Devoted HEALTH PLANS

2026

# Summary of Benefits

## DEVOTED DUAL CHOICE 004 MS (PPO D-SNP) Plan

PBP Number: H7355-004-000

PPO D-SNP

**DEVOTED DUAL CHOICE 004 MS (PPO D-SNP)**

# Summary of Benefits

This Summary of Benefits tells you about our DEVOTED DUAL CHOICE 004 MS (PPO D-SNP) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2026 plan year, which starts on January 1, 2026 and ends on December 31, 2026.

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 DUAL CHOICE 004 MS (PPO D-SNP) is a Dual Eligible Special Needs plan, or PPO D-SNP plan. To join DEVOTED DUAL CHOICE 004 MS (PPO D-SNP), you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must also receive assistance from the Mississippi Medicaid program as either a Qualified Medicare Beneficiary (QMB or QMB+), Specified Low-Income Medicare Beneficiary (SLMB+ or SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individual (QDWI), or Full Benefit Dual Eligible (FBDE). You must also live in our service area, which includes **these counties: Benton, Copiah, DeSoto, Greene, Hancock, Harrison, Hinds, Holmes, Issaquena, Leake, Madison, Marshall, Panola, Pearl River, Perry, Rankin, Scott, Sharkey, Stone, Tate, Tippah, Tunica, Warren, and Yazoo.**
If you have any questions about your Medicaid eligibility or level of assistance, please contact us or your Mississippi 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.

**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 cost share for services received by non-contracted providers.

**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.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may vary. If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (FBDE,**

**SLMB+, QMB+, QMB), you may pay $0 for your Medicare-covered services, as noted in this chart.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share.

# 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, or 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, 2027.
- ☐ 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 a qualifying level of 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.

## Monthly Premium, Deductible, and Limits

| | | |
|---|---|---|
| **Monthly Premium** | $0 to $23.80<br>You must continue to pay your Part B premium, if applicable.<br>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** | This plan does not have a medical deductible. | |
| **Pharmacy (Part D) Deductible** | $615 for Tiers 1-5 only<br>If you receive Extra Help from Medicare, your deductible is $0.<br>The deductible doesn't apply to Tier 6, covered insulin products, and most adult Part D vaccines. | |
| | **In-network** | **In- and out-of-network** |
| **Maximum Out-of-Pocket Responsibility**<br>Benefits that don't count toward your maximum out-of-pocket responsibility are indicated with an asterisk (*).<br>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. | $5,400<br>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. | $8,950<br>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. |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Covered Medical and Hospital Benefits

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Inpatient Hospital Coverage†** | In-network:<br>$0 copay per stay<br><br>Out-of-network:<br>$0<br>or<br>**Days 1 - 9**<br>$275 copay per day<br>**Day 10+**<br>$0 copay per day | In-network:<br>**Days 1 - 9**<br>$275 copay per day<br>**Day 10+**<br>$0 copay per day<br><br>Out-of-network:<br>**Days 1 - 9**<br>$275 copay per day<br>**Day 10+**<br>$0 copay per day |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Outpatient Hospital Coverage†** | In-network:<br><br>**Diagnostic Colonoscopies:** $0 copay<br><br>**Outpatient Surgery and Procedures:**<br><br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Observation Stays:** $0 copay per stay<br><br>Out-of-network:<br><br>**Diagnostic Colonoscopies:** $0 copay<br><br>**Outpatient Surgery and Procedures:**<br><br>• Outpatient Hospital: $0 - $375 copay<br>• Ambulatory Surgical Center (ASC): $0 - $275 copay<br><br>**Observation Stays:** $0 - $275 copay per stay | In-network:<br><br>**Diagnostic Colonoscopies:** $0 copay<br><br>**Outpatient Surgery and Procedures:**<br><br>• Outpatient Hospital: $375 copay<br>• Ambulatory Surgical Center (ASC): $275 copay<br><br>**Observation Stays:** $275 copay per stay<br><br>Out-of-network:<br><br>**Diagnostic Colonoscopies:** $0 copay<br><br>**Outpatient Surgery and Procedures:**<br><br>• Outpatient Hospital: $375 copay<br>• Ambulatory Surgical Center (ASC): $275 copay<br><br>**Observation Stays:** $275 copay per stay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Doctor Visits**<br>You do not need a referral to see a specialist. For telehealth services, you pay the same in- or out-of-network cost share that you would pay for an in-person office visit. | In-network:<br>**Primary Care Provider (PCP):** $0 copay<br>**Specialist:** $0 copay<br>Out-of-network:<br>**Primary Care Provider (PCP):** $0 copay<br>**Specialist:** $0 - $35 copay | In-network:<br>**Primary Care Provider (PCP):** $0 copay<br>**Specialist:** $35 copay<br>Out-of-network:<br>**Primary Care Provider (PCP):** $0 copay<br>**Specialist:** $35 copay |
| **Preventive Care**<br>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. | 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, and COVID shots). | |
| | **With Medicaid cost share assistance** | **Without Medicaid cost share assistance** |
| **Emergency Care**<br>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. This plan also covers emergency services worldwide as a supplemental benefit. | $0 copay per stay | $130 copay per stay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | In-network:<br><br>**PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $0 copay<br><br>Out-of-network:<br><br>**PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $0 - $45 copay | In-network:<br><br>**PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $45 copay<br><br>Out-of-network:<br><br>**PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $45 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Outpatient Care and Services

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging**† Cost share varies based upon location and the type of service being performed. | In-network:<br>• **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $0 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $0 copay Outpatient hospital: $0 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $0 copay Outpatient Hospital: $0 copay<br>• **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 copay Outpatient hospital: $0 copay<br>• **Radiation Therapy** Office or freestanding location: $0 copay Outpatient hospital: $0 copay<br><br>Out-of-network:<br>• **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $0 - $20 copay | • In-network:<br>**Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $20 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $0 - $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 - $200 copay Outpatient Hospital: $200 - $300 copay<br>• **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - $40 copay Outpatient hospital: $95 copay<br>• **Radiation Therapy** Office or freestanding location: 20% coinsurance Outpatient hospital: 20% coinsurance<br><br>Out-of-network:<br>• **Lab Services** Office or freestanding location: $0 copay Outpatient hospital: $20 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

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

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Hearing Services

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Hearing Care**<br>You are covered for a total of 1 routine hearing exam from in- or out-of-network providers. | In-network<br><br>**Routine Hearing Exam*:** $0 copay — 1 visit per year<br><br>**Hearing Aid Fitting and Evaluation*:** $0 copay<br><br>**Medicare-Covered Hearing Care:** $0 copay<br><br>Out-of-network:<br><br>**Routine Hearing Exam*:** $0 copay — 1 visit per year<br><br>**Hearing Aid Fitting and Evaluation*:** $0 copay<br><br>**Medicare-Covered Hearing Care:** $0 - $35 copay | In-network<br><br>**Routine Hearing Exam*:** $0 copay — 1 visit per year<br><br>**Hearing Aid Fitting and Evaluation*:** $0 copay<br><br>**Medicare-Covered Hearing Care:** $35 copay<br><br>Out-of-network:<br><br>**Routine Hearing Exams*:** $0 copay — 1 visit per year<br><br>**Hearing Aid Fitting and Evaluation*:** $0 copay<br><br>**Medicare-Covered Hearing Care:** $35 copay |
| **Hearing Aids***<br>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 or $699 copay per aid<br><br>Hearing aid purchase includes:<br>• First year of follow-up provider visits<br>• 60-day trial period<br>• 3-year extended warranty<br>• 80 batteries per aid for non-rechargeable models | |

## Dental Services†

Devoted Health will pay as much as **$2,000** per year for covered dental services. You pay $0 towards all covered dental services. If you receive dental services from an out-of-network dentist, you will be responsible for paying the difference between the rate we pay the dentist and the rate your dental provider charges, even for services listed as $0. This means you will pay any additional costs above this amount.

Covered dental services include, but are not limited to: periodic oral exams, dental evaluations, cleanings, x-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. See your Evidence of Coverage for more information.

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Vision Services

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Routine Vision*** You are covered for a total of 1 routine eye exam per year from in- or out-of-network providers. | **Routine Eye Exam:** $0 copay — 1 visit per year | **Routine Eye Exam:** $0 copay — 1 visit per year |
| **Eyewear** | Up to **$375** each year for eyeglasses and/or contacts<br><br>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. | |
| | **With Medicaid cost share assistance** | **Without Medicaid cost share assistance** |
| **Medicare-Covered Vision Care** | In-network:<br><br>**Medicare-Covered Diagnostic Eye Exam:** $0 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay<br><br>Out-of-network:<br><br>**Medicare-Covered Diagnostic Eye Exam:** $0 - $35 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | In-network:<br><br>**Medicare-Covered Diagnostic Eye Exam:** $35 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay<br><br>Out-of-network:<br><br>**Medicare-Covered Diagnostic Eye Exam:** $35 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Additional Outpatient Care and Services

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Mental Health Services**† | In-network:<br><br>**Inpatient Mental Health Care:** $0 copay per stay<br><br>**Outpatient Mental Health Care (individual and group):** $0 copay<br><br>**Outpatient Psychiatric Services (individual and group):** $0 copay<br><br>Out-of-network:<br><br>**Inpatient Mental Health Care:**<br>$0 or **Days 1 - 8**<br>$275 copay per day<br>**Days 9 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Care (individual and group):** $0 - $35 copay<br><br>**Outpatient Psychiatric Services (individual and group):** $0 - $35 copay | In-network:<br><br>**Inpatient Mental Health Care: Days 1 - 8**<br>$275 copay per day<br>**Days 9 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Care (individual and group):** $35 copay<br><br>**Outpatient Psychiatric Services (individual and group):** $35 copay<br><br>Out-of-network:<br><br>**Inpatient Mental Health Care: Days 1 - 8**<br>$275 copay per day<br>**Days 9 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Care (individual and group):** $35 copay<br><br>**Outpatient Psychiatric Services (individual and group):** $35 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Skilled Nursing Facility (SNF)**† No prior hospital stay required. | In-network:<br>$0 copay per stay<br><br>Out-of-network:<br>$0<br><br>or<br><br>**Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$218 copay per day | In-network:<br><br>**Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$218 copay per day<br><br>Out-of-Network:<br><br>**Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$218 copay per day |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**† Cost share may vary based upon location. Cost share for re-evaluations may differ. | In-network:<br>• **Physical Therapy:** Office location: $0 copay Outpatient hospital: $0 copay<br>• **Occupational Therapy:** Office location: $0 copay Outpatient hospital: $0 copay<br>• **Speech Therapy:** Office location: $0 copay Outpatient hospital: $0 copay<br><br>Out-of-network:<br>• **Physical Therapy** Office location: $0 - $35 copay Outpatient hospital: $0 - $50 copay<br>• **Occupational Therapy** Office location: $0 - $35 copay Outpatient hospital: $0 - $50 copay<br>• **Speech Therapy** Office location: $0 - $35 copay Outpatient hospital: $0 - $50 copay | In-network:<br>• **Physical Therapy** Office location: $35 copay Outpatient hospital: $50 copay<br>• **Occupational Therapy** Office location: $35 copay Outpatient hospital: $50 copay<br>• **Speech Therapy** Office location: $35 copay Outpatient hospital: $50 copay<br><br>Out-of-network:<br>• **Physical Therapy** Office location: $35 copay Outpatient hospital: $50 copay<br>• **Occupational Therapy** Office location: $35 copay Outpatient hospital: $50 copay<br>• **Speech Therapy** Office location: $35 copay Outpatient hospital: $50 copay |

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Ambulance Services**† | **Ground Ambulance:** $0 copay per one-way trip<br><br>**Air Ambulance:** $0 copay per one-way trip | **Ground Ambulance:** $315 copay per one-way trip<br><br>**Air Ambulance:** 20% coinsurance per one-way trip |
| **Transportation** | Not covered | |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Prescription Drug Benefits

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Medicare Part B Drugs**† Part B drugs are usually given in a doctor's office or an outpatient setting as part of a medical service. Step Therapy may be required. | In-network:<br>**Chemotherapy Drugs:** $0 copay<br>**Other Part B Drugs:** $0 copay<br>Out-of-network:<br>**Chemotherapy Drugs:** $0 - 20% coinsurance<br>**Other Part B Drugs:** $0 - 20% coinsurance | In-network:<br>**Chemotherapy Drugs:** 20% coinsurance<br>**Other Part B Drugs:** 20% coinsurance<br>Out-of-network:<br>**Chemotherapy Drugs:** 20% coinsurance<br>**Other Part B Drugs:** 20% coinsurance |
| **Prescription Drugs**<br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>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.<br>If you do not receive Extra Help, you will be responsible for up to a $615 deductible for Part D drugs on Tiers 1-5.<br>The deductible doesn't apply to Tier 6.<br>**Initial Coverage Stage**<br>If you receive Extra Help, you will never pay more than $12.65 per prescription for covered Part D drugs. Your copays may be less based on your level of Extra Help. If you do not receive Extra Help, you pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,100. | |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | 25% of the total cost | 25% of the total cost |
| **Tier 2:** Generic | 25% of the total cost | 25% of the total cost |
| **Tier 3:** Preferred Brand | 25% of the total cost | 25% of the total cost |
| **Tier 4:** Non-Preferred Drugs | 25% of the total cost | 25% of the total cost |
| **Tier 5:** Specialty | 25% of the total cost | Not available through mail |
| **Tier 6:** Select Care Drugs | $0 per prescription | $0 per prescription |

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 $2,100. For excluded drugs covered under our enhanced benefit, you will pay a $0 copay for a 30-day supply.

## Additional Part D Benefit Information

**Insulin Coverage**

You will 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).

**Other Covered Drugs**

You are covered for the following additional items at a Tier 6 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
- Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## Additional Benefits

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Dialysis** | In-network:<br>$0 copay<br><br>Out-of-network:<br>$0 - 20% coinsurance | In-network:<br>20% coinsurance<br><br>Out-of-network:<br>20% coinsurance |

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Foot Care (Podiatry Services)** | In-network:<br><br>**Medicare-Covered Foot Care:** $0 copay<br><br>Out-of-network:<br><br>**Medicare-Covered Foot Care:** $0 - $35 copay | In-network:<br>**Medicare-Covered Foot Care:** $35 copay<br><br>Out-of-network:<br>**Medicare-Covered Foot Care:** $35 copay |

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | In-network:<br>$0 copay<br><br>Out-of-network:<br>$0 copay | In-network:<br>$0 copay<br><br>Out-of-network:<br>$0 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Durable Medical Equipment (DME)†**<br>See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | In-network:<br>• **Basic Medicare-Covered DME Products:** $0 copay for crutches, $0 copay all other<br>• **Advanced Medicare-Covered DME Products:** $0 copay<br>Out-of-network:<br>• **Basic Medicare-Covered DME Products:** $0 - 20% coinsurance for crutches, $0 - 20% coinsurance all other<br>• **Advanced Medicare-Covered DME Products:** $0 - 30% coinsurance | In-network:<br>• **Basic Medicare-covered DME Products:** 20% coinsurance for crutches, 20% coinsurance all other<br>• **Advanced Medicare-covered DME Products:** 30% coinsurance<br>Out-of-network:<br>• **Basic Medicare-covered DME Products:** 20% coinsurance for crutches, 20% coinsurance all other<br>• **Advanced Medicare-covered DME Products:** 30% coinsurance |
| **Prosthetic Devices and Medical Supplies†** | In-network:<br>**Prosthetic Devices and Related Supplies:** $0 copay<br>**Medical Supplies:** $0 copay<br>Out-of-network:<br>**Prosthetic Devices and Related Supplies:** $0 - 40% coinsurance<br>**Medical Supplies:** $0 - 20% coinsurance | In-network:<br>**Prosthetic Devices and Related Supplies:** 20% coinsurance<br>**Medical Supplies:** 20% coinsurance<br>Out-of-network:<br>**Prosthetic Devices and Related Supplies:** 40% coinsurance<br>**Medical Supplies:** 20% coinsurance |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Diabetes Monitoring Supplies**† For additional details about glucose monitors, see your Evidence of Coverage (EOC). | In-network:<br><br>**Continuous Glucose Monitors (CGMs):** $0 - 30% coinsurance<br><br>**Diabetic Supplies (such as test strips and lancets - Accu-chek):** $0 copay<br><br>Out-of-network:<br><br>**Continuous Glucose Monitors (CGMs):** $0 - 30% coinsurance<br><br>**Diabetic Supplies (such as test strips and lancets):** $0 copay<br><br>Our preferred brand is Accu-Chek. | In-network:<br><br>**Continuous Glucose Monitors (CGMs):** $0 - 30% coinsurance<br><br>**Diabetic Supplies (such as test strips and lancets - Accu-chek):** $0 copay<br><br>Out-of-network:<br><br>**Continuous Glucose Monitors (CGMs):** $0 - 30% coinsurance<br><br>**Diabetic Supplies (such as test strips and lancets):** $0 copay<br><br>Our preferred brand is Accu-Chek. |

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts**† | In-network: $0 copay<br><br>Out-of-network: $0 copay | In-network: $0 copay<br><br>Out-of-network: $0 copay |

| | With Medicaid cost share assistance | Without Medicaid cost share assistance |
|---|---|---|
| **Chiropractic Care** Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | In-network:<br>**Medicare-Covered Chiropractic Services:** $0 copay<br><br>Out-of-network:<br>**Medicare-Covered Chiropractic Services:** $0 - $15 copay | In-network:<br><br>**Medicare-Covered Chiropractic Services:** $15 copay<br><br>Out-of-network:<br><br>**Medicare-Covered Chiropractic Services:** $15 copay |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Over-the-Counter Items (OTC)** | **$50 per quarter** to use toward the purchase of eligible over-the-counter (OTC) items. For complete details, see your Evidence of Coverage (EOC) booklet. |
| **Food & Home Card (Special Supplemental Benefit for the Chronically Ill)** | **$115 per month** to use toward the purchase of eligible food, to pay for utility costs, and/or to pay rent or mortgage costs. Devoted Health will determine your eligibility for this benefit. For complete details, see your Evidence of Coverage (EOC) booklet.<br><br>The Food & Home Card is a special supplemental benefit offered on certain plans and available only to chronically ill members with conditions like diabetes, high blood pressure, high cholesterol, heart problems, and stroke. All applicable plan coverage criteria must be met, and other conditions are eligible. Not all members qualify. |
| **Fitness** | **SilverSneakers®:** $0 membership<br><br>**Devoted Health Wellness Bucks:** $150 per year toward fitness and wellness-related items and activities, including wearable devices, home exercise equipment, fitness classes, weight-loss programs, memory fitness activities, and mindfulness apps. |
| **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 www.devoted.com/devoted-dollars. |

*Costs for these services do not count toward your yearly maximum out-of-pocket responsibility.
†Prior authorization may be required for in-network services.

# 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 Mississippi Division of Medicaid (DOM) at 1-800-421-2408 (TTY: 1-228-206-6062) or visit medicaid.ms.gov.

- Dental
  - General dentistry
  - Oral surgery
  - Orthodontia
- Durable Medical Equipment
  - Durable Medical Equipment (DME)
  - Medical supplies
  - Orthotics/Prosthetics
- Hospital Care
  - 23 hour observation
  - Emergency room services
  - Inpatient care
  - Organ Transplants
  - Outpatient care
- Mental Health
  - Inpatient psychiatric care
  - Outpatient hospital mental health service
  - Psychiatric residential treatment facilities
  - Therapeutic and evaluative mental health services
- Places of Service
  - Ambulatory Surgical Center (ASC)
  - Community homes for individuals with intellectual disabilities
  - Emergency room
  - Federally Qualified Health Center (FQHC)
  - Hospital inpatient and outpatient
  - Indian health
  - Intermediate care facilities for individuals with intellectual disabilities

    - Mississippi Department of Health
    - Nursing facilities
    - Office visits – Physician/Physician Assistant/Nurse Practitioner/Registered Nurse
    - Rural Health Clinics (RHC)
    - Swing bed
- Professional Medical Services
    - Chiropractic
    - Dialysis
    - Expanded Mississippi Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
    - Laboratory
    - Occupational therapy
    - Physical therapy
    - Physician administered drugs and devices
    - Physician/Nurse Practitioner/Registered Nurse office visits
    - Podiatry
    - Private duty nursing
    - Radiology and advanced imaging
    - Speech therapy
- Transportation
    - Air transportation
    - Emergency Transportation
    - Non-Emergency Medical Transportation (NET)
- Wellness
    - Adult wellness screenings
    - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) wellness screenings
    - Lead screening
    - Vaccines for children
- Other Services
    - Family planning
    - Hearing services and hearing aids
    - Home health
    - Hospice
    - Long term care services
    - Prescription drugs
    - School based administrative claims program
    - School health related services program
    - Vaccines and vaccines for children program
    - Vision and eyeglasses

# Notes

# 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.

## 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 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, you can file a grievance with:

Civil Rights Coordinator
Devoted Health % Appeals & Grievances
P.O. 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, the Civil 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/smartscreen/main.jsf**, or by mail, phone, or email at:

Centralized Case Management Operations
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)
Email: OCRComplaint@hhs.gov

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**.
This notice is also available on 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 ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમા ંમાહતિી પૂરી પાડવા માટેની સવે ાઓ પણ વનિા મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા 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।

Have questions? Call us.

**1-800-385-0916** TTY 711

Are you a Devoted Health member? Call:

**1-800-338-6833** TTY 711

or text:

**866-85**

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.

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. **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. SilverSneakers is a registered trademark of Tivity Health, Inc. 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. H7355_26S5_M