



**2022 | DEVOTED HEALTH PLANS**

# Summary of Benefits

## **Devoted Health Prime (HMO) Plan**

**PBP Number: H1290-038-002**

Hernando, Hillsborough, Pasco, Pinellas, Polk  
Counties



## Devoted Health Prime (HMO)

# Summary of Benefits

This Summary of Benefits tells you about our Devoted Health Prime (HMO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2022 plan year, which starts on January 1, 2022 and ends December 31, 2022.

Because this document is a summary, it doesn't list all of the coverage details for this plan. If you need to know more, check the plan's **Evidence of Coverage** at [www.devoted.com](http://www.devoted.com). Or, call us at 1-800-385-0916 (TTY 711) and we can mail you one.

### Can I join this plan?

Devoted Health Prime (HMO) is a Health Maintenance Organization, or HMO plan. To join Devoted Health Prime (HMO), you must be entitled to Medicare Part A and enrolled in Medicare Part B. You also have to live in this plan's service area, which includes these counties: Hernando, Hillsborough, Pasco, Pinellas, Polk. We offer different plans for other counties.

### Does this plan cover my prescription drugs?

Find out by searching our online drug list at [www.devoted.com/search-drugs](http://www.devoted.com/search-drugs). Or, give us a call. We can look up your medications or mail you our list of covered drugs (formulary).

### Does this plan cover my doctors and pharmacies?

Find out by searching our online directory at [www.devoted.com/search-providers](http://www.devoted.com/search-providers). Or, give us a call. We can look up your doctors and pharmacies or mail you a directory.

### What's the difference between copays and coinsurance?

A copay is a flat fee. For example, a \$5 copay for a service means you pay \$5. Coinsurance is a percentage of the cost. For example, 10% coinsurance means you pay 10% of the cost of the service.

### How can I learn about Original Medicare?

Check the latest *Medicare & You* handbook. If you don't have one, visit [www.medicare.gov](http://www.medicare.gov) and enter "Medicare & You handbook" in the search tool. (Include the quotation marks for best results.) Or ask Medicare to send you one by calling 1-800-MEDICARE (1-800-633-4227) any day, any time. TTY users can dial 1-877-486-2048.

### How can I get more help?

Call us at 1-800-385-0916 (TTY 711). We're here 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week). You can also visit us online at [www.devoted.com](http://www.devoted.com).

# 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 Member Services at 1-800-385-0916 (TTY 711).

## Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit [www.devoted.com](http://www.devoted.com) or call 1-800-385-0916 (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 Devoted Health 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 Devoted Health network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- 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, 2023.
- 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).

# Monthly Premium, Deductible, and Limits

## Monthly Premium

\$34.30

You must continue to pay your part B premium. If you receive extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium may be reduced to \$0.

## Medical Deductible

This plan does not have a deductible.

## Pharmacy (Part D) Deductible

\$480 for Tiers 3 - 5 only

If you receive Extra Help from Medicare, your deductible may be as low as \$0.

## Maximum Out-of-Pocket Responsibility

\$2,900

This is the most you will pay for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B-covered medication for the plan year. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (dental, hearing aids) do not apply to this amount.

# Covered Medical and Hospital Benefits

## Inpatient Hospital Coverage

\$0 copay per stay

Prior authorization may be required.

## **Outpatient Hospital Coverage**

Prior authorization may be required for procedures performed in an Outpatient Hospital or Ambulatory Surgical Center.

If you are held in Observation, you will pay your copay for the Observation Stay. Copays for any additional services provided while in Observation will not apply.

### **Diagnostic Colonoscopies**

\$0 copay at any in-network location

### **Ambulatory Surgical Center (ASC)**

\$0 copay for surgery at an ASC

### **Outpatient Hospital**

\$25 copay for surgery at an outpatient hospital

### **Observation Stays**

\$0 copay per stay

## **Doctor Visits**

A referral from your PCP may be required to see a specialist.

### **Primary Care Provider (PCP)**

\$0 copay

### **Specialist**

\$0 copay

## Preventive Care

Our plan covers many preventive services at no cost when you see an in-network provider, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual wellness visit
- Bone mass measurement (bone density)
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy, Cologuard®)
- Depression screening
- Diabetes screening
- Diabetes self-management training
- Glaucoma tests
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Routine physical exam
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines covered under the medical benefit, including flu shots, hepatitis B shots, pneumococcal shots
- “Welcome to Medicare” preventive visit (one time)

Any additional preventive services approved by Medicare during the contract year will be covered.

## Emergency Care

\$120 copay

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.

## **Worldwide Emergency and Urgent Care**

This plan covers emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you generally have to pay the costs yourself at first. Then, you can submit a claim to us so we can pay you back.

### **Emergency Care**

\$120 copay

### **Urgently Needed Services**

\$0 copay

### **Ground Ambulance**

\$150 copay  
per one-way trip

### **Air Ambulance**

20% coinsurance  
per one-way trip

## **Urgently Needed Services**

### **Urgently needed services from your PCP**

\$0 copay

### **Urgently needed services from an urgent care center or retail walk-in center**

\$0 copay

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.



# Outpatient Care and Services

## Diagnostic Services, Labs and Imaging

Prior authorization may be required.

If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost share for the services outlined in this section.

### Lab Services

\$0 copay in an office or freestanding location  
\$25 copay at an outpatient hospital setting

### Outpatient X-rays & Ultrasounds

\$0 copay in an office or freestanding location  
\$10 copay at an outpatient hospital setting

### Diagnostic Radiology (such as CT, MRI, etc.)

\$0 copay in an office or freestanding location  
\$25 copay at an outpatient hospital setting

### Diagnostic Tests and Procedures (such as a stress test, etc.)

\$0 copay in an office or freestanding location  
\$25 copay at an outpatient hospital setting

### Radiation Therapy

20% coinsurance

# Hearing Services

## Hearing Care

### Routine Hearing Exams

\$0 copay — 1 visit per year

### Hearing Aid Fitting and Evaluation

\$0 copay

### Medicare-covered Hearing Care

\$0 copay

## Hearing Aids

You must see a TruHearing® provider to use this benefit.

Benefit includes coverage of up to two TruHearing® Advanced or Premium hearing aids, which come in various styles and colors.

\$199 copay per aid for Advanced Aids\*

\$499 copay per aid for Premium Aids\*

Hearing aid purchase includes:

- First year of follow-up provider visits
- 60-day trial period
- 3-year extended warranty
- 80 batteries per aid for non-rechargeable models
- \$50 additional cost per aid for optional hearing aid rechargeability

\*Hearing aid copayments are not subject to the out-of-pocket maximum.

## Dental Services

### Preventive Dental Services

#### Periodic Oral Exams

\$0 copay

#### Comprehensive Oral Evaluation

\$0 copay

#### Cleanings

\$0 copay

#### X-rays (bitewing, intraoral, and panoramic)

\$0 copay

## Comprehensive Dental Services

Devoted Health will pay as much as **\$2,000** per year for comprehensive dental services. This means you will pay any additional costs above this amount.

Certain limitations apply. This is not an exhaustive list of covered dental services. See the plan's Evidence of Coverage (EOC) for details.

### Fillings

\$0 copay

### Root Planing & Scaling

\$0 copay

### Extractions

\$0 copay

### Full Mouth Debridement

\$0 copay

### Dentures

\$0 copay

### Root Canals

\$0 copay

### Crowns

\$0 copay

### Bridges

\$0 copay

## Vision Services

### Routine Vision

#### Routine Eye Exam

\$0 copay — 1 visit per year

#### Diabetic Eye Exam

\$0 copay - 1 visit per year

#### Glaucoma Screening

\$0 copay

## **Eyewear**

Up to \$400 each year for eyeglasses or contacts

Fitting for contact lenses covered at no additional cost. Allowance can be used for frames or lenses (or a combination of the two), contact lenses, eyeglass upgrades, or eyeglass replacements, up to the allowance amount.

### **Medicare-covered Vision Care**

\$0 copay

## **Additional Outpatient Care and Services**

### **Mental Health Services**

Prior authorization may be required.

Mental health services are coordinated by Magellan, our behavioral health provider.

#### **Inpatient mental health care**

\$0 copay per stay

#### **Outpatient mental health care (individual and group)**

\$0 copay

### **Skilled Nursing Facility (SNF)**

Prior authorization may be required. No prior hospital stay required.

#### **Days 1 - 20**

\$0 copay

#### **Days 21 - 89**

\$50 copay per day

#### **Days 90 - 100**

\$0 copay

### **Physical Therapy**

You may need a referral for Physical, Occupational, and Speech Therapy services.

\$0 copay in an office or freestanding location

\$10 copay at an outpatient hospital setting

## **Ambulance Services**

This plan covers you for ambulance transportation to the nearest emergency room worldwide.

### **Ground Ambulance**

\$150 copay  
per one-way trip

### **Air Ambulance**

20% coinsurance  
per one-way trip

## **Transportation**

### **Trips to your primary care provider**

\$0 copay — unlimited rides

### **Non-emergent medical transportation**

\$0 copay — 48 one-way rides per year

Trips limited to 30 miles per one-way trip to locations such as the doctors' office, the pharmacy, and the gym.

# **Prescription Drug Benefits**

## **Medicare Part B Drugs**

Generally, Part B drugs are usually not self-administered. These drugs can be given in a doctor's office as part of a medical service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection. You only pay the cost-share for the amount of the drug used. This means that if part of the drug is not used, you will not be charged for the unused portion. Prior authorization may be required.

### **Allergy Serum**

\$0 copay

### **Generic Medications Used in a Nebulizer**

\$0 copay

### **Chemotherapy Drugs**

20% coinsurance

### **Other Part B Drugs**

20% coinsurance

## Prescription Drugs

### Pharmacy (Part D) Deductible

\$480 for Tiers 3 - 5 only

If you receive extra help from Medicare, your deductible may be as low as \$0.

There is no deductible for Devoted Health Prime (HMO) for Select Insulins. During the Deductible Stage, your out-of-pocket costs for these Select Insulins will be \$0 for a 30-day supply.

### Initial Coverage Stage

You pay copays or coinsurance until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug cost paid by both you and Devoted Health.

### 30-Day Supply Network Retail Pharmacy

Cost sharing may change when you enter a new phase of the Part D benefit.

#### Tier 1: Preferred Generic

\$0 per prescription

#### Tier 2: Generic

\$0 per prescription

#### Tier 3: Preferred Brand

25% of the total cost

Select Insulin: \$0 per prescription

See the Additional Part D Benefit Information section.

#### Tier 4: Non-Preferred Drugs

25% of the total cost

#### Tier 5: Specialty

25% of the total cost

## **100-Day Supply Network Mail Order**

Cost sharing may change when you enter a new phase of the Part D benefit.

**Tier 1: Preferred Generic**  
\$0 per prescription

**Tier 2: Generic**  
\$0 per prescription

**Tier 3: Preferred Brand**  
25% of the total cost  
Select Insulin: \$0 per prescription  
See the Additional Part D Benefit Information section.

**Tier 4: Non-Preferred Drugs**  
25% of the total cost

**Tier 5: Specialty**  
Not available through mail

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. While you reside in the long term care facility you are able to receive up to a 31 day supply.

## **Coverage Gap or "Donut Hole"**

Most Medicare drug plans have a Coverage Gap or "donut hole." This means that there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after the total yearly drug costs (including what Devoted Health has paid and what you have paid) reaches \$4,430. Please note that not everyone will enter the Coverage Gap.

For the 2022 plan year, while in the coverage gap, you will pay 25% of the total cost for drugs until you reach \$7,050 total out-of-pocket. Devoted Health Prime (HMO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be \$0 for a 30-day supply.

# Catastrophic Coverage

## Yearly Out-of-pocket Drug Costs

**After you reach \$7,050 yearly out-of-pocket drug costs, you pay the greater of:**

5% of the cost

— or —

**Generic Drugs or Drugs that are Treated as Generic**

\$3.95

**Covered Brand Drugs**

\$9.85

Devoted Health pays the rest of the cost.

# Additional Part D Benefit Information

## Insulin Coverage

As a member of this plan, you have extra coverage and savings for select insulin drugs.

**With this plan, you pay a \$0 copay for a 30-day supply of select insulin products covered on our formulary.**

The \$0 copay applies during all phases of the Part D benefit (including the coverage gap) until you reach your yearly out-of-pocket limit for drug costs.

## Erectile Dysfunction Drugs (ED)

Sildenafil (generic Viagra) and Tadalafil (generic Cialis) are both covered as Tier 2 medications. You are covered up to 6 pills per month (a maximum of 72 pills per year), for either medication or combination, but not to exceed 6 pills.



## **Additional Prescription Drug Information**

If you receive Extra Help from Medicare, your costs for prescription drugs may be lower than the cost-shares in this booklet. You pay whichever is less.

Medicare beneficiaries who receive assistance from Medicaid or the state-sponsored Qualified Medicare Beneficiary program may pay nothing for Medicare-covered services. You must meet certain income and resource conditions to be eligible.

If you reside in a long term care facility, you pay the same as at a standard retail pharmacy.

Note: some covered drugs may be subject to quantity limitations, or require step therapy or prior authorization.

## **Additional Benefits**

### **Dialysis**

20% coinsurance

A referral may be required.

### **Foot Care (Podiatry Services)**

#### **Medicare-covered Foot Care**

\$0 copay

#### **Routine Foot Care**

\$0 copay — 12 visits per year

Routine foot care includes hygienic care such as nail trimming and callus removal.

## **Home Health Care**

\$0 copay

Prior authorization may be required.

Home Health Care is limited to Medicare-covered services.

## **Durable Medical Equipment (DME)**

Prior authorization may be required.

### **Basic Medicare-covered DME products**

\$0 copay

Including, but not limited to:

- Oxygen
- CPAP machines and supplies
- Nebulizer equipment
- Non-motorized wheelchair

### **Advanced Medicare-covered DME products (listed below)**

20% coinsurance

- Medicare-covered ventilator
- Bone growth stimulator
- Portable oxygen concentrator
- Bariatric equipment
- Specialty beds
- Custom or specialty wheelchairs and scooters
- Seat lifts
- Specialty brand items
- High-frequency chest compression vests
- Pain infusion pump
- Continuous Glucose Monitor (other than Freestyle Libre - see "Diabetic Monitoring Supplies" section for details)

Equipment is covered only from certain brands and manufacturers. Please contact us for details.

## **Prosthetic Devices and Medical Supplies**

Prior authorization may be required.

### **Prosthetic devices and related supplies**

\$0 copay

### **Medical Supplies**

\$0 copay

### **Supplemental compression stockings**

\$0 copay

### **Supplemental mastectomy sleeves**

\$0 copay

Up to two pairs every 6 months of compression stockings/surgical stockings or mastectomy sleeves

## **Diabetic Monitoring Supplies**

Prior authorization may be required.

### **Supplies to monitor your blood glucose**

\$0 copay

### **"Fingerstick" Glucose Monitors:**

We cover blood glucose monitors and test strips made by LifeScan (OneTouch). Supplies provided by in-network pharmacies and DME suppliers that carry it.

### **Continuous Glucose Monitor (CGM):**

Our preferred product is the Freestyle Libre and is available at in-network pharmacies at no cost to you, when ordered by your physician. Other CGMs are available but require authorization and a Durable Medical Equipment (DME) cost share may apply.

## **Diabetic Shoes & Therapeutic Inserts**

\$0 copay

## Rehabilitation Services

You may need a referral for Physical, Occupational, and Speech Therapy services.

### Cardiac rehabilitation services

\$0 copay

### Pulmonary rehabilitation services

\$0 copay

### Physical Therapy

\$0 copay in an office or freestanding location

\$10 copay at an outpatient hospital setting

### Occupational Therapy

\$0 copay in an office or freestanding location

\$10 copay at an outpatient hospital setting

### Speech Therapy

\$0 copay in an office or freestanding location

\$10 copay at an outpatient hospital setting

## Substance Use Services

\$0 copay

## Telehealth

This benefit may not be offered by all in-network plan providers. Check directly with your provider about the availability of telehealth services. A referral may be required.

### Virtual PCP Visits

\$0 copay

### Virtual PT/OT/SP Visits

\$0 copay

### Virtual Specialist Visits

\$0 copay

# More Benefits and Perks With Your Plan

## **Over-the-Counter Items (OTC)**

You must use our designated vendor for this benefit.

\$110 per month

You can use this benefit more than once, up to the limit per month, but this amount does not roll over.

Eligible items are listed in the OTC catalog. Items not listed in the OTC catalog are not covered under the OTC benefit. To purchase eligible OTC items, you can order online, over the phone, or visit participating CVS stores.

## Fitness

**SilverSneakers:** Devoted Health covers the full cost of this benefit. SilverSneakers fitness program offers access to thousands of fitness locations nationwide. SilverSneakers also provides virtual resources through SilverSneakers LIVE™, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™.

**Devoted Health Wellness Bucks:** Devoted Health will reimburse you up to \$150 per year for participation or purchase of one or more of the following:

1. Purchase of an Apple Watch® or other wearable device that tracks number of steps and heart rate.
2. Fitness equipment to be used in the home. Examples include free weights, treadmill or stationary bike, rowing machines, resistance bands, etc.
3. Participation in instructional fitness classes such as Yoga, Pilates, Zumba, Tai Chi, Crossfit, aerobics/group fitness classes, strength training, spin classes, personal training (taught by a certified instructor), or membership fees associated with a qualifying fitness facility.
4. Program fees for weight loss programs such as Jenny Craig, Weight Watchers, or hospital-based weight loss programs.
5. Memory fitness activities and programs that improve your brain's speed and ability, strengthen memory, and enable learning.
6. Mindfulness apps, such as Calm or Headspace, to support you health and well-being.

## **Acupuncture**

Medicare coverage is limited to treatment of chronic lower back pain. Certain restrictions and limitations apply.

### **Medicare-covered acupuncture**

\$0 copay

## **Meals**

You must use our designated vendor for this benefit.

### **After an Inpatient or Skilled Nursing Facility Stay**

\$0 copay

After an inpatient stay in a hospital or a skilled nursing facility, you can get 2 meals per day for up to 10 days at no extra cost to you.

This benefit may be used up to 4 times per calendar year.

### **New Chronic Condition or Medical Condition requiring a Home Stay**

\$0 copay

If part of your care plan for a chronic condition means changing how you eat, or you are diagnosed with a condition that requires you stay at home, you can have meals delivered to your home to support your condition.

You can get 2 meals a day for 14 days. You can use this service once per calendar year, per diagnosis.

## **Chiropractic Care**

### **Medicare-covered chiropractic services**

\$0 copay

### **Routine chiropractic care**

\$0 copay — 6 visits per year

## **Bathroom Safety Equipment**

### **Standard Raised Toilet Seat:**

\$0 copay

### **Standard Tub Seat:**

\$0 copay

### **Personal Emergency Response System (PERS)**

A Personal Emergency Response System (PERS) is a medical alert monitoring system that provides 24/7 access to help at the push of a button.

We offer multiple styles, including in-home and multiple mobile-enabled wearable devices.

You must use our designated vendor for this benefit.

\$0 copay

There is no cost to you to access this benefit. This includes:

- Cost of the device
- Monthly monitoring fees
- Fall detection (available on certain styles)

### **Wigs for Hair Loss Related to Chemotherapy**

You may use any vendor for this benefit.

Devoted Health will reimburse you up to \$500 each plan year for the purchase of wigs for hair loss related to chemotherapy.



## **Devoted Dollars**

With our rewards program, you can earn Devoted Health Plans Visa® prepaid cards for taking care of yourself.

When we receive a claim from your provider for any of the eligible services, we will issue you a reward.

### **Breast Cancer or Colorectal Cancer Screening:**

Earn a \$20 reward after a breast cancer screening (if you're due for one) OR a colorectal cancer screening (if you're due for one)

**Diabetes Screening:** Earn a \$20 reward after receiving all of the following services (if you have diabetes):

- Get a blood test to check your HbA1c (average blood sugar)
- Get a urine test to check your kidney function
- Get an eye exam for diabetes

**Flu Shot:** Earn a \$10 reward after receiving the flu shot

**PCP Visit:** Earn a \$20 reward after seeing your PCP within 90 days of your plan start date

You need a referral to receive covered services from providers. Certain procedures, services, and drugs may need advance approval from Devoted Health. This is called “prior authorization” or “pre-authorization.” Please contact your PCP or refer to the Evidence of Coverage for services that require a prior authorization from Devoted Health.

# Non-Discrimination Notice

Devoted Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Devoted Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## Devoted Health

Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other language

If you need these services, contact Devoted Health at 1-800-338-6833 (TTY 711).

If you believe that Devoted Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### Dual HMO plans only:

Devoted Health – Appeals & Grievances  
PO Box 21917  
Eagan, MN 55121  
1-800-338-6833 (TTY 711)

### All other HMO plans:

Devoted Health – Appeals & Grievances  
PO Box 21327  
Eagan, MN 55121  
1-800-338-6833 (TTY 711)

You can file a grievance in person, by mail and by phone. If you need help filing a grievance, call 1-800-338-6833 (TTY 711).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through 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, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-338-6833 (TTY 711).

**العربية (Arabic):** المساعدة خدمات اليك متوفر، الإنجليزية اللغة تتحدث كنت إذا: هلمة ملاحظة (Arabic):  
711): البكم و للصم (1-800-338-6833) بالرقم اتصل. مجاناً اللغوية

**您講中文 (Chinese):** 注意：如果您講英語，則可免費獲得語言幫助服務。請呼叫 1-800-338-6833 (TTY 711)。

**فارسی (Farsi):**

توجه : اگر به زبان فارسی صحبت میکنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.  
با این شماره تماس بگیرید: 1-800-338-6833 (TTY 711).

**Français (French):** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-338-6833 (ATS 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-338-6833 (TTY 711).

**ગુજરાતી (Gujarati):** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો ભાષા સહાય સેવાઓ (લેન્ગવેજ આસિસ્ટન્સ સર્વિસીસ) આપના માટે વિનામૂલ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY 711) પર કોલ કરો.

**Kreyòl Ayisyen (Haitian Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-338-6833 (TTY 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, dei servizi di assistenza linguistica gratuiti sono disponibili. Chiamare 1-800-338-6833 (TTY 711).

**日本語 (Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-338-6833 (TTY 711) まで、お電話にてご連絡ください。

**한국어 (Korean):** 주의: 영어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-338-6833 (TTY 711). 번으로 전화해 주십시오.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-338-6833 (TTY 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-338-6833 (TTY 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-338-6833 (телетайп 711).

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-338-6833 (TTY 711).

**Tagalog (Tagalog):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-338-6833(TTY 711).

**ไทย (Thai):** โปรดทราบ: หากคุณสนทนาด้วยภาษาไทย บริการช่วยเหลือด้านภาษาไม่คิดค่าบริการช่วย พร้อมให้บริการโดยไม่คิดค่าบริการที่หมายเลขโทรศัพท์ 1-800-338-6833 (พิมพ์ TTY 711).

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-338-6833 (TTY 711).

This information is not a complete description of benefits. Call 1-800-385-0916 (TTY 711) for more information. Devoted Health is an HMO and PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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Questions? Call us.

**1-800-385-0916**

TTY 711

If you're a Devoted Health  
member, call:

**1-800-338-6833**

TTY 711