Devoted
HEALTH PLANS

2024 | DEVOTED HEALTH PLANS

Summary of Benefits

Devoted CHOICE Arizona (PPO) Plan

PBP Number: H6586-003-000

Pima County

Devoted CHOICE Arizona (PPO)

Summary of Benefits

This Summary of Benefits tells you about our Devoted CHOICE Arizona (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2024 plan year, which starts on January 1, 2024 and ends December 31, 2024.

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. Or, call us at 1-800-385-0916 (TTY 711) or text us at 84305, and we can mail you one.

Can I join this plan?

Devoted CHOICE Arizona (PPO) is a Preferred Provider Organization, or PPO plan. To join Devoted CHOICE Arizona (PPO), 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 this county: Pima. 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. Or, give us a call or text. 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. Or, give us a call or text. We can look up your doctors and pharmacies or mail you a directory.

Can I see out-of-network providers?

Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you, they must not be on any government sanction list, and they must participate in Medicare and accept Medicare reimbursement. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

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 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) or text us at 84305. 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.

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 us at 1-800-385-0916 (TTY 711), or text us at 84305.

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 www.devoted.com, call 1-800-385-0916 (TTY 711), or text 84305 to view a copy of the EOC.
- ☐ As a member of this plan, you can see providers that are in Devoted Health's network, or you can choose to see doctors who are out of network. If you see an out of network doctor, you may pay a higher cost share. You can review the provider directory (or ask your doctor) to see if the doctors you see now are in the Devoted Health network.
- ☐ 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.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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/coinsurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

IMPORTANT: If you receive assistance from Medicaid or "Extra Help," you may pay less than the cost-sharing amounts listed in this document. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the Evidence of Coverage for additional benefit details. For a copy of the Evidence of Coverage, please visit www.devoted.com, call 1-800-385-0916 (TTY 711), or text 84305.

Monthly Premium, Deductible, and Limits

Monthly Premium	$0 You must continue to pay your part B premium.	
Medical Deductible	This plan does not have a deductible.	
Pharmacy (Part D) Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility Benefits that don't count towards your maximum out-of-pocket responsibility are indicated with an asterisk (*).	**In-network** $5,000 This is the most you will pay in the plan year for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B-covered medication you receive from in-network providers. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (such as hearing aids) does not apply to this amount.	**Combined in- and out-of-network** $8,950 This is the most you will pay in the plan year for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B-covered medication you receive from in and out-of-network providers combined. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (such as hearing aids) does not apply to this amount.

Covered Medical and Hospital Benefits

	In-network	Out-of-network
Inpatient Hospital Coverage Prior authorization may be required. You are covered for an unlimited number of days in an inpatient hospital.	**Days 1 - 6** $295 copay per day **Day 7+** $0 copay per day	**Days 1 - 6** $295 copay per day **Day 7+** $0 copay per day
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)** $195 copay for surgery at an ASC **Outpatient Hospital** $225 copay for surgery at an outpatient hospital **Observation Stays** $295 copay per stay	**Diagnostic Colonoscopies** $0 copay at any out-of-network location **Ambulatory Surgical Center (ASC)** $195 copay for surgery at an ASC **Outpatient Hospital** $225 copay for surgery at an outpatient hospital **Observation Stays** $295 copay per stay
Doctor Visits You do not need a referral to see a specialist.	**Primary Care Provider (PCP)** $0 copay **Specialist** $25 copay	**Primary Care Provider (PCP)** $25 copay **Specialist** $25 copay

Preventive Care	Our plan covers many preventive services at no cost, 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 • HIV screening • Kidney disease service education • 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 vaccines, pneumonia vaccines, and COVID-19 vaccines. You are also covered for most Part D vaccines. See the Part D Vaccines section in this booklet for information about Part D vaccine coverage. • “Welcome to Medicare” preventive visit (one time) Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care 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.	$120 copay per stay
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.	**Worldwide Emergency and Urgent Care** $120 copay per stay **Worldwide Ground Ambulance** $350 copay per one-way trip **Worldwide Air Ambulance** 20% coinsurance per one-way trip
Urgently Needed Services Urgently Needed Services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently Needed Services defined in this section are for services provided in the U.S. and its territories.	**Urgently Needed Services from your PCP** $0 copay in-network $25 copay out-of-network **Urgently Needed Services from an Urgent Care Center or Retail Walk-in Center** $35 copay

Outpatient Care and Services

Diagnostic Services, Labs and Imaging	In-network	Out-of-network
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 **Outpatient X-rays and 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 $200 copay at an outpatient hospital setting **Diagnostic Tests and Procedures (such as a stress test, etc.)** $0 copay in an office or freestanding location $10 copay at an outpatient hospital setting **Radiation Therapy** 20% coinsurance	**Lab Services** $0 copay **Outpatient X-rays and 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 $200 copay at an outpatient hospital setting **Diagnostic Tests and Procedures (such as a stress test, etc.)** $0 copay in an office or freestanding location $10 copay at an outpatient hospital setting **Radiation Therapy** 40% coinsurance

Hearing Services

Hearing Care	In-network	Out-of-network
	Routine Hearing Exams $0 copay — 1 visit per year	**Routine Hearing Exams** $0 copay — 1 visit per year
	Hearing Aid Fitting and Evaluation $0 copay	**Hearing Aid Fitting and Evaluation** $0 copay
	Medicare-Covered Hearing Care $25 copay	**Medicare-Covered Hearing Care** $25 copay
	You are covered for a total of 1 routine hearing exam from in- or out-of-network providers.	
Hearing Aids*	$199 copay per aid for Advanced Aids	
You must see a TruHearing® provider to use this benefit.	$499 copay per aid for Premium Aids	
Benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors.	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	

Dental Services

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

If you receive dental services from an out-of-network dentist, you will be responsible for paying the difference between the negotiated fees and the fees your dental provider charges, including any applicable cost-share, even for services listed as $0. See your Evidence of Coverage for more information.

Preventive Dental Services	In-network	Out-of-network
Devoted Health will cover the costs for preventive dental services covered by the plan.	**Periodic Oral Exams** $0 copay **Dental Evaluation** $0 copay **Cleanings** $0 copay **X-rays (bitewing, intraoral, and panoramic)** $0 copay	**Periodic Oral Exams** $0 copay **Dental Evaluation** $0 copay **Cleanings** $0 copay **X-rays (bitewing, intraoral, and panoramic)** $0 copay
Comprehensive Dental Services* Prior authorization may be required. Devoted Health will pay as much as **$5,000** per year for comprehensive dental services. This means you will pay any additional costs above this amount.	**In-network** **Fillings** $0 copay **Deep Cleaning** $0 copay **Extractions** $0 copay **Dentures** $0 copay **Root Canals** $0 copay **Crowns** $0 copay **Bridges** $0 copay	**Out-of-network** **Fillings** 50% coinsurance **Deep Cleaning** 50% coinsurance **Extractions** 50% coinsurance **Dentures** 50% coinsurance **Root Canals** 50% coinsurance **Crowns** 50% coinsurance **Bridges** 50% coinsurance

Vision Services

Routine Vision	**In-network**	**Out-of-network**
	Routine Eye Exam $0 copay — 1 visit per year	**Routine Eye Exam** $0 copay — 1 visit per year
	You are covered for a total of 1 routine eye exam per year from in- or out-of-network providers.	
Eyewear	Your plan pays up to **$350 per year** towards eyewear. You can visit any eyewear provider. You can choose to see an in-network provider, or you can go to an out-of-network provider. If you get your eyewear from an in-network provider, they will bill the plan. If you choose to get your eyewear at an out-of-network provider, you'll pay the costs yourself at first. Then, you can submit a request for reimbursement. We will reimburse you up to your annual limit. See your Evidence of Coverage for more information. Benefit can be used for frames or lenses (or a combination of the two), contact lenses, eyeglass upgrades, and/or eyeglass replacements, up to the allowance amount.	
Medicare-covered Vision Care	**In-network**	**Out-of-network**
	Medicare-Covered Diagnostic Eye Exam $25 copay	**Medicare-Covered Diagnostic Eye Exam** $25 copay
	Medicare-Covered Glaucoma Screening $0 copay — 1 visit per year	**Medicare-Covered Glaucoma Screening** $0 copay — 1 visit per year
	Diabetic Eye Exam $0 copay — 1 visit per year	**Diabetic Eye Exam** $0 copay — 1 visit per year
	You are covered for a total of 1 diabetic eye exam and 1 Medicare-covered glaucoma screening from in- or out-of-network providers.	

Additional Outpatient Care and Services

Mental Health Services Prior authorization may be required. Mental health services are coordinated by Magellan, our behavioral health provider. You are covered for up to 90 days each benefit period for inpatient mental health care.	**In-network** **Inpatient Mental Health Care** **Days 1 - 6** $295 copay per day **Days 7 - 90** $0 copay per day **Outpatient Mental Health Care (individual and group)** $25 copay	**Out-of-network** **Inpatient Mental Health Care** **Days 1 - 6** $295 copay per day **Days 7 - 90** $0 copay per day **Outpatient Mental Health Care (individual and group)** $25 copay
Skilled Nursing Facility (SNF) Prior authorization may be required. No prior hospital stay required. You are covered for up to 100 days each benefit period for inpatient services in a SNF.	**In-network** **Days 1 - 20** $0 copay per day **Days 21 - 45** $203 copay per day **Days 46 - 100** $0 copay per day	**Out-of-network** 40% coinsurance
Physical Therapy	**In-network** $25 copay	**Out-of-network** $25 copay
Ambulance Services This plan covers you for emergent ambulance transportation to the nearest emergency room or nearest hospital able to meet your needs.	**In-network** **Ground Ambulance** $350 copay per one-way trip **Air Ambulance** 20% coinsurance per one-way trip	**Out-of-network** **Ground Ambulance** $350 copay per one-way trip **Air Ambulance** 20% coinsurance per one-way trip
Transportation	Not covered	

Prescription Drug Benefits

Medicare Part B Drugs	In-network	Out-of-network
Prior authorization may be required. 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 you will not be responsible for the cost of the unused portion.	**Allergy Serum** $0 copay **Generic Medications Used in a Nebulizer** $0 copay **Chemotherapy Drugs** 20% coinsurance **Other Part B Drugs** 20% coinsurance	**Allergy Serum** 40% coinsurance **Generic Medications Used in a Nebulizer** 40% coinsurance **Chemotherapy Drugs** 40% coinsurance **Other Part B Drugs** 40% coinsurance

The amount you pay for Part B rebatable drugs will be reduced if the drug's price has increased at a rate faster than the rate of inflation. The list of Part B rebatable drugs, as well as the amount you pay for those drugs, may change each quarter (January, April, July, October); however, you will never pay more than your Part B drug cost.

You will pay no more than $35 (or $0 depending on your level of Medicaid eligibility) for a 30-day supply of Medicare Part B-covered insulins (when you use insulin via a pump).

See your Evidence of Coverage (EOC) for details.

Prescription Drugs	
Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization.	**Pharmacy (Part D) Deductible** This plan does not have a deductible. **Initial Coverage Stage** You pay copays or coinsurance until your total yearly drug costs reach $5,030. 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** $47 per prescription **Tier 4 : Non-Preferred Drugs** $100 per prescription **Tier 5 : Specialty** 33% 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. If you do not receive your 100-day mail order supply through Caremark, your costs may be different.	**Tier 1 : Preferred Generic** $0 per prescription **Tier 2 : Generic** $0 per prescription **Tier 3 : Preferred Brand** $117.50 per prescription **Tier 4 : Non-Preferred Drugs** $300 per prescription **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 $5,030. Please note that not everyone will enter the Coverage Gap.

This plan provides partial tier gap coverage for some tier 1 and tier 2 drugs. This means that for some of the drugs covered on tier 1 and tier 2, you will continue to pay a copay. **For the 2024 plan year, while in the coverage gap, you will pay $0 copay for certain drugs on tier 1, $0 copay for certain drugs on tier 2,** and 25% coinsurance for all other drugs until you reach $8,000 total out-of-pocket. Drugs that have gap coverage are indicated in the Plan Formulary (Drug list).

Your plan also provides additional coverage for some drugs that are not normally covered in a Medicare prescription drug plan. These drugs are covered at your tier 2 copay for the entire year, no matter what coverage phase you are in. Additional information about these drugs can be found in the Erectile Dysfunction Drugs (ED) & Other Covered Drugs sections below.

Catastrophic Coverage

Yearly Out-of-Pocket Drug Costs	You will pay $0 for covered Part D drugs after your Yearly Out-of-Pocket Drug Costs reach $8,000.

Additional Part D Benefit Information

Insulin Coverage	You’ll pay no more than $35 for a 30-day supply for all Part D covered insulins. You will pay no more than $35 (or $0 depending on your level of Medicaid eligibility) for a 30-day supply of Medicare Part B-covered insulins (when you use insulin via a pump). See your Evidence of Coverage (EOC) for details.

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 for either medication or a combination of both medications, but not to exceed 6 pills per month. There is a maximum of 72 pills per year of either medication or the combination of these medications.
Other Covered Drugs	You are covered for the following additional items as Tier 2 medications (see the Prescription Drug Benefits section above for cost-sharing information): • Folic acid 1mg tablets • Vitamin D (ergocalciferol) 50,000 unit capsules • B12 injection (cyanocobalamin) 1000mcg/ml
Part D Vaccines	Our plan covers most Part D vaccines at $0 cost-share. Part D vaccines, such as Shingrix, are usually dispensed by a pharmacy. You can find coverage information for these vaccines in the plan's List of Covered Drugs (Formulary). If you receive a Part D vaccine in your provider's office, you may be billed for the entire cost of the vaccine. You can then ask our plan to pay our share of the cost by submitting a request for reimbursement. See our Evidence of Coverage (EOC) for additional details or call Member Services. Some vaccines are considered medical benefits (See the Preventive Care section in this booklet for medical benefit information).
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.

Additional Benefits

Dialysis	In-network	Out-of-network
	20% coinsurance	20% coinsurance

Foot Care (Podiatry Services)	In-network	Out-of-network
	Medicare-Covered Foot Care $25 copay **Routine Foot Care*** $25 copay — 6 visits per year	**Medicare-Covered Foot Care** $25 copay **Routine Foot Care*** $25 copay — 6 visits per year
	You are covered for 6 visits per year from in- or out-of-network providers. Routine foot care includes hygienic care such as nail trimming and callus removal.	

Home Health Care	In-network	Out-of-network
Prior authorization may be required. Home Health Care is limited to Medicare-covered services. See the plan's Evidence of Coverage (EOC) for more details.	$0 copay	40% coinsurance

Durable Medical Equipment (DME)	In-network	Out-of-network
Prior authorization may be required.	**Basic Medicare-covered DME Products** 20% coinsurance **Advanced Medicare-covered DME Products** 20% coinsurance	**Basic Medicare-covered DME Products** 40% coinsurance **Advanced Medicare-covered DME Products** 40% coinsurance

Equipment may only be covered if it is a certain brand or from certain manufacturers. Please contact us for details.

Basic DME Products include, but aren't limited to:

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

Advanced DME Products include:

- 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 our preferred product—see "Diabetes Monitoring Supplies" section for details, including coinsurance)

	In-network	Out-of-network
Prosthetic Devices and Medical Supplies Prior authorization may be required.	**Prosthetic Devices and Related Supplies** 20% coinsurance	**Prosthetic Devices and Related Supplies** 40% coinsurance
	Medical Supplies $0 copay	**Medical Supplies** 40% coinsurance
	Supplemental Compression Stockings $0 copay	**Supplemental Compression Stockings*** 40% coinsurance
	Supplemental Mastectomy Sleeves $0 copay	**Supplemental Mastectomy Sleeves*** 40% coinsurance

You are covered for up to 2 pairs of compression stockings/surgical stockings or mastectomy sleeves every 6 months.

Diabetes Monitoring Supplies	In-network	Out-of-network
Prior authorization may be required. **"Fingerstick" Glucose Monitors:** We cover blood glucose monitors, test strips, and lancets made by LifeScan (OneTouch). Supplies provided by in-network pharmacies and DME suppliers that carry them. **Continuous Glucose Monitor (CGM):** We cover Freestyle Libre continuous glucose monitors (CGM) and their supplies with a $0 copay at in-network pharmacies. Other CGMs are available at in-network DME suppliers and require authorization. A Durable Medical Equipment (DME) cost-share may apply.	**Continuous Glucose Monitor (CGM) - Freestyle Libre** $0 copay **Continuous Glucose Monitor (CGM) - Non-Preferred Brands** 20% coinsurance **Diabetic Supplies (such as test strips and lancets)** $0 copay	**Continuous Glucose Monitor (CGM) - Freestyle Libre** $0 copay **Continuous Glucose Monitor (CGM) - Non-Preferred Brands** 40% coinsurance **Diabetic Supplies (such as test strips and lancets)** 40% coinsurance

Diabetic Shoes & Therapeutic Inserts	In-network	Out-of-network
Prior authorization may be required.	$0 copay	40% coinsurance

Rehabilitation Services	In-network	Out-of-network
	Cardiac Rehabilitation Services $25 copay	**Cardiac Rehabilitation Services** $25 copay
	Pulmonary Rehabilitation Services $15 copay	**Pulmonary Rehabilitation Services** $15 copay
	Physical Therapy $25 copay	**Physical Therapy** $25 copay
	Occupational Therapy $25 copay	**Occupational Therapy** $25 copay
	Speech Therapy $25 copay	**Speech Therapy** $25 copay

Substance Use Services	In-network	Out-of-network
	Outpatient Substance Use Services $25 copay	**Outpatient Substance Use Services** $25 copay
	Opioid Treatment Program Services $25 copay	**Opioid Treatment Program Services** $25 copay

Telehealth	In-network	Out-of-network
This benefit may not be offered by all providers. Check directly with your provider about the availability of telehealth services.	**Virtual PCP Visits** $0 copay	**Virtual PCP Visits** $25 copay
	Virtual PT/OT/SP Visits $25 copay	**Virtual PT/OT/SP Visits** $25 copay
	Virtual Specialist Visits $25 copay	**Virtual Specialist Visits** $25 copay
	Your costs may be less depending on the provider you see.	

More Benefits and Perks With Your Plan

Over-the-Counter Items (OTC) You must use our designated vendor for this benefit.	$125 per quarter (every 3 months) You can use this benefit more than once, up to the limit per quarter, 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. For more information or to get started, go to SilverSneakers.com/StartHere. **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 your health and well-being.

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	**In-network**	**Out-of-network**
	Medicare-Covered Chiropractic Services $20 copay	**Medicare-Covered Chiropractic Services** $20 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)

Devoted Dollars	With our rewards program, you earn Devoted Dollars rewards for taking care of yourself. Your rewards are good for groceries and gas. Earn $100 by opting into the Devoted Dollars program and completing 4 or more of these activities in 2024: • Health Connections Checklist at my.devoted.com/checklist or by phone • Visit with your Primary Care Provider (PCP) • In-depth health check-in, like a Devoted to Me visit • Flu shot for the 2024 season • Colorectal cancer screening (if you're due for one) • Breast cancer screening (if you're due for one) • Bone density screening (if you're due for one) • Routine diabetes exams (if you have diabetes)

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.

*Costs for these services do not count toward your yearly Maximum Out-of-Pocket responsibility.

Non-Discrimination Notice

Devoted Health complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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 languages

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 **1-800-338-6833** (TTY 711). This is a free service. Hours are 8am to 8pm, 7 days a week from October 1 to March 31, and 8am to 8pm Monday to Friday from April 1 to September 30.

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Devoted Health – Appeals & Grievances
PO Box 21327
Eagan, MN 55121
Fax: 1-877-358-0711

You can file a grievance by mail, fax, or phone. If you need help filing a grievance, call us at **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: 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 1-800-338-6833 (TTY 711). Someone who speaks English can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de interpretación para responder las preguntas que tenga sobre su plan de salud o medicamentos. Para acceder a un intérprete, solo llámenos al 1-800-338-6833 (TTY 711). Una persona que hable español podrá ayudarle. Este es un servicio gratuito.

Chinese (Traditional US/Taiwan): 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打 1-800-338-6833 (TTY 711) 聯絡我們。會說中文的人員可以協助您。此爲免費服務。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch viên miễn phí có thể trả lời mọi thắc mắc của quý vị về chương trình y tế hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-800-338-6833 (TTY 711). Một người nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

French Creole (Haitian Creole): Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan 1-800-338-6833 (TTY 711). Yon moun ki pale Kreyòl Ayisyen kapab ede w. Sa se yon sèvis ki gratis.

Korean: 의료 또는 의약품 플랜에 대해서 있을 수 있는 질문에 대답하기 위해서 무료 통역 서비스가 있습니다. 통역 서비스를 이용하기 위해서는 1-800-338-6833(TTY 711)에 전화하십시오. 한국어를 구사하는 사람이 도와드릴 것입니다. 이것은 무료 서비스입니다.

:Arabic
نوفر خدمة مترجم فوري مجانية للإجابة عن أي أسئلة قد تكون لديك بشأن خطة الرعاية الصحية أو خطة الأدوية. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم 1-800-338-6833 (الهاتف النصي 711). يمكن لشخص يتحدث اللغة العربية مساعدتك. هذه خدمة

Tagalog: Mayroon kaming libreng mga serbisyo ng interpreter para sagutin anumang tanong mo tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan kami sa 1-800-338-6833 (TTY 711) Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

Polish: Mamy do Państwa dyspozycji bezpłatne wsparcie tłumaczy, którzy odpowiedzą na wszelkie pytania na temat zdrowia lub planu przyjmowania leków. Aby uzyskać pomoc tłumacza, prosimy o kontakt pod numerem 1-800-338-6833 (TTY 711). Osoba znająca język polski pomoże Państwu. Przypominamy, że jest to usługa bezpłatna.

Russian: Мы предоставляем бесплатные услуги устного переводчика, чтобы ответить на любые вопросы, которые могут у вас возникнуть о нашем плане медицинского страхования или покрытия стоимости лекарств. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-338-6833 (TTY 711). Переводчик, владеющий русский языком, сможет вам помочь. Эта услуга предоставляется бесплатно.

French (France/International): Nous offrons des services gratuits d'interprétation pour répondre à toutes vos éventuelles questions concernant notre régime d'assurance santé ou médicaments. Pour obtenir les services d'un interprète, appelez-nous au 1-800-338-6833 (TTY 711). Une personne parlant français peut vous aider. Ce service est gratuit.

German: Wir haben einen kostenlosen Dolmetscherservice zur Beantwortung aller Fragen, die Sie möglicherweise zu Ihrem Gesundheits- oder Medikamentenplan haben. Rufen Sie uns einfach unter 1-800-338-6833 (TTY 711) an, um einen Dolmetscher zu bekommen. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist kostenlos.

Gujarati: અમારી સ્વાસ્થ્ય અથવા દવા યોજના અંગે તમને હોઇ શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે નિ:શુલ્ક દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, માત્ર અમને 1-800-338-6833 (TTY 711) પર કોલ કરો. કોઇ વ્યક્તિ જે ગુજરાતી બોલે છે તે તમારી મદદ કરી શકે છે. આ એક નિ:શુલ્ક સેવા છે.

Japanese: 当社には、健康または薬計画に関する質問に答えるための無料通訳サービスがあります。通訳を利用するには、1-800-338-6833 (TTY 711)までお電話ください。日本語話す人がお手伝いいたします。これは無料サービスです

Italian: Abbiamo servizi di interpretariato gratuiti per rispondere a qualsiasi domanda tu possa avere sul nostro piano sanitario o farmacologico. Per ottenere un interprete, chiamaci al numero 1-800-338-6833 (TTY 711). Qualcuno che parla italiano potrà aiutarti. Questo è un servizio gratuito.

Portuguese (Brazil): Contamos com serviços gratuitos de interpretação para responder a quaisquer perguntas que você possa ter sobre seu plano de saúde ou de medicamentos. Para obter um intérprete, ligue para nós pelo telefone 1-800-338-6833 (TTY 711). Alguém que fala Português poderá lhe ajudar. Este serviço é gratuito.

Hindi: हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं हैं। कोई दुभाषिया पाने के लिए, बस 1-800-338-6833 (TTY 711) पर हमें कॉल करें। हिंदी बोलने वाला कोई आपकी मदद कर सकता है। यह मुफ्त सेवा है।

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/or PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Devoted Dollars: Use your Devoted Health Plans Prepaid Mastercard at any grocery or gas merchant in the U.S. that accepts Mastercard debit cards. Issued by The Bancorp Bank, Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated. Your use of the prepaid card is governed by the Cardholder Agreement, and some fees may apply. This is not a gift card. Exclusions apply and card is not redeemable for cash. Please note that prepaid cards are subject to expiration, so pay close attention to the expiration date of the card. This card is issued for loyalty, award or promotional purposes. More details can be found at www.devoted.com/devoted-dollars.

Devoted Health is not affiliated with Apple Inc. Apple Watch® and all other Apple product names are trademarks or registered trademarks of Apple Inc. For questions on how to use your Devoted Wellness Bucks you may contact us at 1-800-DEVOTED. For Apple Watch sales, service or support please visit an Apple authorized retailer.

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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

Or text us at 866-85