Devoted
HEALTH PLANS

2025 | DEVOTED HEALTH PLANS

Summary of Benefits

Devoted CHOICE DUAL PLUS Arkansas (PPO D-SNP) Plan

PBP Number: H7397-003-000

Benton, Carroll, Conway, Crittenden, Cross, Dallas, Franklin, Grant, Lee, Lonoke, Madison, Mississippi, Newton, Perry, Pulaski, St. Francis, Washington, and Yell Counties

Devoted CHOICE DUAL PLUS Arkansas (PPO D-SNP)

Summary of Benefits

This Summary of Benefits tells you about our Devoted CHOICE DUAL PLUS Arkansas (PPO D-SNP) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2025 plan year, which starts on January 1, 2025 and ends on December 31, 2025.

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 (EOC)** at www.devoted.com. Call us at 1-800-385-0916 (TTY 711) and we can mail you one.

Can I join this plan?

Devoted CHOICE DUAL PLUS Arkansas (PPO D-SNP) is a Dual Eligible Special Needs plan, or HMO D-SNP plan. To join Devoted CHOICE DUAL PLUS Arkansas (PPO D-SNP), you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must also receive assistance from the Arkansas Medicaid program as either a Qualified Medicare Beneficiary (QMB+ or QMB), Specified Low-Income Medicare Beneficiary (SLMB+), or Full Benefit Dual Eligible (FBDE). You must also live in our service area, which includes these counties: Benton, Carroll, Conway, Crittenden, Cross, Dallas, Franklin, Grant, Lee, Lonoke, Madison, Mississippi, Newton, Perry, Pulaski, St. Francis, Washington, and Yell. If you have any questions about your Medicaid eligibility or level of assistance, please contact us or your Arkansas Medicaid office.

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.

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. If you are eligible for Medicare cost-sharing assistance under Medicaid, you do not pay anything for Medicare-covered services listed in this document that are provided by in-network providers, as long as you meet the coverage requirements described in this document.

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). 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).

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) 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 may choose 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.
- [ ] Your costs with this plan (premiums, copayments, coinsurance, and deductibles) will vary based on your level of Medicaid eligibility and the assistance you receive from Medicaid as well as the amount of "Extra Help" you get from Medicare.
- [ ] Benefits, premiums, and/or copayments/ coinsurance may change on January 1, 2026.
- [ ] 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.
- [ ] 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.

In: = In-Network **Out:** = Out-of-Network

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).

Monthly Premium, Deductible, and Limits

Monthly Premium	$0 to $20.90 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 will be reduced to $0.
Medical Deductible	$500 If you receive cost-sharing assistance under Medicaid, you are not responsible for paying your plan's medical deductible for services provided by in-network providers; it is paid by your state Medicaid program. If you receive services from an out-of-network provider, you may be liable for full cost share if the out-of-network provider does not accept Medicaid, even if Medicaid normally covers your cost share for Medicare services. If your category of Medicaid eligibility changes, or if you receive services from out-of-network providers who do not accept Medicaid, you may be responsible for a $500 deductible for your covered medical services.
Pharmacy (Part D) Deductible	$0 If you receive “Extra Help” to pay for your Medicare prescription drug program costs, this plan does not have a Part D deductible. If you do not receive "Extra Help," you will be responsible for up to a $590 deductible for Part D drugs on Tiers 1-5. The deductible does not apply to covered Part D insulins and most adult Part D vaccines.

In: = In-Network **Out:** = Out-of-Network

Maximum Out-of-Pocket Responsibility Benefits that don't count toward your maximum out-of-pocket responsibility are indicated with an asterisk (*).	In-network maximum amount: $9,350 This amount applies to in-network providers. Combined in- and out-of-network maximum amount: $14,000 This amount applies to in- and out-of-network providers combined. This is the most you will pay in the plan year for copays, coinsurance, and other costs for Medicare-covered medical Part A and Part B services, supplies, and Part B-covered medications you receive from in-network providers or for 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 these amounts.

Covered Medical and Hospital Benefits

	With Medicaid cost-share assistance	Without Medicaid cost-share assistance
Inpatient Hospital Coverage Prior authorization may be required. You are covered for an unlimited number of days in an inpatient hospital.	In-network: $0 copay per stay Out-of-network: 30% coinsurance	In-network: $1,350 copay per stay Out-of-network: 30% coinsurance

In: = In-Network **Out:** = Out-of-Network

Outpatient Hospital Coverage	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
Prior authorization may be required for procedures performed in an outpatient hospital or ambulatory surgical center.	In-network: • **Diagnostic Colonoscopies:** $0 copay • **Outpatient Surgery and Procedures:** Outpatient Hospital: $0 copay Ambulatory Surgical Center (ASC): $0 copay • **Observation Stays:** $0 copay Out-of-network: • **Diagnostic Colonoscopies:** 40% coinsurance • **Outpatient Surgery and Procedures:** Outpatient Hospital: 40% coinsurance Ambulatory Surgical Center (ASC): 40% coinsurance • **Observation Stays:** 40% coinsurance	In-network: • **Diagnostic Colonoscopies:** 40% coinsurance • **Outpatient Surgery and Procedures:** Outpatient Hospital: 40% coinsurance Ambulatory Surgical Center (ASC): 40% coinsurance • **Observation Stays:** 40% coinsurance Out-of-network: • **Diagnostic Colonoscopies:** 40% coinsurance • **Outpatient Surgery and Procedures:** Outpatient Hospital: 40% coinsurance Ambulatory Surgical Center (ASC): 40% coinsurance • **Observation Stays:** 40% coinsurance

In: = In-Network **Out:** = Out-of-Network

Doctor Visits You do not need a referral to see a specialist. Balance exams are used to identify balance issues.	**With Medicaid cost-share assistance** In-network: • **Primary Care Provider (PCP):** $0 copay • **Specialist:** $0 copay Balance Exams are also covered at $0 copay. Out-of-network: • **Primary Care Provider (PCP):** $0 copay • **Specialist:** 20% coinsurance Balance Exams are also covered at 20% coinsurance.	**Without Medicaid cost-share assistance** In-network: • **Primary Care Provider (PCP):** $0 copay • **Specialist:** $0 copay Balance Exams are also covered at $0 copay. Out-of-network: • **Primary Care Provider (PCP):** $0 copay • **Specialist:** 20% coinsurance Balance Exams are also covered at 20% coinsurance.
Preventive Care	Our plan covers many preventive services at no cost, including Annual Wellness visits, Bone mass measurements, Breast cancer screenings (mammograms), Cardiovascular screenings, Cervical and vaginal cancer screenings, Colorectal cancer screenings, Diabetes screenings, Hepatitis B virus screenings, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots, COVID shots). Any additional preventive services approved by Medicare during the contract year will be covered. Our plan also covers certain preventive services more frequently than Medicare.	
Emergency Care	**With Medicaid cost-share assistance** $0 copay per stay	**Without Medicaid cost-share assistance** $110 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 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:** $0 copay per stay • **Worldwide Ground Ambulance:** $0 copay per one-way trip • **Worldwide Air Ambulance:** $0 copay per one-way trip	
Urgently Needed Services in the United States and its Territories	**With Medicaid cost-share assistance** In-network: • **PCP office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** $0 copay Out-of-network: • **PCP Office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** 35% coinsurance	**Without Medicaid cost-share assistance** In-network: • **PCP Office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** 35% coinsurance Out-of-network: • **PCP Office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** 35% coinsurance

Outpatient Care and Services

Diagnostic Services, Labs, and Imaging Prior authorization may be required. Cost share varies based upon location and the type of service being performed. Cost share for genetic testing may vary.	**With Medicaid cost-share assistance** In-network: • **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $0 copay • **Outpatient X-rays and Ultrasounds** Office or freestanding location: $0 copay Outpatient hospital: $0 copay • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $0 copay Outpatient Hospital: $0 copay • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 copay Outpatient hospital: $0 copay • **Radiation Therapy** Office or freestanding location: $0 copay Outpatient hospital: $0 copay Out-of-network: • **Lab Services** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance	**Without Medicaid cost-share assistance** In-network: • **Lab Services** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance • **Outpatient X-rays and Ultrasounds** Office or freestanding location: 35% - 40% coinsurance Outpatient hospital: 35% - 40% coinsurance • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: 40% coinsurance Outpatient Hospital: 40% coinsurance • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - 40% coinsurance Outpatient hospital: 40% coinsurance • **Radiation Therapy** Office or freestanding location: 20% coinsurance Outpatient hospital: 20% coinsurance Out-of-network:

	• **Outpatient X-rays and Ultrasounds** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: 40% coinsurance Outpatient Hospital: 40% coinsurance • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - 40% coinsurance Outpatient hospital: 40% coinsurance • **Radiation Therapy** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance	• **Lab Services** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance • **Outpatient X-rays and Ultrasounds** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: 40% coinsurance Outpatient Hospital: 40% coinsurance • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - 40% coinsurance Outpatient hospital: 40% coinsurance • **Radiation Therapy** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance

Hearing Services

	With Medicaid cost-share assistance	Without Medicaid cost-share assistance
Hearing Care	In-network • **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** $0 copay Out-of-network: • **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** 40% coinsurance	In-network • **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** 40% coinsurance Out-of-network: • **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** 40% coinsurance
	You are covered for a total of 1 routine hearing exam from in- or out-of-network providers.	
Hearing Aids* You must see a TruHearing® provider to use this benefit. Benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options.	$399 copay per aid for Advanced Aids $699 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	

Dental & Eyewear Card

You have **$500** per year towards Preventive Dental, Comprehensive Dental, and/or Eyewear combined. You can see any licensed dentist or visit any eyewear retailer. The $500 will be preloaded onto a debit card. You can use your card at any dental or eyewear provider who accepts MasterCard. Cosmetic procedures, dental implants, and/or elective procedures are not eligible.

Vision Services

Routine Vision	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
	In- and out-of-network: **Routine Eye Exam*:** $0 copay — 1 visit per year	In- and out-of-network: **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.	
Medicare-Covered Vision Care	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
	In-network: • **Medicare-Covered Diagnostic Eye Exam:** $0 copay Out-of-network: • **Medicare-Covered Diagnostic Eye Exam:** 40% coinsurance	In-network: • **Medicare-Covered Diagnostic Eye Exam:** 40% coinsurance Out-of-network: • **Medicare-Covered Diagnostic Eye Exam:** 40% coinsurance

Additional Outpatient Care and Services

Mental Health Services Prior authorization may be required. Mental health services are coordinated by Magellan, our behavioral health provider.	**With Medicaid cost-share assistance** In-network: • **Inpatient Mental Health Care:** $0 copay per stay • **Outpatient Mental Health Care (individual and group):** $0 copay Out-of-network: • **Inpatient Mental Health Care:** 30% coinsurance • **Outpatient Mental Health Care (individual and group):** 20% coinsurance	**Without Medicaid cost-share assistance** In-network: • **Inpatient Mental Health Care:** $1,350 copay per stay • **Outpatient Mental Health Care (individual and group):** $0 copay Out-of-network: • **Inpatient Mental Health Care:** 30% coinsurance • **Outpatient Mental Health Care (individual and group):** 20% coinsurance
Skilled Nursing Facility (SNF) Prior authorization may be required. No prior hospital stay required.	**With Medicaid cost-share assistance** In-network: $0 copay per stay Out-of-network: 40% coinsurance	**Without Medicaid cost-share assistance** In-network: **Days 1 - 20** $0 copay per day **Days 21 - 100** $214 copay per day Out-of-Network: 40% coinsurance

Physical Therapy and Other Rehabilitation Services	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
	In-network: • **Physical Therapy** Office location: $0 copay Outpatient hospital: $0 copay • **Occupational Therapy** Office location: $0 copay Outpatient hospital: $0 copay • **Speech Therapy** Office location: $0 copay Outpatient hospital: $0 copay Out-of-network: • **Physical Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance • **Occupational Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance • **Speech Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance Cost share may vary based upon location.	In-network • **Physical Therapy** Office location: $0 copay Outpatient hospital: $0 copay • **Occupational Therapy** Office location: $0 copay Outpatient hospital: $0 copay • **Speech Therapy** Office location: $0 copay Outpatient hospital: $0 copay Out-of-network: • **Physical Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance • **Occupational Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance • **Speech Therapy** Office location: 20% coinsurance Outpatient hospital: 20% coinsurance
Ambulance Services You pay $0 for facility-to-facility transfers via ground ambulance. Prior authorization may be required for non-emergency transportation.	**With Medicaid cost-share assistance** • **Ground Ambulance:** $0 copay per one-way trip • **Air Ambulance:** $0 copay per one-way trip	**Without Medicaid cost-share assistance** • **Ground Ambulance:** 40% coinsurance per one-way trip • **Air Ambulance:** 40% coinsurance per one-way trip

Transportation	Not covered

Prescription Drug Benefits

Medicare Part B Drugs
Prior authorization may be required. Part B drugs are usually given in a doctor's office or an outpatient setting as part of a medical service.

With Medicaid cost-share assistance

In-network:
- **Allergy Serum:** $0 copay
- **Generic Medications Used in a Nebulizer:** $0 copay
- **Chemotherapy Drugs:** $0 copay
- **Other Part B Drugs:** $0 copay

Out-of-network:
- **Allergy Serum:** 40% coinsurance
- **Generic Medications Used in a Nebulizer:** 40% coinsurance
- **Chemotherapy Drugs:** 40% coinsurance
- **Other Part B Drugs:** 40% coinsurance

Without Medicaid cost-share assistance

In-network:
- **Allergy Serum:** 20% coinsurance
- **Generic Medications Used in a Nebulizer:** 20% coinsurance
- **Chemotherapy Drugs:** 20% coinsurance
- **Other Part B Drugs:** 20% coinsurance

Out-of-network:
- **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).

Some Part B drugs may be subject to step therapy. The following link will take you to a list of these drugs: www.devoted.com/prescription-drugs/drug-coveragelimits/2025-st-list-part-b-drugs.

Prescription Drugs Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization.	**Pharmacy (Part D) Deductible** If you receive “Extra Help” to pay for your Medicare prescription drug program costs, you are eligible for reduced cost-sharing. This means that you will pay $0 for your Part D deductible. If you do not receive "Extra Help," you will be responsible for up to a $590 deductible for Part D drugs on Tiers 1-5. The deductible does not apply to covered Part D insulins and most adult Part D vaccines. **Initial Coverage Stage** If you receive “Extra Help,” you are eligible for reduced cost-sharing. This means that you will pay $0 for all covered Part D Drugs on our formulary (drug list) as well as Part D covered drugs approved through a non-formulary exception. If you do not receive "Extra Help," you pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,000.
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** $0 per prescription • **Tier 4: Non-Preferred Drugs** $0 per prescription • **Tier 5: Specialty** $0 per prescription If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible for reduced cost-sharing. This means that you will pay $0 for covered Part D Drugs. If you do not receive "Extra Help," you will pay 25% of the total cost for covered Part D drugs.

In: = In-Network **Out:** = Out-of-Network

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** $0 per prescription • **Tier 4: Non-Preferred Drugs** $0 per prescription • **Tier 5: Specialty** Not available through mail If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible for reduced cost-sharing. This means that you will pay $0 for covered Part D Drugs. If you do not receive "Extra Help," you will pay 25% of the total cost for covered Part D drugs.

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.

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 $2,000.

Additional Part D Benefit Information

Insulin Coverage	If you receive "Extra Help," your cost for covered Part D insulins will be $0 for a 30-day supply. If you do not receive "Extra Help," your cost-share for covered Part D insulins will be no more than $35 for a 30-day supply. 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).

Part D Vaccines	If you receive "Extra Help," your cost for covered Part D vaccines, such as Shingrix, will be $0. If you do not receive "Extra Help," your cost-share for most Part D vaccines, including shingles, tetanus, and whooping cough vaccines, will still be $0, even if you haven't met your deductible. See your plan's list of covered drugs (formulary) for a complete list.

Additional Benefits

Dialysis	**With Medicaid cost-share assistance** In-network: $0 copay Out-of-network: 20% coinsurance	**Without Medicaid cost-share assistance** In-network: 20% coinsurance Out-of-network: 20% coinsurance
Foot Care (Podiatry Services)	In-network: **Medicare-Covered Foot Care:** $0 copay Out-of-network: **Medicare-Covered Foot Care:** 20% coinsurance	
Home Health Care Prior authorization may be required. Home Health Care is limited to Medicare-covered services.	**With Medicaid cost-share assistance** In-network: $0 copay Out-of-network: 40% coinsurance	**Without Medicaid cost-share assistance** In-network: $0 copay Out-of-network: 40% coinsurance

	With Medicaid cost-share assistance	Without Medicaid cost-share assistance
Durable Medical Equipment (DME) Prior authorization may be required.	In-network: • **Basic Medicare-covered DME Products:** $0 copay for crutches, $0 copay all other • **Advanced Medicare-covered DME Products:** $0 copay Out-of-network: • **Basic Medicare-covered DME Products:** 35% coinsurance for crutches, 35% coinsurance all other • **Advanced Medicare-covered DME Products:** 35% coinsurance	In-network: • **Basic Medicare-Covered DME Products:** 20% coinsurance crutches, 20% coinsurance all other • **Advanced Medicare-Covered DME Products:** 20% coinsurance Out-of-network: • **Basic Medicare-Covered DME Products:** 35% coinsurance crutches, 35% coinsurance all other • **Advanced Medicare-Covered DME Products:** 35% coinsurance
Prosthetic Devices and Medical Supplies Prior authorization may be required.	In-network: • **Prosthetic Devices and Related Supplies:** $0 copay • **Medical Supplies:** $0 copay Out-of-network: • **Prosthetic Devices and Related Supplies:** 40% coinsurance • **Medical Supplies:** 40% coinsurance You are covered for up to 2 pairs of compression stockings/ surgical stockings or mastectomy sleeves every 6 months.	In-network: • **Prosthetic Devices and Related Supplies:** 20% coinsurance • **Medical Supplies:** 20% coinsurance Out-of-network: • **Prosthetic Devices and Related Supplies:** 40% coinsurance • **Medical Supplies:** 40% coinsurance

Diabetes Monitoring Supplies	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
Prior authorization may be required. **"Fingerstick" Glucose Monitors:** We cover blood glucose monitors, test strips, and lancets made by LifeScan (OneTouch). Supplies are provided by retail pharmacies and DME suppliers that carry them. **Continuous Glucose Monitors (CGMs):** We cover Freestyle Libre CGMs and their supplies at retail pharmacies without prior authorization. Dexcom CGMs and their supplies are available at retail pharmacies & DME suppliers and require prior authorization. Other CGMs are only available at DME suppliers and require prior authorization.	In-network: • **Freestyle Libre CGM:** $0 copay • **Non-Preferred Brand CGM:** $0 copay • **Diabetic Supplies (such as test strips and lancets - OneTouch):** $0 copay Out-of-network: • **Freestyle Libre CGM:** $0 copay • **Non-Preferred Brand CGM:** 35% coinsurance • **Diabetic Supplies (such as test strips and lancets - OneTouch):** 40% coinsurance	In-network: • **Freestyle Libre CGM:** $0 copay • **Non-Preferred Brand CGM:** 20% coinsurance • **Diabetic Supplies (such as test strips and lancets - OneTouch):** 20% coinsurance Out-of-network: • **Freestyle Libre CGM:** $0 copay • **Non-Preferred Brand CGM:** 35% coinsurance • **Diabetic Supplies (such as test strips and lancets - OneTouch):** 40% coinsurance

Diabetic Shoes and Therapeutic Inserts	**With Medicaid cost-share assistance**	**Without Medicaid cost-share assistance**
Prior authorization may be required.	In-network: $0 copay Out-of-network: 40% coinsurance	In-network: $0 copay Out-of-network: 40% coinsurance

Chiropractic Care
Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation.

In-network:

Medicare-Covered Chiropractic Services: $0 copay

Out-of-network:

Medicare-Covered Chiropractic Services: 20% coinsurance

Telehealth This benefit may not be offered by all providers. Check directly with your provider about the availability of telehealth services.	You pay the same in- or out-of-network cost share that you would pay for an in-person office visit.

More Benefits and Perks With Your Plan

Food & Home Card	$219 per month You can use this benefit to: • Purchase foods at participating grocery and other retail stores • Purchase over-the-counter (OTC) items at participating retail stores • Pay for utility costs, such as electric or water bills • Pay for rent or mortgage costs You can use this benefit more than once, up to the limit per month, but this amount does not roll over. Devoted Health will automatically add more money to your card on the first day of each month. Pay with your card or use the mobile app at checkout for eligible costs. Vendor must accept Visa for utilities, rent, or mortgage payments. You must receive "Extra Help" to qualify for this benefit.

In: = In-Network **Out:** = Out-of-Network

Fitness	**SilverSneakers®:** $0 membership SilverSneakers gives you the opportunity to stay active at the gym, from home and at locations around your community. **Devoted Health Wellness Bucks:** Devoted Health will reimburse you up to **$150 per year** for the following: 1. Purchase of an Apple Watch® or other wearable device that tracks the number of steps and heart rate. 2. Fitness equipment to be used in the home. Examples include free weights, treadmill, stationary bike, rowing machine, 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.
Devoted Dollars	With our rewards program, you earn Devoted Dollars rewards for taking care of yourself. Earn $20 when you complete your yearly Health Risk Assessment (HRA) - your first reward when you complete it within 90 days of your plan start date, and another reward annually after that. For more information, visit devoted.com/devoted-dollars.

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.

Summary of Medicaid-Covered Benefits

Information for people with Medicare and Medicaid

If you are covered by Medicaid, you may be eligible for additional benefits through your state Medicaid program. Your Devoted Health D-SNP plan covers the Medicare services described in the Summary of Benefits above. Medicaid covers the benefits listed below. Medicare services are paid first by Devoted Health and then by Medicaid. For services covered by both Devoted and Medicaid, Medicaid may pay your Medicare cost-sharing amount, depending on your Medicaid coverage level. Even if you qualify for Medicare cost share assistance, Medicaid may only cover your Medicare cost share for services provided by out-of-network providers if the out-of-network provider accepts Medicaid. Medicaid may also provide coverage if a benefit is used up or not covered by us. Your Medicaid benefits and cost-share amounts may vary based on the level of your Medicaid coverage; benefit limitations, referrals, and prior authorizations may apply.

If you receive services from an out-of-network provider, you may be liable for full cost share if the out-of-network provider does not accept Medicaid, even if Medicaid normally covers your cost share for Medicare services.

Have questions? For more information about Medicaid eligibility and Medicaid benefits, call Arkansas Medicaid at 1-888-987-1200 or visit humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-clients.

- Adult Behavioral Health Services for Community Independence (ABHSCI)
- Adult Developmental Day Treatment (ADDT)
- Ambulance Service (Emergency Only)
- Ambulatory Surgical Center
- ARChoices in Home Care
- Autism Waiver
- Chiropractor
- Community and Employment Supports Waiver
- Community Health Centers
- Dental Care
- Disability Services
- Doctor's Services
- Early Intervention Day Treatment (EIDT)
- Early Periodic Screening, Diagnosis, and Testing Services (EPSDT)
- Emergency Room Services
- Federally Qualified Health Center (FQHC)
- Hearing
- Home Health Services
- Hospice Care
- Hospital Care
- Immunizations
- Independent Choices

- Lab Tests and X-Rays
- LivingChoices Assisted Living
- Long-Term Care Treatment
- Medicaid or ARKids First-A
- Medical Equipment
- Medical Supplies
- Mental Health Services
- Non-Emergency Transportation (NET) Program
- Nurse-Midwife (Certified)
- Nurse Practitioners
- Nursing Home Care
- Program of All-Inclusive Care for the Elderly (PACE)
- Personal Care
- Podiatrist
- Obstetrics
- Prescription Drugs
- Rehabilitative Services
- Rural Health Clinic
- Targeted Case Management
- Tax Equity and Fiscal Responsibility Act (TEFRA) Program
- Therapy (Physical, Occupational, or Speech)
- Tobacco Cessation
- Vision Care
- Well-Child Care
- Women's Health

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 intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes).

Devoted Health

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator, Emily Reilly, using the contact information below.

Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **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 intersex traits, pregnancy or related conditions, sexual orientation, and gender identity, and sex stereotypes), you can file a grievance with:

Emily Reilly, Civil Rights Coordinator
Devoted Health % Appeals & Grievances
PO Box 21327
Eagan, MN 55121
Phone: 1-800-338-6833 (TTY 711)
Fax: 1-877-358-0711
Email: CivilRightsCoordinator@devoted.com

You can file a grievance by mail, fax, phone, or email. If you need help filing a grievance, Emily Reilly, Civils Rights Coordinator for Devoted Health is available to help you using the contact information above.

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**.
This notice is also available at Devoted Health's website: **https://www.devoted.com/nondiscrimination-notice/**

English ATTENTION If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-338-6833 (TTY 711) or speak to your provider.

Spanish (Español) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-338-6833 (TTY 711) o hable con su proveedor.

Chinese (Traditional US/Taiwan) (中文) 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙形式提供資訊。請致電 1-800-338-6833 (TTY 711）或與您的提供者討論。

Vietnamese (Việt): LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-338-6833 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

French Creole (Haitian Creole) (Kreyòl Ayisyen) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-338-6833 (TTY:711) oswa pale avèk founisè w la.

Korean (한국어) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-338-6833 (TTY 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Arabic العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-338-6833 (الهاتف النصي 711) أو تحدث إلى مقدم الخدمة.

Tagalog PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap sa iyong provider.

Polish (POLSKI) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-338-6833 (TTY 711) lub porozmawiaj ze swoim dostawcą.

Russian (РУССКИЙ) ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-338-6833 (TTY 711) или обратитесь к своему поставщику услуг.

French (France/International) (Français) ATTENTION : si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-338-6833 (TTY 711) ou parlez à votre fournisseur.

German (Deutsch) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-338-6833 (TTY 711) an oder sprechen Sie mit Ihrem Provider.

Gujarati (ગજુ રાતી): ધ્યાન આપો: જો તમે ગજુ રાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સવે ાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝલિરી સહાય અને ઍક્સસેબિલ ફૉર્મેટમા ંમાહતિી પૂરી પાડવા માટેની સવે ાઓ પણ વનિા મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Japanese (日本語) 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-338-6833（TTY 711）までお電話ください。または、ご利用の事業者にご相談ください。

Italian (Italiano) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-338-6833 (tty 711) o parla con il tuo fornitore.

Portuguese (Brazil) (Português do Brasil) ATENÇÃO: Se você fala português do Brasil, tem à disposição serviços gratuitos de assistência linguística. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-338-6833 (TTY 711) ou fale com seu provedor.

Hindi (हिंदी) ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होतीहैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं।1-800-338-6833 (TTY 711) पर कॉल करें या अपने प्रदाता से बात करें।

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