कोई व्यक्ति जो कहन्दी बोिता 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 1-855-855-0668. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** 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 1-855-855-0668. 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 1-855-855-0668. 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 1-855-855-0668. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 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があります。通訳をご用命になるには、1-855-855-0668 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。