Devoted HEALTH PLANS

2026

Summary of Benefits

DEVOTED DUAL FULL 026 PA (HMO D-SNP) Plan

PBP Number: H6852-026-000

HMO D-SNP

Summary of Benefits

This Summary of Benefits tells you about our DEVOTED DUAL FULL 026 PA (HMO 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 FULL 026 PA (HMO D-SNP) is a Dual Eligible Special Needs plan, or HMO D-SNP plan. To join DEVOTED DUAL FULL 026 PA (HMO D-SNP), you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must also receive assistance from the Pennsylvania Medicaid program as either a Qualified Medicare Beneficiary (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: Bucks, Chester, Delaware, Montgomery, and Philadelphia.**
If you have any questions about your Medicaid eligibility or level of assistance, please contact us or your Pennsylvania 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.

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+), 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.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the Devoted Health network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the Devoted Health network. If the pharmacy is not listed, you 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.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- [ ] 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.

Monthly Premium, Deductible, and Limits

Monthly Premium	$0 to $19.50 You must continue to pay your Part B premium, if applicable. 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	$0 to $840 If you receive cost-sharing assistance under Medicaid, you are not responsible for paying your plan's medical deductible; it is paid by your state Medicaid program. If your category of Medicaid eligibility changes, you may be responsible for a $840 deductible for your covered medical services. The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services.
Pharmacy (Part D) Deductible	$615 for Tiers 1-5 only If you receive Extra Help from Medicare, your deductible is $0. The deductible doesn't apply to Tier 6, covered insulin products, 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 (*). 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.	$9,250 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.

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

Covered Medical and Hospital Benefits

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Inpatient Hospital Coverage† A Medicaid copay of $3 for each day you are in a hospital, up to $21 for one hospital stay, may apply.	$0 copay per stay	$2,230 copay per stay
Outpatient Hospital Coverage† A Medicaid copay of up to $3.80 may apply.	**Diagnostic Colonoscopies:** $0 copay **Outpatient Surgery and Procedures:** • Outpatient Hospital: $0 copay • Ambulatory Surgical Center (ASC): $0 copay **Observation Stays:** $0 copay	**Diagnostic Colonoscopies:** $0 copay **Outpatient Surgery and Procedures:** • Outpatient Hospital: 50% coinsurance • Ambulatory Surgical Center (ASC): 50% coinsurance **Observation Stays:** 50% coinsurance
Doctor Visits 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. A Medicaid copay of $3.80 may apply for specialist visits.	**Primary Care Provider (PCP):** $0 copay **Specialist:** $0 copay	**Primary Care Provider (PCP):** $0 copay **Specialist:** 30% coinsurance

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

Preventive Care 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 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. A Medicaid copay of up to $3.80 may apply if the visit is determined not to be an emergency. This plan also covers emergency services worldwide as a supplemental benefit.	$0 copay per stay	$115 copay per stay
	With Medicaid cost share assistance	**Without Medicaid cost share assistance**
Urgently Needed Services in the United States and its Territories A Medicaid copay of up to $3.80 may apply for non-PCP urgent care services.	**PCP office:** $0 copay **Urgent Care Center or Retail Walk-in Center:** $0 copay	**PCP office:** $0 copay **Urgent Care Center or Retail Walk-in Center:** 30% coinsurance

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

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. A Medicaid copay of $1.00 may apply for diagnostic radiology, nuclear medicine, radiation therapy, and medical diagnostic services.	• **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	• **Lab Services** Office or freestanding location: 50% coinsurance Outpatient hospital: 50% coinsurance • **Outpatient X-rays and Ultrasounds** Office or freestanding location: 30% coinsurance Outpatient hospital: 30% coinsurance • **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: 50% coinsurance Outpatient Hospital: 50% coinsurance • **Diagnostic Tests and Procedures (such as a stress test, etc.)** Office or freestanding location: $0 - 50% coinsurance Outpatient hospital: 50% coinsurance • **Radiation Therapy** Office or freestanding location: 20% coinsurance Outpatient hospital: 20% coinsurance

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

Hearing Services

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Hearing Care A Medicaid copay of up to $3.80 may apply for Medicare-Covered Hearing Care.	**Routine Hearing Exam*:** $0 copay — 1 visit per year **Hearing Aid Fitting and Evaluation*:** $0 copay **Medicare-Covered Hearing Care:** $0 copay	**Routine Hearing Exam*:** $0 copay — 1 visit per year **Hearing Aid Fitting and Evaluation*:** $0 copay **Medicare-Covered Hearing Care:** 50% coinsurance
Hearing Aids* Benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options.	$0 copay or $299 copay per aid 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 Services†

Devoted Health will pay as much as **$2,000** per year for covered dental services. You pay $0 towards all covered dental services. You must receive services from a participating dental provider. 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.

Vision Services

Routine Vision*	**Routine Eye Exam:** $0 copay — 1 visit per year
Eyewear You must use our designated vendor for this benefit.	Up to **$400** each year for eyeglasses and/or contacts

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

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Medicare-Covered Vision Care A Medicaid copay of up to $3.80 may apply for diagnostic eye exams.	**Medicare-Covered Diagnostic Eye Exam:** $0 copay **Diabetic Retinopathy Exam:** $0 copay	**Medicare-Covered Diagnostic Eye Exam:** 50% coinsurance **Diabetic Retinopathy Exam:** $0 copay

Additional Outpatient Care and Services

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Mental Health Services† For inpatient stays, a Medicaid copay of $3 for each day you are in a hospital, up to $21 for one hospital stay, may apply. For outpatient care, a Medicaid copay of $0.50 may apply per unit of outpatient psychotherapy service.	**Inpatient Mental Health Care:** $0 copay per stay **Outpatient Mental Health Services (individual and group):** $0 copay **Outpatient Psychiatric Services (individual and group):** $0 copay	**Inpatient Mental Health Care:** $2,080 copay per stay **Outpatient Mental Health Services (individual and group):** 30% coinsurance **Outpatient Psychiatric Services (individual and group):** 30% coinsurance

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Skilled Nursing Facility (SNF)† No prior hospital stay required. A Medicaid copay of up to $3.80 may apply.	$0 copay per stay	**Days 1 - 20** $0 copay per day **Days 21 - 100** $218 copay per day

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

	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. A Medicaid copay of up to $3.80 may apply.	• **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	• **Physical Therapy** Office location: 30% coinsurance Outpatient hospital: 30% coinsurance • **Occupational Therapy** Office location: 30% coinsurance Outpatient hospital: 30% coinsurance • **Speech Therapy** Office location: 30% coinsurance Outpatient hospital: 30% coinsurance

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Ambulance Services† A Medicaid copay of up to $3.80 may apply.	**Ground Ambulance:** $0 copay per one-way trip **Air Ambulance:** $0 copay per one-way trip	**Ground Ambulance:** 50% coinsurance per one-way trip **Air Ambulance:** 50% 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.

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. A Medicaid copay of $3.00 for brand prescriptions or $1.00 for generic prescriptions may apply. Drugs, including immunizations, dispensed by a physician or CRNP in the following categories are excluded from Medicaid copays: Anticonvulsants, Antidiabetic agents, Antiglaucoma agents, Antihypertensive agents, Antieoplastic agents, Antiparkinson drugs, Cardiovascular preparations, Family planning drugs, HIV/AIDS, Naloxone, and Antipsychotic agents, except those that are also Schedule C-IV antianxiety agents.	**Chemotherapy Drugs:** $0 copay **Other Part B Drugs:** $0 copay	**Chemotherapy Drugs**: 20% coinsurance **Other Part B Drugs:** 20% coinsurance

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

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 $615 deductible for Part D drugs on Tiers 1-5.

The deductible doesn't apply to Tier 6.

Initial Coverage Stage
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.

	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.

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

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

Additional Benefits

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Dialysis	$0 copay	20% coinsurance

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Foot Care (Podiatry Services) A Medicaid copay of up to $3.80 may apply.	**Medicare-Covered Foot Care:** $0 copay	**Medicare-Covered Foot Care:** 30% coinsurance

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Home Health Care† Home Health Care is limited to Medicare-covered services.	$0 copay	$0 copay

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

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Durable Medical Equipment (DME)† See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. A Medicaid copay of up to $3.80 may apply for non-rented DME.	**Basic Medicare-Covered DME Products:** $0 copay for crutches, $0 copay all other **Advanced Medicare-Covered DME Products:** $0 copay	**Basic Medicare-Covered DME Products:** 20% coinsurance for crutches, 20% coinsurance all other **Advanced Medicare-Covered DME Products:** 20% coinsurance

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Prosthetic Devices and Medical Supplies† A Medicaid copay of up to $3.80 may apply for prosthetic devices and related supplies and for non-ostomy medical supplies.	**Prosthetic Devices and Related Supplies:** $0 copay **Medical Supplies:** $0 copay	**Prosthetic Devices and Related Supplies:** 20% coinsurance **Medical Supplies:** 20% coinsurance

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

	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). A Medicaid copay of up to $3.80 may apply.	**Freestyle Libre and Dexcom Continuous Glucose Monitors (CGMs):** $0 copay when obtained at a retail pharmacy; $0 copay when obtained through a Durable Medical Equipment provider. **Non-Preferred Continuous Glucose Monitors (CGMs):** $0 copay when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy. **Diabetic Supplies (such as test strips and lancets):** $0 copay Our preferred brand is Accu-Chek.	**Freestyle Libre and Dexcom Continuous Glucose Monitors (CGMs):** 20% coinsurance when obtained at a retail pharmacy; 20% coinsurance when obtained through a Durable Medical Equipment provider. **Non-Preferred Continuous Glucose Monitors (CGMs):** 20% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy. **Diabetic Supplies (such as test strips and lancets):** 20% coinsurance Our preferred brand is Accu-Chek.

	With Medicaid cost share assistance	Without Medicaid cost share assistance
Diabetic Shoes and Therapeutic Inserts† A Medicaid copay of up to $3.80 may apply.	$0 copay	20% coinsurance

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

	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. A Medicaid copay of up to $3.80 may apply.	**Medicare-Covered Chiropractic Services:** $0 copay	**Medicare-Covered Chiropractic Services:** 30% coinsurance

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)	**$350 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. 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 **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.

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. 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.

Have questions? For more information about Medicaid eligibility and Medicaid benefits, call Pennsylvania Department of Human Services (Medicaid) at 1-800-692-7462 / 1-866-550-4355 (TTY: 1-800-451-5886).

Pennsylvania Medicaid State Plan Benefits - Adult Benefit Package

- *Where no limitations are noted, no limitations apply.*
- *All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.*
- *Children's benefit plan will include all medically necessary services without limitation.*

Category 1: Ambulatory Services

- Primary Care Provider
- Physician Services and Medical and Surgical Services provided by a Dentist
- Certified Registered Nurse Practitioner
- Federally Qualified Health Center/Rural Health Clinic
    - *Limitations:* No limits except for Dental Care Services as described below
- Independent Clinic
- Outpatient Hospital Clinic
- Podiatrist Services
- Chiropractor Services
- Optometrist Services
    - *Limitations:* 2 visits (exams) per calendar year
- Hospice Care
    - *Key Limitations:* Respite care may not exceed a total of 5 consecutive days in a 60-day certification period
- Radiology (for example: X-Rays, MRIs, and CTs)
- Dental Care Services, including diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation
    - *Key Limitations:*
        - Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime
        - Denture relines - either full or partial, limited to 1 arch every 2 calendar years
        - Oral exams - 1 per 180 days
        - Dental prophylaxis - 1 per 180 days
        - Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years

        - Crowns, Periodontics and Endodontics only via approved benefit limit exception
- Outpatient Hospital Short Procedure Unit (SPU)
- Outpatient Ambulatory Surgical Center (ASC)
- Non-Emergency Medical Transport
    - *Limitations:* Only to and from Medicaid covered services
- Family Planning Clinic, Services and Supplies
- Renal Dialysis
    - *Limitations:* Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility are limited to no more than 75 per calendar year.

Category 2: Emergency Services

- Emergency Room
- Ambulance

Category 3: Hospitalization

- Inpatient Acute Hospital
- Inpatient Rehab Hospital
- Inpatient Psychiatric Hospital
- Inpatient Drug & Alcohol

Category 4: Maternity and Newborn

- Maternity – Physician, Certified Nurse Midwives, Birth Centers

Category 5: Mental Health and Substance Abuse (Behavioral Health)

- Outpatient Psychiatric Clinic
- Mobile Mental Health Treatment
- Outpatient Drug and Alcohol Treatment
- Methadone Maintenance
- Clozapine
- Psychiatric Partial Hospital
- Peer Support
- Crisis
- Targeted Case Management – other than Behavioral Health
    - *Limitations:* Limited to individuals identified in the target group (No limits)
- Targeted Case Management – Behavioral Health Only
    - *Limitations:* Limited to individuals with Serious Mental Illness (SMI) only (No limits)

Category 6: Prescription Drugs

- Prescription Drugs
- Nutritional Supplements

Category 7: Rehabilitation and Habilitation Services and Devices

- Nursing Facility
    - *Limitations:* 365 days per calendar year
- Home Health Care (includes nursing, aide and therapy services)
    - *Limitations:* Unlimited for first 28 days; limited to 15 days every month thereafter

- ICF/IID and ICF/ORC
    - *Limitations:* Requires an institutional level of care (No limits)
- Durable Medical Equipment
- Prosthetics and Orthotics
    - *Limitations:*
        - Orthopedic Shoes and Hearing Aids are not covered
        - Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications
        - Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint
        - Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years
        - Coverage for an eye ocular is limited to 1 per calendar year
- Eyeglass Lenses
    - *Limitations:* Limited to individuals diagnosed with aphakia - 4 lenses per calendar year
- Eyeglass Frames
    - *Limitations:* Limited to individuals diagnosed with aphakia - 2 frames per calendar year. Deluxe frames not included.
- Contact Lenses
    - *Limitations:* Limited to individuals diagnosed with aphakia - 4 lenses per calendar year
- Medical Supplies
- Therapy (physical, occupational, speech) – Rehabilitative
    - *Limitations:* Only when provided by a hospital, outpatient clinic, or home health provider
- Therapy (physical, occupational, speech) – Habilitative
    - *Limitations:* Only when provided by a hospital, outpatient clinic, or home health provider

Category 8: Laboratory Services

- Laboratory

Category 9: Preventative/Wellness Services and Chronic Care

- Tobacco Cessation
    - *Limitations:* 70, 15-minute units per calendar year
- For a full listing of preventative services beyond tobacco cessation, please contact your MCO.

Pennsylvania Medicaid Home and Community-Based Services (HCBS)

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third-party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

- Adult Daily Living Services
- Assistive Technology
- Behavior Therapy
- Benefits Counseling
- Career Assessment
- Chore Services
- Cognitive Rehabilitation Therapy

- Community Integration
    - *Limitations:* Each distinct goal may not be more than 26 weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, OLTL retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks.
- Community Transition Services
    - *Limitations:* Limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.
- Counseling
- Employment Skills Development
    - *Limitations:* Total combined hours for Employment Skills Development or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.
- Home Adaptations
- Home Delivered Meals
- Home Health Aide
- Home Health – Nursing
- Home Health – Occupational Therapy
- Home Health – Physical Therapy
- Home Health – Speech and Language
- Therapy
- Job Coaching
    - *Limitations:* Total combined hours for Employment Skills Development or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.
- Job Finding
- Non-Medical Transportation
- Nutritional Counseling
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Pest Eradication
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
    - *Limitations:* Non-covered items include:
        - All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)
        - Items covered under third party payer liability
        - Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability
        - Food, food supplements, food substitutes (including formulas), and thickening agents
        - Eyeglasses, frames, and lenses
        - Dentures
        - Any item labeled as experimental that has been denied by Medicare and/or Medicaid
        - Recreational or exercise equipment and adaptive devices for such

- Structured Day Habilitation
- TeleCare
- Vehicle Modifications

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. H6852_26S43_M