Devoted
HEALTH PLANS

2025 | DEVOTED HEALTH PLANS

Summary of Benefits

Devoted CHOICE Illinois (PPO) Plan

PBP Number: H8320-001-000

Cass, Christian, De Witt, Logan, Macoupin, Menard, Montgomery, Sangamon, Scott, and Shelby Counties

Devoted CHOICE Illinois (PPO)

Summary of Benefits

This Summary of Benefits tells you about our Devoted CHOICE Illinois (PPO) 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. Or call us at 1-800-385-0916 (TTY 711) and we can mail you one.

Can I join this plan?

Devoted CHOICE Illinois (PPO) is a Preferred Provider Organization, or PPO plan. To join Devoted CHOICE Illinois (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 these counties: Cass, Christian, De Witt, Logan, Macoupin, Menard, Montgomery, Sangamon, Scott, and Shelby. 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). 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.
- [ ] 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, 2026.
- [ ] 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).

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 medical deductible.	
Pharmacy (Part D) Deductible	$590 for Tiers 3-5 only If you receive "Extra Help" from Medicare, your deductible is $0. The deductible does not apply to covered Part D insulins and most adult Part D vaccines.	
Maximum Out-of-Pocket Responsibility Benefits that don't count toward 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 Part A and Part B services, supplies, and Part B-covered medications you receive from in-network providers.	**In- and out-of-network** $9,550 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- and out-of-network providers combined.

Covered Medical and Hospital Benefits

Inpatient Hospital Coverage Prior authorization may be required. You are covered for an unlimited number of days in an inpatient hospital.	**In-network** **Days 1 - 5** $330 copay per day **Day 6+** $0 copay per day	**Out-of-network** **Days 1 - 5** $330 copay per day **Day 6+** $0 copay per day

Outpatient Hospital Coverage 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: $430 copay Ambulatory Surgical Center (ASC): $330 copay • **Observation Stays:** $330 copay per stay	**Out-of-network** • **Diagnostic Colonoscopies:** $0 copay • **Outpatient Surgery and Procedures:** Outpatient Hospital: $430 copay Ambulatory Surgical Center (ASC): $330 copay • **Observation Stays:** $330 copay per stay
Doctor Visits You do not need a referral to see a specialist. Balance exams are used to identify balance issues.	**In-network** • **Primary Care Provider (PCP):** $0 copay • **Specialist:** $40 copay Balance Exams are also covered at $40 copay.	**Out-of-network** • **Primary Care Provider (PCP):** $0 copay • **Specialist:** $40 copay Balance Exams are also covered at $40 copay.
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	$125 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:** $125 copay per stay • **Worldwide Ground Ambulance:** $295 copay per one-way trip • **Worldwide Air Ambulance:** 20% coinsurance per one-way trip	
Urgently Needed Services in the United States and its Territories	**In-network** • **PCP office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** $45 copay	**Out-of-network** • **PCP Office:** $0 copay • **Urgent Care Center or Retail Walk-in Center:** $45 copay

Outpatient Care and Services

	In-network	Out-of-network
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.	• **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $20 copay • **Outpatient X-rays and Ultrasounds** Office or freestanding location: $0 - $25 copay Outpatient hospital: $75 copay • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 - $200 copay Outpatient Hospital: $200 - $300 copay • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - $40 copay Outpatient hospital: $95 copay • **Radiation Therapy** Office or freestanding location: 20% coinsurance Outpatient hospital: 20% coinsurance	• **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $20 copay • **Outpatient X-rays and Ultrasounds** Office or freestanding location: $0 - $25 copay Outpatient hospital: $75 copay • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 - $200 copay Outpatient Hospital: $200 - $300 copay • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - $40 copay Outpatient hospital: $95 copay • **Radiation Therapy** Office or freestanding location: 40% coinsurance Outpatient hospital: 40% coinsurance

Hearing Services

	In-network	Out-of-network
Hearing Care	• **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** $40 copay	• **Routine Hearing Exams*:** $0 copay — 1 visit per year • **Hearing Aid Fitting and Evaluation*:** $0 copay • **Medicare-Covered Hearing Care:** $40 copay
	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 and Eyewear Allowance

You have a **$1,000** yearly allowance toward Preventive Dental, Comprehensive Dental, and/or Eyewear combined. You can see any licensed dentist or visit any eyewear retailer.

You'll pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted. Cosmetic procedures, dental implants, and/or elective procedures are not covered.

Vision Services

	In-network	Out-of-network
Routine Vision	**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.	

Medicare-Covered Vision Care	**In-network** **Medicare-Covered Diagnostic Eye Exam:** $40 copay	**Out-of-network** **Medicare-Covered Diagnostic Eye Exam:** $40 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.	**In-network** • **Inpatient Mental Health Care:** **Days 1 - 5** $330 copay per day **Days 6 - 90** $0 copay per day • **Outpatient Mental Health Care (individual and group):** $40 copay	**Out-of-network** • **Inpatient Mental Health Care:** **Days 1 - 5** $330 copay per day **Days 6 - 90** $0 copay per day • **Outpatient Mental Health Care (individual and group):** $40 copay
Skilled Nursing Facility (SNF) Prior authorization may be required. No prior hospital stay required.	**In-network** **Days 1 - 20** $0 copay per day **Days 21 - 60** $214 copay per day **Days 61 - 100** $0 copay per day	**Out-of-network** 35% coinsurance

Physical Therapy and Other Rehabilitation Services	**In-network** • **Physical Therapy** Office location: $40 copay Outpatient hospital: $50 copay • **Occupational Therapy** Office location: $40 copay Outpatient hospital: $45 copay • **Speech Therapy** Office location: $40 copay Outpatient hospital: $50 copay Cost share may vary based upon location. Cost share for re-evaluations may differ.	**Out-of-network** • **Physical Therapy** Office location: $40 copay Outpatient hospital: $50 copay • **Occupational Therapy** Office location: $40 copay Outpatient hospital: $45 copay • **Speech Therapy** Office location: $40 copay Outpatient hospital: $50 copay
Ambulance Services You pay $0 for facility-to-facility transfers via ground ambulance. Prior authorization may be required for non-emergency transportation.	• **Ground Ambulance:** $295 copay per one-way trip • **Air Ambulance:** 20% 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.

In-network

- **Allergy Serum:** $0 copay
- **Generic Medications Used in a Nebulizer:** $0 copay
- **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 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
$590 for Tiers 3-5 only
If you receive "Extra Help" from Medicare, your deductible is $0.

The deductible does not apply to covered Part D insulins and most adult Part D vaccines.

Initial Coverage Stage
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** $5 per prescription • **Tier 3: Preferred Brand** 25% of the total cost • **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. 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** $12.50 per prescription • **Tier 3: Preferred Brand** 25% of the total cost • **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.

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. For excluded drugs covered under our enhanced benefit, you will pay a $5 copay for a 30-day supply.

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 for a 30-day supply of Medicare Part B-covered insulins (when you use insulin via a pump).

Erectile Dysfunction (ED) Drugs	Sildenafil (generic Viagra) is covered at a Tier 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information). You are covered for up to 6 tablets per month. There is a maximum of 72 tablets per year.
Other Covered Drugs	You are covered for the following additional items at a Tier 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information): • Vitamin D (ergocalciferol) 50,000 unit capsules • B12 injection (cyanocobalamin) 1,000 mcg/ml
Part D Vaccines	Our plan covers most Part D vaccines at $0 cost-share, including shingles, tetanus, and whooping cough vaccines, even if you haven't paid your deductible. See your plan's list of covered drugs (formulary) for a full list.
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.

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: $40 copay	**Medicare-Covered Foot Care:** $40 copay
Home Health Care Prior authorization may be required. Home Health Care is limited to Medicare-covered services.	**In-network**	**Out-of-network**
	$0 copay	40% coinsurance

Durable Medical Equipment (DME) Prior authorization may be required.	**In-network** • **Basic Medicare-Covered DME Products:** 20% coinsurance for crutches, 20% coinsurance all other • **Advanced Medicare-Covered DME Products:** 20% coinsurance	**Out-of-network** • **Basic Medicare-Covered DME Products:** 20% coinsurance crutches, 20% coinsurance all other • **Advanced Medicare-Covered DME Products:** 20% coinsurance
Prosthetic Devices and Medical Supplies Prior authorization may be required.	**In-network** • **Prosthetic Devices and Related Supplies:** 20% coinsurance • **Medical Supplies:** 20% coinsurance	**Out-of-network** • **Prosthetic Devices and Related Supplies:** 20% coinsurance • **Medical Supplies:** 20% coinsurance
Diabetes Monitoring Supplies 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:** 20% coinsurance • **Diabetic Supplies (such as test strips and lancets - OneTouch):** $0 copay	**Out-of-network** • **Freestyle Libre CGM:** $0 copay • **Non-Preferred Brand CGM:** 20% coinsurance • **Diabetic Supplies (such as test strips and lancets - OneTouch):** 20% coinsurance

Diabetic Shoes and Therapeutic Inserts Prior authorization may be required.	**In-network** $0 copay	**Out-of-network** 20% coinsurance
Chiropractic Care Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation.	**In-network** **Medicare-Covered Chiropractic Services:** $20 copay	**Out-of-network** **Medicare-Covered Chiropractic Services:** $20 copay
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 (Special Supplemental Benefit for the Chronically Ill)	$77 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. The Food & Home Card is a special supplemental benefit available only to qualifying members with eligible chronic health conditions, like diabetes, high blood pressure, high cholesterol, heart problems, and stroke. We'll work with you to determine if you qualify for the benefit.

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.

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 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.

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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