# Devoted Health — 2027 New York Plans

Official 2027 Summaries of Benefits, in plan-number order:

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|---|---|
| **H5334-007** | Devoted Choice 007 NY (PPO) |
| **H5334-008** | Devoted Choice Giveback 008 NY (PPO) |
| **H5334-009** | Devoted Choice 009 NY (PPO) |
| **H5334-010** | Devoted Choice Giveback 010 NY (PPO) |
| **H5334-031** | Devoted Choice Giveback Extras 031 NY (PPO) |
| **H5334-032** | Devoted Choice Giveback Extras 032 NY (PPO) |

*Source: devoted.com — official 2027 plan documents. Prepared for jillsterninsurance.com.*

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE 007 NY (PPO) Plan

PBP Number: H5334-007-000

**Service Area**

Kings and Queens

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE 007 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 007 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE 007 NY (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: Kings and Queens.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- 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, 2028.
- 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<br>You must continue to pay your Part B premium. | |
| **Medical Deductible** | $365<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). | |
| **Pharmacy (Part D) Deductible** | $650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. | |
| | **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. | $9,350<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. | $13,950<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 6**<br>$405 copay per day<br>**Day 7+**<br>$0 copay per day | **Days 1 - 6**<br>$405 copay per day<br>**Day 7+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $480 copay<br>• Ambulatory Surgical Center (ASC): $380 copay<br><br>**Observation Stays:** $380 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $480 copay<br>• Ambulatory Surgical Center (ASC): $380 copay<br><br>**Observation Stays:** $380 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $50 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $50 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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging**† Cost share varies based upon location and the type of service being performed. | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $45 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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>• **Genetic Testing** 20% coinsurance | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $45 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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: 40% coinsurance Outpatient hospital: 40% coinsurance<br>• **Genetic Testing** 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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $45 copay | **Medicare-Covered Hearing Care:** $45 copay |
| **Hearing Aids*** | $399 copay or $699 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$1,750** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

For all covered preventive dental services, like exams and routine cleanings, you will receive 100% reimbursement up to the yearly allowance.

For all covered comprehensive dental services, you will receive 50% reimbursement up to the yearly allowance.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$300** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $45 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $45 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$380 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$45 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$45 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 6**<br>$380 copay per day<br>**Days 7 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$45 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$45 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$221 copay per day | 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay |

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|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$325 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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

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|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $2 per prescription | $5 per prescription |
| **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 | 26% of the total cost | 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

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|---|---|
| **Yearly Out-of-Pocket Drug Costs** | You will pay $0 for covered Part D drugs after your yearly out-of-pocket drug costs reach $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $2 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 for in-network services.

## Additional Part D Benefit Information

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|---|---|
| **Insulin Coverage** | You will pay no more than $35 for a 30-day supply for all Part D-covered insulins.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $45 copay | **Medicare-Covered Foot Care:** $45 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% coinsurance |
| | **In-network** | **Out-of-network** |
| **Durable Medical Equipment (DME)**† See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 19% coinsurance for crutches, 19% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 19% coinsurance | **Basic Medicare-Covered DME Products:** 45% coinsurance for crutches, 45% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 45% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 19% coinsurance<br><br>**Medical Supplies:** 19% coinsurance | **Prosthetic Devices and Related Supplies:** 35% coinsurance<br><br>**Medical Supplies:** 35% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 19% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 19% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 19% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained at a retail pharmacy; 45% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 45% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

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

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts†** | $0 copay | 50% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care** Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Fitness** | **SilverSneakers®:** $0 membership<br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S49_M

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE GIVEBACK 008 NY (PPO) Plan

PBP Number: H5334-008-000

**Service Area**

Kings and Queens

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE GIVEBACK 008 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 GIVEBACK 008 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE GIVEBACK 008 NY (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: Kings and Queens.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- This plan offers a Part B buydown. If you are responsible for a Part B premium, we will reduce your monthly Part B premium by $118 per month. This reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Sometimes reductions can take several months to be issued; however, you will receive a full credit.

- Benefits, premiums, and/or copayments/ coinsurance may change on January 1, 2028.
- 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<br>You must continue to pay your Part B premium. |
| **Part B Buydown** | Your Part B premium is reduced by $118 per month.<br>If your Medicare Part B premium is paid by Medicaid or others on your behalf, you are not eligible for the monthly $118 reduction. |
| **Medical Deductible** | $50<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). |
| **Pharmacy (Part D) Deductible** | $650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. |

| | 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. | $9,850<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. | $14,800<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<br>$0 copay per day | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $500 copay<br>• Ambulatory Surgical Center (ASC): $400 copay<br><br>**Observation Stays:** $490 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $540 copay<br>• Ambulatory Surgical Center (ASC): $440 copay<br><br>**Observation Stays:** $490 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $50 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $50 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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging†**<br>Cost share varies based upon location and the type of service being performed. | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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<br>• **Genetic Testing**<br>20% coinsurance | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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: 40% coinsurance<br>Outpatient hospital: 40% coinsurance<br>• **Genetic Testing**<br>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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $50 copay | **Medicare-Covered Hearing Care:** $50 copay |
| **Hearing Aids*** | $599 copay or $899 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$250** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$400** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $50 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $50 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 4**<br>$490 copay per day<br>**Days 5 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$490 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$200 copay per day | 35% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay |

| | |
|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$350 copay per one-way trip<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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

| | |
|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $5 per prescription | $12.50 per prescription |
| **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 | 26% of the total cost | 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 $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $5 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 for in-network services.

## 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.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Folic acid 1 mg tablets<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year<br>• Tadalafil (generic Cialis) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $50 copay | **Medicare-Covered Foot Care:** $50 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Durable Medical Equipment (DME)†** See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 15% coinsurance for crutches, 15% coinsurance all other<br><br>**Advanced Medicare-Covered DME Products:** 15% coinsurance | **Basic Medicare-Covered DME Products:** 40% coinsurance for crutches, 40% coinsurance all other<br><br>**Advanced Medicare-Covered DME Products:** 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 15% coinsurance<br><br>**Medical Supplies:** 15% coinsurance | **Prosthetic Devices and Related Supplies:** 30% coinsurance<br><br>**Medical Supplies:** 30% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 15% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 15% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 15% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 40% coinsurance when obtained at a retail pharmacy; 40% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 40% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 40% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts†** | $0 copay | 50% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care**<br>Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Over-the-Counter Items (OTC)** | **$39 per quarter** to use toward the purchase of eligible over-the-counter (OTC) items. You pay nothing out-of-pocket, up to your benefit allowance, when shopping for eligible items at participating CVS, Longs, or Navarro locations. You get the most out of your OTC benefits when you shop at participating locations.<br><br>If you purchase items at non-participating stores, you will be responsible for a 90% coinsurance. You pay the full amount for your items out of pocket first, then send a reimbursement request. You will be reimbursed 10% towards eligible items up to your quarterly allowance. For complete details, see your Evidence of Coverage (EOC) booklet. |
| **Fitness** | **SilverSneakers®:** $0 membership<br><br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br><br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# Notes

# Notes

# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S48_M

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE 009 NY (PPO) Plan

PBP Number: H5334-009-000

**Service Area**

Nassau and Richmond

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE 009 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 009 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE 009 NY (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: Nassau and Richmond.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- 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, 2028.
- 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<br>You must continue to pay your Part B premium. | |
| **Medical Deductible** | $235<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). | |
| **Pharmacy (Part D) Deductible** | $650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. | |
| | **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. | $9,500<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. | $13,950<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 6**<br>$405 copay per day<br>**Day 7+**<br>$0 copay per day | **Days 1 - 6**<br>$405 copay per day<br>**Day 7+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $505 copay<br>• Ambulatory Surgical Center (ASC): $405 copay<br><br>**Observation Stays:** $405 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $505 copay<br>• Ambulatory Surgical Center (ASC): $405 copay<br><br>**Observation Stays:** $405 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $55 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $55 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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging**† Cost share varies based upon location and the type of service being performed. | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $45 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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>• **Genetic Testing** 20% coinsurance | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $45 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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: 40% coinsurance Outpatient hospital: 40% coinsurance<br>• **Genetic Testing** 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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $45 copay | **Medicare-Covered Hearing Care:** $45 copay |
| **Hearing Aids*** | $399 copay or $699 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$1,750** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

For all covered preventive dental services, like exams and routine cleanings, you will receive 100% reimbursement up to the yearly allowance.

For all covered comprehensive dental services, you will receive 50% reimbursement up to the yearly allowance.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$150** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| | **In-network** | **Out-of-network** |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $45 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $45 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$405 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$45 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$45 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 6**<br>$405 copay per day<br>**Days 7 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$45 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$45 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$221 copay per day | 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $45 copay<br>Outpatient hospital: $50 copay |

| | |
|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$300 copay per one-way trip<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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

| | |
|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $2 per prescription | $5 per prescription |
| **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 | 26% of the total cost | 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 $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $2 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 for in-network services.

## 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.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $45 copay | **Medicare-Covered Foot Care:** $45 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% coinsurance |
| | **In-network** | **Out-of-network** |
| **Durable Medical Equipment (DME)**† See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 19% coinsurance for crutches, 19% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 19% coinsurance | **Basic Medicare-Covered DME Products:** 45% coinsurance for crutches, 45% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 45% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 19% coinsurance<br><br>**Medical Supplies:** 19% coinsurance | **Prosthetic Devices and Related Supplies:** 35% coinsurance<br><br>**Medical Supplies:** 35% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 19% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 19% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 19% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained at a retail pharmacy; 45% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 45% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

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

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts†** | $0 copay | 50% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care** Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Fitness** | **SilverSneakers®:** $0 membership<br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S47_M

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE GIVEBACK 010 NY (PPO) Plan

PBP Number: H5334-010-000

**Service Area**

Nassau and Richmond

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE GIVEBACK 010 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 GIVEBACK 010 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE GIVEBACK 010 NY (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: Nassau and Richmond.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- This plan offers a Part B buydown. If you are responsible for a Part B premium, we will reduce your monthly Part B premium by $118 per month. This reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Sometimes reductions can take several months to be issued; however, you will receive a full credit.

- Benefits, premiums, and/or copayments/ coinsurance may change on January 1, 2028.
- 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

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|---|---|
| **Monthly Premium** | $0<br>You must continue to pay your Part B premium. |
| **Part B Buydown** | Your Part B premium is reduced by $118 per month.<br>If your Medicare Part B premium is paid by Medicaid or others on your behalf, you are not eligible for the monthly $118 reduction. |
| **Medical Deductible** | $180<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). |
| **Pharmacy (Part D) Deductible** | $650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. |

| | 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. | $9,850<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. | $14,800<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<br>$0 copay per day | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $590 copay<br>• Ambulatory Surgical Center (ASC): $490 copay<br><br>**Observation Stays:** $490 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $590 copay<br>• Ambulatory Surgical Center (ASC): $490 copay<br><br>**Observation Stays:** $490 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $50 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $50 copay |

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|---|---|
| **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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging†**<br>Cost share varies based upon location and the type of service being performed. | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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<br>• **Genetic Testing**<br>20% coinsurance | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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: 40% coinsurance<br>Outpatient hospital: 40% coinsurance<br>• **Genetic Testing**<br>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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $50 copay | **Medicare-Covered Hearing Care:** $50 copay |
| **Hearing Aids*** | $599 copay or $899 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$250** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$400** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $50 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $50 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 4**<br>$490 copay per day<br>**Days 5 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$490 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$221 copay per day | 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay |

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|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$350 copay per one-way trip<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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

| | |
|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$650 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $5 per prescription | $12.50 per prescription |
| **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 | 26% of the total cost | 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

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|---|---|
| **Yearly Out-of-Pocket Drug Costs** | You will pay $0 for covered Part D drugs after your yearly out-of-pocket drug costs reach $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $5 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 for in-network services.

## Additional Part D Benefit Information

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|---|---|
| **Insulin Coverage** | You will pay no more than $35 for a 30-day supply for all Part D-covered insulins.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Folic acid 1 mg tablets<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year<br>• Tadalafil (generic Cialis) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $50 copay | **Medicare-Covered Foot Care:** $50 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Durable Medical Equipment (DME)†** See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 16% coinsurance for crutches, 16% coinsurance all other<br><br>**Advanced Medicare-Covered DME Products:** 16% coinsurance | **Basic Medicare-Covered DME Products:** 40% coinsurance for crutches, 40% coinsurance all other<br><br>**Advanced Medicare-Covered DME Products:** 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 16% coinsurance<br><br>**Medical Supplies:** 16% coinsurance | **Prosthetic Devices and Related Supplies:** 30% coinsurance<br><br>**Medical Supplies:** 30% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 16% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 16% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 16% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 40% coinsurance when obtained at a retail pharmacy; 40% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 40% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 40% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts†** | $0 copay | 50% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care**<br>Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

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|---|---|
| **Over-the-Counter Items (OTC)** | **$39 per quarter** to use toward the purchase of eligible over-the-counter (OTC) items. You pay nothing out-of-pocket, up to your benefit allowance, when shopping for eligible items at participating CVS, Longs, or Navarro locations. You get the most out of your OTC benefits when you shop at participating locations.<br><br>If you purchase items at non-participating stores, you will be responsible for a 90% coinsurance. You pay the full amount for your items out of pocket first, then send a reimbursement request. You will be reimbursed 10% towards eligible items up to your quarterly allowance. For complete details, see your Evidence of Coverage (EOC) booklet. |
| **Fitness** | **SilverSneakers®:** $0 membership<br><br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br><br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# Notes

# Notes

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# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S46_M

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE GIVEBACK EXTRAS 031 NY (PPO) Plan

PBP Number: H5334-031-000

**Service Area**

Kings and Queens

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE GIVEBACK EXTRAS 031 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 GIVEBACK EXTRAS 031 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE GIVEBACK EXTRAS 031 NY (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: Kings and Queens.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- This plan offers a Part B buydown. If you are responsible for a Part B premium, we will reduce your monthly Part B premium by $70 per month. This reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Sometimes reductions can take several months to be issued; however, you will receive a full credit.

- Benefits, premiums, and/or copayments/ coinsurance may change on January 1, 2028.
- 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<br>You must continue to pay your Part B premium. |
| **Part B Buydown** | Your Part B premium is reduced by $70 per month.<br>If your Medicare Part B premium is paid by Medicaid or others on your behalf, you are not eligible for the monthly $70 reduction. |
| **Medical Deductible** | $380<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). |
| **Pharmacy (Part D) Deductible** | $700 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. |

| | 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. | $9,650<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. | $14,450<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<br>$0 copay per day | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $555 copay<br>• Ambulatory Surgical Center (ASC): $455 copay<br><br>**Observation Stays:** $455 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $555 copay<br>• Ambulatory Surgical Center (ASC): $455 copay<br><br>**Observation Stays:** $455 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $50 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $50 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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging**† Cost share varies based upon location and the type of service being performed. | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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>• **Genetic Testing** 20% coinsurance | • **Lab Services** Dedicated testing laboratory: $0 copay Office or Freestanding location: $0 copay Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds** Office or freestanding location: $25 copay Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)** Office or freestanding location: $100 or $200 copay Outpatient Hospital: $200 or $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: 40% coinsurance Outpatient hospital: 40% coinsurance<br>• **Genetic Testing** 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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $50 copay | **Medicare-Covered Hearing Care:** $50 copay |
| **Hearing Aids*** | $599 copay or $899 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$2,000** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

For all covered preventive dental services, like exams and routine cleanings, you will receive 100% reimbursement up to the yearly allowance.

For all covered comprehensive dental services, you will receive 50% reimbursement up to the yearly allowance.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$350** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $50 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $50 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 4**<br>$455 copay per day<br>**Days 5 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$455 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$221 copay per day | 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay |

| | |
|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$340 copay per one-way trip<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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

| | |
|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$700 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $2 per prescription | $5 per prescription |
| **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 |

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 $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $2 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 for in-network services.

## 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.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $50 copay | **Medicare-Covered Foot Care:** $50 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% coinsurance |
| | **In-network** | **Out-of-network** |
| **Durable Medical Equipment (DME)**† See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 17% coinsurance for crutches, 17% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 17% coinsurance | **Basic Medicare-Covered DME Products:** 45% coinsurance for crutches, 45% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 45% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 17% coinsurance<br><br>**Medical Supplies:** 17% coinsurance | **Prosthetic Devices and Related Supplies:** 35% coinsurance<br><br>**Medical Supplies:** 35% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 17% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 17% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 17% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained at a retail pharmacy; 45% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 45% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

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

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts†** | $0 copay | 50% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care** Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Over-the-Counter Items (OTC)** | **$97 per quarter** to use toward the purchase of eligible over-the-counter (OTC) items. You pay nothing out-of-pocket, up to your benefit allowance, when shopping for eligible items at participating CVS, Longs, or Navarro locations. You get the most out of your OTC benefits when you shop at participating locations.<br><br>If you purchase items at non-participating stores, you will be responsible for a 90% coinsurance. You pay the full amount for your items out of pocket first, then send a reimbursement request. You will be reimbursed 10% towards eligible items up to your quarterly allowance. For complete details, see your Evidence of Coverage (EOC) booklet. |
| **Fitness** | **SilverSneakers®:** $0 membership<br><br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br><br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S35_M

Devoted HEALTH PLANS

2027

# Summary of Benefits

## DEVOTED CHOICE GIVEBACK EXTRAS 032 NY (PPO) Plan

PBP Number: H5334-032-000

**Service Area**

Nassau and Richmond

PPO

This Summary of Benefits tells you about our DEVOTED CHOICE GIVEBACK EXTRAS 032 NY (PPO) plan. It includes information on plan costs and some of the common services we cover. It's valid for the 2027 plan year, which starts on January 1, 2027 and ends on December 31, 2027.

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 GIVEBACK EXTRAS 032 NY (PPO) is a Preferred Provider Organization, or PPO plan. To join DEVOTED CHOICE GIVEBACK EXTRAS 032 NY (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: Nassau and Richmond.** 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 chat. 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 chat. 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 in order for the plan to cover Medicare-covered services. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher cost share for services provided 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.

Once you are a Devoted Health member, you can also chat with us, manage your plan, and more in the MyDevoted™ app or at my.devoted.com.

**IMPORTANT: If you receive Medicaid or Extra Help, your cost-sharing may be lower than what's listed here.**
Changes in your Medicaid eligibility or Extra Help level may affect your cost share. For more details, refer to the Evidence of Coverage. To get it, visit www.devoted.com or call 1-800-385-0916 (TTY 711).

# 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.
- This plan offers a Part B buydown. If you are responsible for a Part B premium, we will reduce your monthly Part B premium by $70 per month. This reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Sometimes reductions can take several months to be issued; however, you will receive a full credit.

- Benefits, premiums, and/or copayments/ coinsurance may change on January 1, 2028.
- 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<br>You must continue to pay your Part B premium. |
| **Part B Buydown** | Your Part B premium is reduced by $70 per month.<br>If your Medicare Part B premium is paid by Medicaid or others on your behalf, you are not eligible for the monthly $70 reduction. |
| **Medical Deductible** | $250<br>The deductible does not apply to Medicare Part B-covered insulin (when you use insulin via a pump) or Medicare-covered preventive services, and some Medicare-covered services.<br>For a list of services for which the deductible applies, see the plan's Evidence of Coverage (EOC). |
| **Pharmacy (Part D) Deductible** | $700 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0. |

| | 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. | $9,750<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. | $14,450<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. |

## Covered Medical and Hospital Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Inpatient Hospital Coverage†** | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<br>$0 copay per day | **Days 1 - 5**<br>$490 copay per day<br>**Day 6+**<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.

| | In-network | Out-of-network |
|---|---|---|
| **Outpatient Hospital Coverage†** | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $560 copay<br>• Ambulatory Surgical Center (ASC): $460 copay<br><br>**Observation Stays:** $460 copay per day | **Diagnostic Colonoscopies:**<br>• Outpatient Hospital: $0 copay<br>• Ambulatory Surgical Center (ASC): $0 copay<br><br>**Outpatient Surgery and Procedures:**<br>• Outpatient Hospital: $560 copay<br>• Ambulatory Surgical Center (ASC): $460 copay<br><br>**Observation Stays:** $460 copay per day |

| | In-network | Out-of-network |
|---|---|---|
| **Doctor Visits** | **Primary Care Provider (PCP):** $0 copay<br><br>**Specialist:** $50 copay | **Primary Care Provider (PCP):** $5 copay<br><br>**Specialist:** $50 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). |
| **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. | $115 per visit |

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

| | In-network | Out-of-network |
|---|---|---|
| **Urgently Needed Services in the United States and its Territories** | **PCP office:** $0 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay | **PCP office:** $5 copay<br><br>**Urgent Care Center or Retail Walk-in Center:** $40 copay |

## Outpatient Care and Services

| | In-network | Out-of-network |
|---|---|---|
| **Diagnostic Services, Labs, and Imaging†**<br>Cost share varies based upon location and the type of service being performed. | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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<br>• **Genetic Testing**<br>20% coinsurance | • **Lab Services**<br>Dedicated testing laboratory: $0 copay<br>Office or Freestanding location: $0 copay<br>Outpatient hospital: $0 or $50 copay<br>• **Outpatient X-rays and Ultrasounds**<br>Office or freestanding location: $25 copay<br>Outpatient hospital: $75 copay<br>• **Diagnostic Radiology (such as CT, PET Scan, etc.)**<br>Office or freestanding location: $100 or $200 copay<br>Outpatient Hospital: $200 or $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: 40% coinsurance<br>Outpatient hospital: 40% coinsurance<br>• **Genetic Testing**<br>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

| | In-network | Out-of-network |
|---|---|---|
| **Hearing Care** | **Routine Hearing Exam*:** $0 copay — 1 visit per year | **Routine Hearing Exam*:** $35 copay — 1 visit per year |
| | **Hearing Aid Fitting and Evaluation*:** $0 copay | **Hearing Aid Fitting and Evaluation*:** $35 copay |
| | **Medicare-Covered Hearing Care:** $50 copay | **Medicare-Covered Hearing Care:** $50 copay |
| **Hearing Aids*** | $599 copay or $899 copay per aid<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<br>• $50 additional cost per aid for optional hearing aid rechargeability | |

The in-network benefit includes coverage of up to 2 TruHearing® Advanced or Premium hearing aids, which come in various styles and colors, including rechargeable options. You get the most out of your benefits when you use a participating provider with TruHearing.

If you choose to purchase hearing aids at a non-participating provider, you will be responsible for a 90% coinsurance. You will pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you 10% towards eligible items.

For complete details, see your Evidence of Coverage (EOC) booklet.

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

## Dental Allowance

You have a **$2,000** yearly allowance toward Preventive Dental and Comprehensive Dental. You can see any licensed dentist in the United States.

You will pay the costs yourself at first. Then, you can submit a request for reimbursement to Devoted.

For all covered preventive dental services, like exams and routine cleanings, you will receive 100% reimbursement up to the yearly allowance.

For all covered comprehensive dental services, you will receive 50% reimbursement up to the yearly allowance.

Covered dental services are limited to specific dental codes as listed in your Evidence of Coverage, and include, but are not limited to: periodic oral exams, dental evaluations, cleanings, X-rays, fillings, deep cleanings, extractions, dentures, root canals, crowns, and bridges. Cosmetic procedures, dental implants, and/or elective procedures are not covered. See your Evidence of Coverage for a full list of covered services and coverage limitations.

## Vision Services

| | In-network | Out-of-network |
|---|---|---|
| **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 **$200** each year for eyeglasses and/or contacts<br><br>You can visit any eyewear provider, in-network or out-of-network. 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. | |
| **Medicare-Covered Vision Care** | **Medicare-Covered Diagnostic Eye Exam:** $50 copay<br><br>**Diabetic Retinopathy Exam:** $0 copay | **Medicare-Covered Diagnostic Eye Exam:** $50 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

| | In-network | Out-of-network |
|---|---|---|
| **Mental Health Services**† | **Inpatient Mental Health Care:**<br>**Days 1 - 4**<br>$460 copay per day<br>**Days 5 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay | **Inpatient Mental Health Care:**<br>**Days 1 - 5**<br>$460 copay per day<br>**Days 6 - 90**<br>$0 copay per day<br><br>**Outpatient Mental Health Services (individual and group):**<br>$50 copay<br><br>**Outpatient Psychiatric Services (individual and group):**<br>$50 copay |

| | In-network | Out-of-network |
|---|---|---|
| **Skilled Nursing Facility (SNF)**†<br>No prior hospital stay required. | **Days 1 - 20**<br>$0 copay per day<br>**Days 21 - 100**<br>$221 copay per day | 40% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Physical Therapy and Other Rehabilitation Services**†<br>Cost share may vary based upon location. Cost share for re-evaluations may differ. | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay | • **Physical Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay<br>• **Occupational Therapy**<br>Office location: $35 copay<br>Outpatient hospital: $35 copay<br>• **Speech Therapy**<br>Office location: $50 copay<br>Outpatient hospital: $50 copay |

| | |
|---|---|
| **Ambulance Services**† | **Ground Ambulance:**<br>$325 copay per one-way trip<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

| | In-network | Out-of-network |
|---|---|---|
| **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. | **Chemotherapy Drugs:** 20% coinsurance<br><br>**Other Part B Drugs:** 20% coinsurance | **Chemotherapy Drugs**: 40% coinsurance<br><br>**Other Part B Drugs:** 40% coinsurance |

| | |
|---|---|
| **Prescription Drugs**<br><br>Some covered drugs may be subject to quantity limitations or require step therapy or prior authorization. | **Pharmacy (Part D) Deductible**<br>$700 for Tiers 3-5<br>If you receive Extra Help from Medicare, your deductible is $0.<br><br>**Initial Coverage Stage**<br>You pay copays or coinsurance until your out-of-pocket costs for Part D drugs reach $2,400. |

| | 30-Day Supply Network Retail Pharmacy | 100-Day Supply Network Mail Order |
|---|---|---|
| **Tier 1:** Preferred Generic | $0 per prescription | $0 per prescription |
| **Tier 2:** Generic | $2 per prescription | $5 per prescription |
| **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 |

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 $2,400. For excluded drugs covered under our enhanced benefit, you will pay a $2 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 for in-network services.

## 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.<br>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 2 cost share throughout the entire plan year (see the Prescription Drug Benefits section above for cost-sharing information):<br>• Vitamin D (ergocalciferol) 50,000 unit capsules<br>• B12 injection (cyanocobalamin) 1,000 mcg/ml<br>• Sildenafil (generic Viagra) up to 6 tablets per month, with a maximum of 72 tablets per year |

## Additional Benefits

| | In-network | Out-of-network |
|---|---|---|
| **Dialysis** | 20% coinsurance | 20% coinsurance |
| | **In-network** | **Out-of-network** |
| **Foot Care (Podiatry Services)** | **Medicare-Covered Foot Care:** $50 copay | **Medicare-Covered Foot Care:** $50 copay |
| | **In-network** | **Out-of-network** |
| **Home Health Care**† Home Health Care is limited to Medicare-covered services. | $0 copay | 40% coinsurance |
| | **In-network** | **Out-of-network** |
| **Durable Medical Equipment (DME)**† See the Evidence of Coverage (EOC) for details on the difference between Basic and Advanced DME. | **Basic Medicare-Covered DME Products:** 18% coinsurance for crutches, 18% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 18% coinsurance | **Basic Medicare-Covered DME Products:** 45% coinsurance for crutches, 45% coinsurance all other<br>**Advanced Medicare-Covered DME Products:** 45% 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.

| | In-network | Out-of-network |
|---|---|---|
| **Prosthetic Devices and Medical Supplies†** | **Prosthetic Devices and Related Supplies:** 18% coinsurance<br><br>**Medical Supplies:** 18% coinsurance | **Prosthetic Devices and Related Supplies:** 35% coinsurance<br><br>**Medical Supplies:** 35% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Diabetes Monitoring Supplies†**<br>For additional details about glucose monitors, see your Evidence of Coverage (EOC). | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** $0 copay when obtained at a retail pharmacy; 18% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 18% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 18% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** $0 copay<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. | **Dexcom Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained at a retail pharmacy; 45% coinsurance when obtained through a Durable Medical Equipment provider.<br><br>**Non-Preferred Continuous Glucose Monitors (CGMs) and supplies, including sensors:** 45% coinsurance when obtained through a Durable Medical Equipment provider. These devices are not available at a retail pharmacy, except for Freestyle Libre products, which are available at a retail pharmacy at 45% coinsurance.<br><br>**Diabetic Supplies (blood glucose monitors, test strips, lancets, and control solutions):** 50% coinsurance<br><br>Our preferred brand of blood glucose monitors is Accu-Chek. |

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

| | In-network | Out-of-network |
|---|---|---|
| **Diabetic Shoes and Therapeutic Inserts**† | $0 copay | 50% coinsurance |

| | In-network | Out-of-network |
|---|---|---|
| **Chiropractic Care** Medicare-covered chiropractic services are limited to manual manipulation of the spine to correct subluxation. | **Medicare-Covered Chiropractic Services:** $15 copay | **Medicare-Covered Chiropractic Services:** $15 copay |

## More Benefits and Perks With Your Plan

| | |
|---|---|
| **Over-the-Counter Items (OTC)** | **$95 per quarter** to use toward the purchase of eligible over-the-counter (OTC) items. You pay nothing out-of-pocket, up to your benefit allowance, when shopping for eligible items at participating CVS, Longs, or Navarro locations. You get the most out of your OTC benefits when you shop at participating locations.<br><br>If you purchase items at non-participating stores, you will be responsible for a 90% coinsurance. You pay the full amount for your items out of pocket first, then send a reimbursement request. You will be reimbursed 10% towards eligible items up to your quarterly allowance. For complete details, see your Evidence of Coverage (EOC) booklet. |
| **Fitness** | **SilverSneakers®:** $0 membership<br><br>You get the most out of your fitness benefits when you go to a SilverSneakers® participating location.<br><br>If you choose to go to a non-participating fitness facility, you will be responsible for a 90% coinsurance. You pay the full amount out of pocket first, then send a reimbursement request to Devoted Health. Devoted Health will then reimburse you up to 10% towards eligible fitness services. For complete details, see your Evidence of Coverage (EOC) booklet.<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. |

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

# 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 ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સવે ાઓ પણ વિના મલૂ ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY711) પર કૉલ કરો અથવા તમારા પૂરદાતા સાથે વાત કરો.

**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।

**Filipino** (Filipino): PAALALA: Kung nagsasalita ka ng Filipino, magagamit mo ang mga libreng serbisyong tulong sa wika. Makukuha rin nang walang bayad ang naaangkop na mga pantulong na kagamitan at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-338-6833 (TTY 711) o makipag-usap ka sa iyong provider.

**Urdu** (اردو):

توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لسانی امدادی خدمات دستیاب ہیں۔ معلومات کو قابلِ رسائی فارمیٹس میں فراہم کرنے کے لیے مناسب معاونت اور خدمات بھی مفت دستیاب ہیں۔ 1-800-338-6833 (TTY 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. Certain limitations apply. See the plan's Evidence of Coverage (EOC) for more details. 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. H5334_27S37_M