Devoted
HEALTH PLANS

January 1 - December 31, 2024

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of:

Devoted LIBERTY CHOICE Arizona (PPO)

Your Medicare Health Benefits and Services as a Member of *Devoted LIBERTY CHOICE Arizona (PPO)*

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-800-DEVOTED (1-800-338-6833) for additional information. (TTY users should call 711). Hours are 8am to 8pm 7 days a week from October 1 to March 31, and 8am to 8pm Monday to Friday and 8am to 5pm on Saturday from April 1 to September 30. This call is free.

This plan, *Devoted LIBERTY CHOICE Arizona (PPO)*, is offered by *Devoted Health*. (When this *Evidence of Coverage* says "we," "us," or "our," it means *Devoted Health.* When it says "plan" or "our plan," it means *Devoted LIBERTY CHOICE Arizona (PPO).*)

This document is available for free in English and Spanish.If you need information in a different language or format (such as braille, or large print) — or you need any help at all — call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2025.

The pharmacy network and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage
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CHAPTER 1 :
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Devoted LIBERTY CHOICE Arizona (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Devoted LIBERTY CHOICE Arizona (PPO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Devoted LIBERTY CHOICE Arizona (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Devoted LIBERTY CHOICE Arizona (PPO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Devoted LIBERTY CHOICE Arizona (PPO) covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Devoted LIBERTY CHOICE Arizona (PPO) between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Devoted LIBERTY CHOICE Arizona (PPO) after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Devoted LIBERTY CHOICE Arizona (PPO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Devoted LIBERTY CHOICE Arizona (PPO)

Devoted LIBERTY CHOICE Arizona (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes this county/counties in Arizona: **Pima.**

We offer coverage in several states and other counties in Arizona. However, there may be cost or other differences between the plans we offer in each state or county. If you move out of state and into a state that is still within our service area, you must call Member Services in order to update your information.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

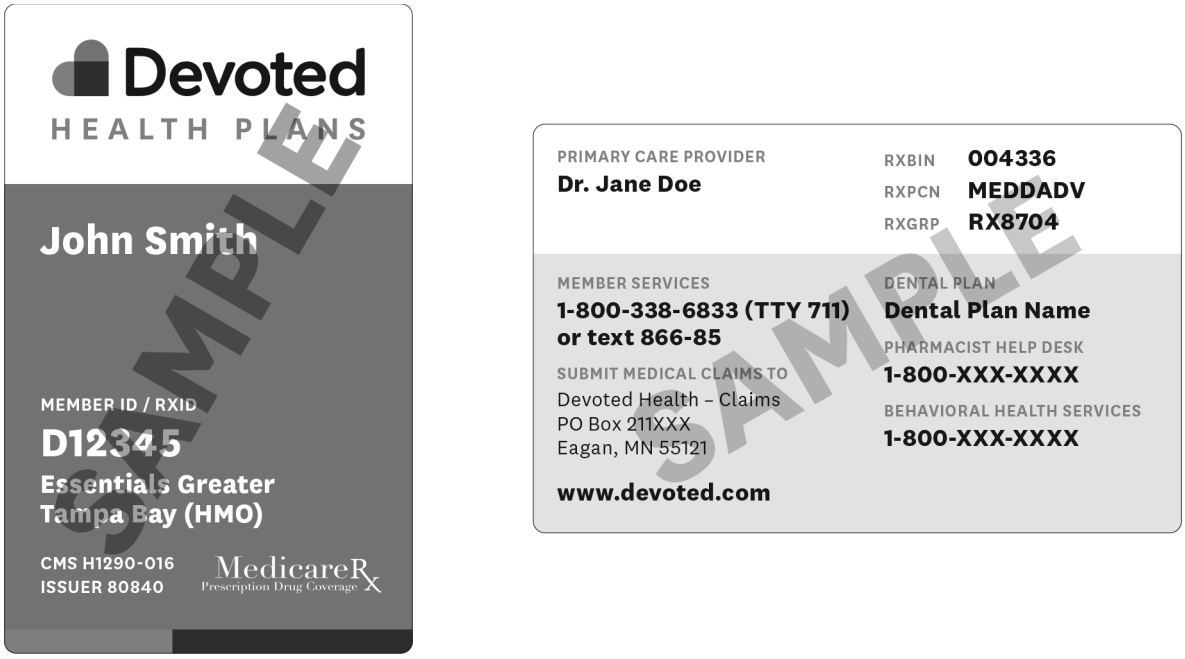
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Devoted LIBERTY CHOICE Arizona (PPO) if you are not eligible to remain a member on this basis. Devoted LIBERTY CHOICE Arizona (PPO) must disenroll you if you do not meet this requirement.

SECTION 3 Important Membership Materials You Will Receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here’s a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Devoted LIBERTY CHOICE Arizona (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies, also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 The *Devoted Health Provider & Pharmacy Directory*

The *Devoted Health Provider & Pharmacy Directory* lists our current network providers and pharmacies.

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Devoted Health Provider & Pharmacy Directory* to find the network pharmacy you want to use. This plan only provides coverage for Part B drugs and does not include Part D drug coverage.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Devoted LIBERTY CHOICE Arizona (PPO) authorizes use of out-of-network providers.

The most recent list of providers and pharmacies is available on our website at www.devoted.com.

If you don't have your copy of the *Devoted Health Provider & Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider Directories will be mailed to you within three business days.

SECTION 4 Your monthly costs for Devoted LIBERTY CHOICE Arizona (PPO)

Your costs may include the following:

- Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Devoted LIBERTY CHOICE Arizona (PPO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

As a member of Devoted LIBERTY CHOICE Arizona (PPO), Devoted Health will reduce your monthly Medicare Part B Premium by $150. The 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.**You must continue paying your Medicare premiums to**

remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider if you select one.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

If any of this information changes, please let us know by calling Member Services.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2 :
Important phone numbers and resources

SECTION 1 Devoted LIBERTY CHOICE Arizona (PPO) contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Devoted LIBERTY CHOICE Arizona (PPO) Member Services. We will be happy to help you.

Method	Member services – Contact Information
CALL	1-800-DEVOTED (1-800-338-6833) Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30 Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30
FAX	1-877-234-9988
WRITE	Devoted Health, Inc. P.O. Box 211037 Eagan, MN 55121
TEXT	866-85
WEBSITE	www.devoted.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-DEVOTED (1-800-338-6833) Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30 Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30
FAX	1-877-264-3872
WRITE	Devoted Health P.O. Box 211037 Eagan, MN 55121
WEBSITE	www.devoted.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals and Complaints about Medical Care – Contact Information
CALL	1-800-DEVOTED (1-800-338-6833) Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30 Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30
FAX	1-877-358-0711
WRITE	Devoted Health - Appeals and Grievances P.O. Box 21327 Eagan, MN 55121
WEBSITE	www.devoted.com
MEDICARE WEBSITE	You can submit a complaint about Devoted LIBERTY CHOICE Arizona (PPO) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay our share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Medical Care Payment Requests – Contact Information
WRITE	Devoted Health ATTN: Member Reimbursements P.O. Box 211524 Eagan, MN 55121
WEBSITE	https://www.devoted.com/paymeback/

Method	Request for payment of Dental Services – Contact Information
WRITE	Delta Dental Insurance Company PO Box 1809 Alpharetta, GA 30023-1809
WEBSITE	www.devoted.com

Method	Request for payment for Vision Care Services – Contact Information
WRITE	EyeMed Vision Care Attn: OON Claims PO Box 8504, Mason, OH 45040-7111
WEBSITE	www.eyemed.com

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Devoted LIBERTY CHOICE Arizona (PPO): • **Tell Medicare about your complaint:** You can submit a complaint about Devoted LIBERTY CHOICE Arizona (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Arizona, the SHIP is called Arizona State Health Insurance Assistance Program (SHIP).

Arizona State Health Insurance Assistance Program (SHIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Arizona State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Arizona State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Click on **Talk to Someone** in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	Arizona State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-432-4040 Hours: 8 a.m. to 5 p.m.
TTY	711
WRITE	Division of Aging and Adult Services Arizona Department of Economic Security 1789 W. Jefferson Street, #950A Phoenix, AZ 85007 contactdaas@azdes.gov
WEBSITE	https://des.az.gov/services/older-adults/medicare-assistance

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Arizona, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta – Contact Information
CALL	1-877-588-1123
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite. 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com/en

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or ESRD and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Arizona Health Care Cost Containment System (AHCCCS).

Method	Arizona Health Care Cost Containment System (AHCCCS) – Contact Information
CALL	1-800-523-0231 Monday through Friday, 8 a.m. to 5 p.m. MT
TTY	1-800-842-6520 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	AHCCCS 801 E. Jefferson Street Phoenix, AZ 85034
WEBSITE	www.azahcccs.gov

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov

SECTION 8 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3 :
Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, Part B prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart (what is covered and what you pay)*).

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Devoted LIBERTY CHOICE Arizona (PPO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Devoted LIBERTY CHOICE Arizona (PPO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

The providers in our network are listed in the *Devoted Health Provider & Pharmacy Directory*.

If you use an out-of-network provider, your share of the costs for your covered services may be higher.

Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

A PCP is your Primary Care Provider. Your PCP is a provider who meets state requirements and is trained to give you basic medical care. As a member of our plan, you may choose a PCP from the choices listed in the *Devoted Health Provider & Pharmacy Directory*. **Note:** you can choose to see an out-of-network PCP, but you may need to pay a higher cost-share.

How do you choose your PCP?

If you already have an in-network PCP, call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711 to officially make them your PCP. If your current PCP is not in network, or if you do not have a PCP, you can call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711 if you would like help identifying a PCP. **Note:** you can choose to see an out-of-network PCP, but you may need to pay a higher cost-share.

Changing your PCP

You may change your PCP for any reason, at any time. To change your PCP, call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711. You may also submit a written request to the Member Service Department.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.
- When your PCP thinks you need specialized treatment, he/she may recommend you see a specialist or certain other providers in our network. **You do not need a referral from your PCP to see a network specialist or behavioral/mental health provider.** Although you do not need a referral from your PCP to see a specialist, your PCP can recommend an appropriate specialist for your medical condition, answer questions you have regarding a specialist's treatment plan and provide follow-up health care as needed. So that your PCP can keep track of your care, we recommend you notify your PCP when you see a specialist.
- Hospitals will be considered either in-network or out-of-network. If there are specific hospitals you want to use, you should find out whether the hospital is in-network or out-of-network. You may pay a higher cost-share for out-of-network providers.
- Please refer to the *Devoted Health Provider and Pharmacy Directory* for a listing of plan specialists and hospitals available through our network, or check our online directory at www.devoted.com, or call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711.
- For some types of services, your doctor may need to get approval in advance from our plan (this is called getting prior authorization). See Chapter 4, Section 2.1 for information about which services require prior authorization.
- Prior authorization may be needed for certain services (please see Chapter 4 or information which services require prior authorization). Authorization can be obtained from the plan. **You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination.** If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.
- If you do not have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don’t need to get a referral or prior authorization when you get care from out-of-network providers. **However, before getting services from out-of-network providers you**

may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. You are also covered for urgent and emergency services anywhere in the world.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about

your emergency care, usually within 48 hours. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 from 8am to 8pm, 7 days a week, from October 1 to March 31, and 8am to 8pm, Monday to Friday, and 8am to 5pm, Saturday, from April 1 to September 30 so we can help.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Getting care when you have an urgent need for services

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care.

If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment.

Our plan covers worldwide emergency and urgent care services outside the United States. If you have an urgent need for care outside of the U.S. and its territories, you will be responsible for paying for the services rendered upfront. We will reimburse you for all the relevant covered costs. For more information please see Chapter 4 or call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.devoted.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Devoted LIBERTY CHOICE Arizona (PPO) covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a

benefit limit has been reached does not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is non-excepted.

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

You are covered for an unlimited number of medically necessary inpatient hospital days. See Chapter 4 (Medical Benefits Chart (what is covered and what you pay)) for details.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Devoted LIBERTY CHOICE Arizona (PPO), the same rules apply. People who rent the relevant types of DME own the equipment after paying copayments for the item for 13 months. Once Devoted Health transfers ownership to you, we will still cover necessary repairs on your behalf, subject to any applicable cost share highlighted in Chapter 4, Section 2.1.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Devoted LIBERTY CHOICE Arizona (PPO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Devoted LIBERTY CHOICE Arizona (PPO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4 :
Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Devoted LIBERTY CHOICE Arizona (PPO). It also describes supplemental benefits you receive. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $6,350. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical

Benefits Chart.) If you have paid $6,350 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $8,950*.* This is the most you pay during the calendar year for covered Medicare Part A and Part B *s*ervices received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $8,950 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

As a member of Devoted LIBERTY CHOICE Arizona (PPO), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Member Services.

When you get covered care from Medicare participating providers, you are never responsible for paying more than the cost share amounts listed in this Evidence of Coverage.

- If you pay a provider upfront and submit a request for Devoted Health to pay you back, Devoted Health will pay you the Medicare Allowable amount less your cost share amount. If the provider charged you more than the Medicare Allowable amount, the provider should reimburse you the difference between that charge amount and the Medicare Allowable amount as they are not allowed to charge more than Medicare's defined fee schedule.
- If you run into issues, give us a call at 1-800-DEVOTED.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Devoted LIBERTY CHOICE Arizona (PPO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Devoted LIBERTY CHOICE Arizona (PPO).
    - Covered services that need approval in advance to be covered as in-network services are marked in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

🍎 You will see this apple next to the preventive services in the benefits chart.

Services that are covered for you	What you must pay when you get these services
🍎 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.** • You don’t need a prior authorization for your plan to pay for this screening. But you do need your provider to check that you need it — and to order one for you.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Medicare-covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually for Medicare-covered services. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/ clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	**In-network** **Acupuncture for chronic low back pain:** **$0 copay** **Out-of-network** **Acupuncture for chronic low back pain:** **$0 copay** Total number of covered acupuncture visits are for in- and out-of-network visits combined

Services that are covered for you	What you must pay when you get these services
• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Services that are covered for you	What you must pay when you get these services

Ambulance Services
 	
• Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.
• If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. If you receive non-emergency transportation by ambulance, you will be responsible for the ambulance copay.
 	
Your plan also pays for supplemental (extra) benefits:
 	
• You're covered for emergency ambulance services worldwide. If you have an emergency outside of the U.S. and its territories, you have to pay the costs yourself at first. Then, you can submit a claim to us so we can pay you back.
  • We do not cover transportation back to the United States from another country, unless the nearest medical facility is in the United States.
  • We'll cover costs up to what we pay providers in the US — if your costs are higher, you'll have to pay the difference.
  • You still have to pay your typical share of the costs, such as your standard copayment for an ambulance service. For more information, please see Chapter 5 or call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.
  • Ambulance services which are **not covered** under any circumstances:
	Ground Ambulance
	$350 copay per one-way trip
	
	Air Ambulance
	20% coinsurance per one-way trip
	
	You will not be responsible for additional ambulance copays for facility to facility transfers.
	
	If it's an emergency, you don't need prior authorization.
	
	If it's not an emergency, you may need prior authorization. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more.
	
	Worldwide Ambulance Services (Services outside the United States)*
	
	Your cost-shares for ambulance services worldwide are:
	
	• **Ground Ambulance: $350 copay per one-way trip**
	• **Air Ambulance: 20% coinsurance per one-way trip**

Services that are covered for you	What you must pay when you get these services
• Self-directed ambulance services when there is no longer an emergency (including concierge service or commercial flights back to the United States).	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	**There is no coinsurance, copayment, or deductible for the annual wellness visit.**
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.**
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	**There is no coinsurance, copayment, or deductible for covered screening mammograms.**

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network** **$35 copay** • Your provider must check that you need this service — and order it for you. **Out-of-network** **$35 copay** • Your provider must check that you need this service — and order it for you.
 **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.**
 **Cardiovascular disease testing** Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.**

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.** • However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the new or existing medical condition.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	**In-network** **Medicare-covered chiropractic visits:** **$20 copay** • You don't need prior authorization for chiropractic services. **Out-of-network** **Medicare-covered chiropractic visits:** **$20 copay**

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria, such as Cologuard®. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	**There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.** • If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. • However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the new or existing medical condition.

Services that are covered for you	What you must pay when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: • Cleanings, routine exams, x-rays, and more. See Mandatory Supplemental Dental Benefits at the end of this chart for details, including what services are covered and what you will pay. **Exclusions:** You are only covered for the services, codes and limits listed in the Evidence of Coverage. Any dental services that are furnished that are not listed as a covered code, not medically necessary, or if you exceed the maximum service limit (or annual maximum), will not be covered by Devoted Health and you will be responsible for the full cost. **If you receive dental services from an out- of-network dentist, you will be responsible for paying the difference between the negotiated fees and the fees your dental provider charges, including any applicable cost share, even for services listed as $0. See the Mandatory Supplemental Dental Benefits at the end of this chapter for full details on applicable cost sharing** You are covered for up to $1,000 per year from in or out-of-network providers for covered dental services.	**In-network** **Dental services covered by Medicare** • **$45 copay** • See the *Outpatient diagnostic tests and therapeutic services and supplies*, and/or the *Outpatient surgery*, and/ or the *Inpatient hospital care, and/or the Physician/ Practitioner Services* sections in this chart. **Dental services covered by supplemental benefits** • Devoted Health will pay as much as **$1,000 per year** for covered dental services from in- and out-of-network providers combined. • See the dental code grid located under *Mandatory Supplemental Dental Benefits* at the end of this chapter for full details, including any applicable cost share • Prior authorization may be required. **Out-of-network** **Dental services covered by Medicare** • **$45 copay**

Services that are covered for you	What you must pay when you get these services
	• See the *Outpatient diagnostic tests and therapeutic services and supplies*, and/or the *Outpatient surgery*, and/or the *Inpatient hospital care, and/or the Physician/ Practitioner Services* sections in this chart. **Dental services covered by supplemental benefits** • Devoted Health will pay as much as **$1,000 per year** for covered dental services from in- and out-of-network providers combined. • You may have a cost-share for any out-of-network dental services you receive. See the dental code grid located under *Mandatory Supplemental Dental Benefits* at the end of this chapter for full details, including any applicable cost share. • Advanced determination encouraged. Contact us for more information.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**There is no coinsurance, copayment, or deductible for an annual depression screening visit.**

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.**

Services that are covered for you	What you must pay when you get these services

Diabetes self-management training, diabetic services and supplies
 	
For all people who have diabetes (insulin and non-insulin users). Covered services include:
 	
Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancing devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.
 	
The only covered brand of blood glucose monitors and supplies is OneTouch, manufactured by LifeScan. In general, alternate non-preferred brand products are not covered unless your doctor provides adequate information that the use of an alternate brand is medically necessary in your specific situation. If you are new to Devoted Health and are using a non-preferred brand of blood glucose monitor and test strips, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate non-preferred brand. During this time, you should talk with your doctor to decide whether any of the preferred product brands listed above are medically appropriate for you. Non-preferred brand products will not be covered following the initial 90 days of coverage without an approved prior authorization for a coverage exception. For both existing and new members, if it is medically necessary for you to use or continue to use an alternate non-preferred brand product, you or your provider may request a coverage exception to have Devoted Health cover a non-preferred brand product through the end of the benefit year. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. For more information on making an appeal, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
	In-network
	
	<u>Diabetes Self-Management Training:</u>
	
	$0 copay
	
	<u>Diabetic Services and Supplies:</u>
	
	$0 copay
	
	• Blood glucose monitor
	• Continuous glucose monitor
	  • Our preferred product, Freestyle Libre, is available at no cost to you when ordered by a physician.
	  • If any other CGM is authorized, your Durable Medical Equipment (DME) cost-share will apply.
	• Test strips
	• Lancets and lancing devices
	• Prior authorization may be required.
	
	<u>Diabetic Shoes & Therapeutic Inserts:</u>
	
	$0 copay
	
	You may need prior authorization for any of the above supplies. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more.
	
	Out-of-network

Services that are covered for you	What you must pay when you get these services

• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.
• Diabetes self-management training is covered under certain conditions.
• **Continuous Glucose Monitors (CGM):** Our preferred product is Freestyle Libre, which is available at in-network pharmacies with a $0 copay. If you utilize an out-of-network pharmacy to obtain our preferred product, you will need to pay up-front and submit for reimbursement from the plan. Other CGMs are available through DME suppliers that carry them. Other products will be considered DME, and your DME cost-share will apply. All other CGM devices will require prior authorization.
	<u>Diabetes Self-Management Training:</u>
	
	$0 copay
	
	<u>Diabetic Services and Supplies:</u>
	
	40% coinsurance
	
	• Blood glucose monitor
	• Continuous glucose monitor
	  • Our preferred product, Freestyle Libre, is available at no cost to you when ordered by a physician.
	  • If any other CGM is authorized, your Durable Medical Equipment (DME) cost-share will apply.
	• Test strips
	• Lancets and lancing devices
	• Advanced determination encouraged. Contact us for more information.
	
	<u>Diabetic Shoes & Therapeutic Inserts:</u>
	
	40% coinsurance
	
	Advanced determination encouraged for any of the above supplies. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 10 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. With this *Evidence of Coverage* document, we sent you Devoted LIBERTY CHOICE Arizona (PPO)'s list of DME. The list tells you the brands and manufacturers of DME that we will cover. We included a copy of our DME supplier directory in the envelope with this document. The most recent list of brands, manufacturers, and suppliers is also available on our website at www.devoted.com. Generally, Devoted LIBERTY CHOICE Arizona (PPO) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to Devoted LIBERTY CHOICE Arizona (PPO) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)	**In-network** **Advanced Durable Medical Equipment (listed below): 20% coinsurance** • Medicare-covered ventilator • Bone growth stimulator • Portable oxygen concentrator • Bariatric equipment • Specialty beds • Custom or specialty wheelchairs and scooters • Seat lifts • Specialty brand items • High Frequency Chest Compression Vests • Pain Infusion Pump • Continuous Glucose Monitor (We cover a Freestyle Libre CGM at $0 copay. All other Continuous Glucose Monitor products will have 20% coinsurance. See *Diabetes self-management training, diabetic services and supplies* in this chart for more information.) Prior authorization may be required for the above items. **All other Durable Medical Equipment and Supplies: 20% coinsurance**

Services that are covered for you	What you must pay when you get these services
If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 7, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* **Your plan also pays for supplemental (extra) benefits:** **Bathroom Safety Equipment:** The following Bathroom Safety Equipment is covered by Devoted Health for members who have a functional impairment when having the item will improve safety (installation is not covered by Devoted Health): • Standard Raised Toilet Seat: 1 per member every year • Standard Tub Seat: 1 per member every year	Your cost-sharing for Medicare oxygen and oxygen supplies coverage is 20% coinsurance, every month for delivery of oxygen and oxygen contents, tubing and related oxygen accessories for the delivery of oxygen and oxygen contents, and maintenance and repairs of oxygen equipment. Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month for rental of oxygen equipment. If prior to enrolling in Devoted LIBERTY CHOICE Arizona (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in Devoted LIBERTY CHOICE Arizona (PPO) remains the same as described above. Prior authorization may be required for the above items. **Bathroom Safety Equipment:** **Standard Raised Toilet Seat:** **$0 copay** **Standard Tub Seat:** **$0 copay** You need your provider to check that you need these items — and to order them for you. **Out-of-network**

Services that are covered for you	What you must pay when you get these services
	<u>Advanced Durable Medical Equipment (listed below)</u>: 40% coinsurance • Medicare-covered ventilator • Bone growth stimulator • Portable oxygen concentrator • Bariatric equipment • Specialty beds • Custom or specialty wheelchairs and scooters • Seat lifts • Specialty brand items • High Frequency Chest Compression Vests • Pain Infusion Pump • Continuous Glucose Monitor (other than Freestyle Libre) Advanced determination encouraged. Contact us for more information. **<u>All other Durable Medical Equipment and Supplies</u>: 40% coinsurance** Your cost-sharing for Medicare oxygen and oxygen supplies coverage is 40% coinsurance, every month for delivery of oxygen and oxygen contents, tubing and related oxygen accessories for the delivery of oxygen and oxygen contents, and maintenance and repairs of oxygen equipment. Your cost-sharing for Medicare oxygen equipment coverage is 40% coinsurance, every month for rental of oxygen equipment.

Services that are covered for you	What you must pay when you get these services
	If prior to enrolling in Devoted LIBERTY CHOICE Arizona (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in Devoted LIBERTY CHOICE Arizona (PPO) remains the same as described above. Advanced determination encouraged. Contact us for more information. **Bathroom Safety Equipment*:** **Standard Raised Toilet Seat: 40% coinsurance** **Standard Tub Seat: 40% coinsurance** You need your provider to check that you need these items — and to order them for you.

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Your plan also pays for supplemental (extra) benefits:** You're covered for emergency care worldwide. When you have an emergency outside of the U.S. and its territories, you have to pay the costs yourself at first. Then, you submit a claim to us so we can pay you back. But there are a few things to know: • We'll cover costs up to what we pay providers in the US — if your costs are higher, you'll have to pay the difference. • You still have to pay your typical share of the costs, such as your standard copayment for an emergency room visit. For more information, please see Chapter 5 or call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.	**$120 copay per stay for each emergency room visit** • If you're admitted to the hospital within 24 hours — for the issue you went to the emergency room for — you won't have a copayment. (For more on the costs of a hospital stay, see the Inpatient Hospital Care section of this chart.) • If you move into an observation status, your emergency care copay will be waived and you will pay your observation stay copay. For more information, see the outpatient hospital observation section of this chart. **Worldwide Emergency Care (Services outside the United States)*** • Your cost-share for emergency services worldwide is: • **$120 copay per stay**

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs — SilverSneakers® **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations.[1] You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. Your SilverSneakers membership also gives you GetSetUp[3], with hundreds of interactive online classes to ignite your interests in topics like cooking and nutrition, technology and brain games. Activate your free online account at SilverSneakers.com to view your SilverSneakers Member ID number, and all program features available to you at no additional cost. For additional questions, go to SilverSneakers.com or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.** 1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.	**SilverSneakers® Membership** **$0 membership** • Devoted Health covers the full cost of this benefit. • There is no coinsurance, copayment, or deductible for covered gym membership.

Services that are covered for you	What you must pay when you get these services
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. 3. GetSetUp is a third-party service provider and is not owned or operated by Tivity Health, Inc. (“Tivity”) or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.	

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs — Wellness Bucks **Devoted Health Wellness Bucks** Devoted Health will **reimburse you up to $150 per year** for participation or purchase of one or more of the following: *Purchase of activity/fitness trackers:* • Apple Watch® or other device that tracks number of steps and heart rate *Participation in instructional fitness or educational classes such as:* • Yoga, Pilates, Zumba, Tai Chi, aerobics/group fitness classes, strength training, spin classes, Crossfit, personal training (taught by a certified instructor), etc. • Nutritional counseling with a licensed nutritional counselor or registered dietitian, diabetes workshop programs, AAA Senior Driving program, etc. *Program fees for weight-loss programs such as:* • Jenny Craig, Weight Watchers, or hospital-based weight-loss programs. • The purchase of food in conjunction with these programs is not covered. *Memory fitness activities:* • Programs that improve your brain's speed and ability, strengthen memory, and enable learning. Eligible programs must help you set a goal and must track your progress towards your memory fitness goals. *Program fees for mindfulness applications:*	**Devoted Health Wellness Bucks** **$150 per year**

Services that are covered for you	What you must pay when you get these services
• Subscription costs for mindfulness applications, such as Calm or Headspace, to support your health and well-being. *Purchase of fitness equipment to be used in the home:* • Examples include free weights, treadmill or stationary bike, rowing machines, resistance bands, or other items that can be used in the home to support health and fitness goals. *Membership in a qualified health club or fitness facility:* • A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment. To get the most out of your benefits, you can use your $0 SilverSneakers membership to access fitness facilities and reserve your Wellness Bucks for other eligible purchases. *Certain over the counter items used in conjunction with a Devoted Health care or disease management program* • Connected (3G/LTE) blood pressure cuff for those members enrolled in and consistently participating in Devoted's Blood Pressure Monitoring Program • Connected (3G/LTE) scale for those members enrolled in and consistently participating in Devoted's Congestive Heart Failure Monitoring Program • Spirometers for those members enrolled in and consistently participating in Devoted's COPD Monitoring Program • Pulse oximeter for those members enrolled in and consistently participating in Devoted's Care Management programs	

Services that are covered for you	What you must pay when you get these services
Devoted Health will reimburse you up to $150 per year towards your cost for any of the above programs and/ or services. You can submit as many reimbursement forms as necessary but you will be responsible for all costs above $150 per year. While services can be combined, the total amount reimbursed by Devoted Health will not exceed $150 per year. This is a reimbursable benefit. You must pay out-of-pocket and submit for reimbursement. Reimbursement requests must be received by March 31, 2025. We are unable to process any 2024 "Wellness Bucks" reimbursements after this date. The date of service or purchase must be after your effective date with Devoted Health and must be within the 2024 plan year. 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. **Wellness Bucks Exclusions**: Outdoor recreational equipment (bicycles, bowling balls, game balls, golf clubs, rollerblades, skates, skis, tennis equipment), membership fees for recreational clubs, rod and gun clubs, country clubs, social clubs, public and private golf courses and green fees, fitness clothing and shoes, medical ID bracelets, saunas, ice therapy machines, spa services, massage equipment, exercise CDs/ videos, lodging, meals, vitamins and supplements are not eligible for reimbursements. You may not use Wellness Bucks towards copayments and/or coinsurance for services in this grid. You may not use Wellness Bucks towards copayments and/or coinsurance for any prescription or over-the-counter medications. For more information, visit us online at www.devoted.com or give us a call.	

Services that are covered for you	What you must pay when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. The services above are all covered by Medicare. **Your plan also pays for supplemental (extra) benefits:** Your plan also pays for supplemental (extra) hearing benefits, including coverage for routine hearing exams, hearing aid evaluations and fittings, and hearing aids. **Hearing aids:** Up to two TruHearing®-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing®'s Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for an additional $50 per aid. Benefit is combined in- and out-of-network. You must see a TruHearing® provider to use this benefit. Call Member Services at 1-800-DEVOTED (1-800-338-6833) to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits	**In-network** **Hearing services covered by Medicare** **$45 copay** **Routine hearing exam** **$0 copay** • You are covered for 1 routine hearing exam from in- or out-of-network providers each year. **Hearing aid fitting** **$0 copay** **Hearing aids*** **$599 copay per ear** for Advanced hearing aid **$899 copay per ear** for Premium hearing aid • You are covered for up to two hearing aids per year, one per ear. • You must use Devoted Health's hearing aid vendor to obtain this benefit. If you utilize other providers you will be responsible for the full cost. • $50 additional cost per aid for optional hearing aid rechargeability. **Out-of-network** **Hearing services covered by Medicare** **$45 copay**

Services that are covered for you	What you must pay when you get these services
• Additional batteries; batteries when a rechargeable hearing aid is • Hearing aids that are not TruHearing®-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	**Routine hearing exam** **$0 copay** • You are covered for 1 routine hearing exam from in- or out-of-network providers each year. **Hearing aid fitting** **$0 copay** **Hearing aids*** **$599 copay per ear** for Advanced hearing aid **$899 copay per ear** for Premium hearing aid • You are covered for up to two hearing aids per year, one per ear. • You must use Devoted Health's hearing aid vendor to obtain this benefit. If you utilize other providers you will be responsible for the full cost. • $50 additional cost per aid for optional hearing aid rechargeability • TruHearing® provider must be used for in- and out-of-network hearing aid benefit

Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.**
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-network** **$0 copay** • Authorization is not required for an initial home health care evaluation, but your PCP must order one for you. • You may need prior authorization for ongoing home health care or for durable medical equipment. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more. **Out-of-network** **40% coinsurance** • Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In-network** **Professional Services** **$0 copay** **Patient Training & Education** **$0 copay** **Remote Patient Monitoring** **$0 copay** **Durable Medical Equipment**: Please refer to the "Durable medical equipment (DME) and related supplies" in this chart. **Part B Drugs**: Please refer to the "Medicare Part B prescription drugs" section in this chart. **Medical Supplies**: Please refer to the "Outpatient diagnostic tests and therapeutic services and supplies" section in this chart. Prior authorization may be required. **Out-of-network** **Professional Services** $0 copay **Patient Training & Education** $0 copay **Remote Patient Monitoring** $0 copay

Services that are covered for you	What you must pay when you get these services
	Durable Medical Equipment: Please refer to the "Durable medical equipment (DME) and related supplies" in this chart. **Part B Drugs**: Please refer to the "Medicare Part B prescription drugs" section in this chart **Medical Supplies**: Please refer to the "Outpatient diagnostic tests and therapeutic services and supplies" section in this chart Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums, if applicable. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Devoted LIBERTY CHOICE Arizona (PPO). **Initial hospice assessment** **$0 copay** • There is no coinsurance, copayment, or deductible for an initial hospice assessment.

Services that are covered for you	What you must pay when you get these services
• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Devoted LIBERTY CHOICE Arizona (PPO) but are not covered by Medicare Part A or B: Devoted LIBERTY CHOICE Arizona (PPO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.**

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	**In-network** **You pay $395 per day for days 1 through 6** **You pay $0 for day(s) 7+** • With Devoted Health, you are covered for an unlimited number of days in an inpatient hospital. • Your doctor should notify us if you require an inpatient admission. • You need prior authorization for elective inpatient admissions. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more. **Out-of-network** **You pay $395 per day for days 1 through 6** **You pay $0 for day(s) 7+** • With Devoted Health, you are covered for an unlimited number of days in an inpatient hospital. • Your doctor should notify us if you require an inpatient admission. • Advanced determination encouraged for all elective admissions. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Devoted LIBERTY CHOICE Arizona (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711 so we can help. • Blood — including storage and administration. Coverage begins with the first pint used (including for whole blood, packed red cells and all other components of blood) • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	

Services that are covered for you	What you must pay when you get these services
You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. You can get inpatient care at a psychiatric hospital for a total of 190 days over the course of your life. If you get inpatient mental health care in the psychiatric unit of a general hospital, it doesn't count toward your 190 days.	**In-network** **You pay $395 per day for days 1 through 5** **You pay $0 per day for days 6 through 90** • You are covered for up to 90 days each benefit period for inpatient services in an inpatient psychiatric hospital, based on Medicare guidelines. • You may need prior authorization. • Call Magellan, our behavioral health provider, to find a network provider. You can reach them at 1-800-776-8684. **Out-of-network** **You pay $395 per day for days 1 through 5** **You pay $0 per day for days 6 through 90** • You are covered for up to 90 days each benefit period for inpatient services in an inpatient psychiatric hospital, based on Medicare guidelines. • Advanced determination encouraged. Contact Magellan at 1-800-776-8684 for more information. • Your doctor should notify us if you require an inpatient admission.

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	When the cost of the inpatient stay itself isn't covered, your plan still pays for some of the services you receive. To check your coverage and costs, you can look up specific services in this chart. Prior authorization may be required.

Services that are covered for you	What you must pay when you get these services
Meals **Your plan also pays for supplemental (extra) benefits:** **Post-Discharge Meal Service** • After an inpatient stay in a hospital or a skilled nursing facility, you can get 2 meals per day for up to 10 days. • You'll get precooked, frozen meals delivered to your home. • You can use this benefit 4 times per calendar year. **Chronic Condition Meal Service** • If part of your care plan for a chronic condition means changing how you eat, or you are diagnosed with a condition that requires you stay at home, you can have meals delivered to your home to support your condition. • You can get up to 2 meals per day for up to 14 days. • You can use this service only once per calendar year per new diagnosis. You must use Devoted Health's vendor to access this benefit.	**Post-Discharge Meal Service:** **$0 copay** • To start your meal service, you or your PCP can call us at 1-800-DEVOTED (1-800-338-6833) TTY 711. **Chronic Condition Meal Service:** **$0 copay** • To start your meal service, you or your PCP can call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.**
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight-loss and a healthy lifestyle.	**There is no coinsurance, copayment, or deductible for the MDPP benefit.**

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.devoted.com/prescription-drugs/drug-coverage-limits/2024-st-list-part-b-drugs	**In-network** **Allergy Serum:** **$0 copay at:** • A PCP's office • A specialist's office • An outpatient hospital setting **Generic Nebulized Medications:** **$0 copay at:** • A PCP's office • A specialist's office • An outpatient hospital setting **Chemotherapy Drugs:** **20% coinsurance at:** • A PCP's office • A specialist's office • In the home • An outpatient hospital setting **All Other Part B Drugs:** **20% coinsurance at:** • A PCP's office • A specialist's office • In the home • An outpatient hospital setting If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. Any of your out-of-pocket costs for Part B drugs will count towards your annual maximum out-of-pocket.

Services that are covered for you	What you must pay when you get these services
We also cover some vaccines under our Part B prescription drug benefit. The amount you pay for Part B rebatable drugs will be reduced if the drug's price has increased at a rate faster than the rate of inflation. The list of Part B rebatable drugs, as well as the amount you pay for those drugs, may change each quarter (January, April, July, October); however, you will never pay more than your Part B drug cost. You will pay no more than $35 for a 30-day supply of Medicare Part B-covered insulins (when you use insulin via a pump). Please give us a call if you have any questions.	You may also have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." You may need prior authorization for the above services. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more details. **Out-of-network** **<u>Allergy Serum:</u>** **35% coinsurance at:** • A PCP's office • A specialist's office • An outpatient hospital setting **<u>Generic Nebulized Medications:</u>** **35% coinsurance at:** • A PCP's office • A specialist's office • An outpatient hospital setting **<u>Chemotherapy Drugs:</u>** **35% coinsurance at:** • A PCP's office • A specialist's office • In the home • An outpatient hospital setting **<u>All Other Part B Drugs:</u>** **35% coinsurance at:** • A PCP's office • A specialist's office • In the home • An outpatient hospital setting

Services that are covered for you	What you must pay when you get these services
	If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. Any of your out-of-pocket costs for Part B drugs will count towards your annual maximum out-of-pocket. Advanced determination encouraged. Contact us for more information.
🍏 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.**

Services that are covered for you	What you must pay when you get these services
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Devoted Health also covers methadone treatment for opioid dependence.	**In-network** **$45 copay** • Call Magellan, our behavioral health provider, to find a network provider. You can reach them at 1-800-776-8684. **Out-of-network** **$45 copay**

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood — including storage and administration. Coverage begins with the first pint used (including for whole blood, packed red cells and all other components of blood). • Other outpatient diagnostic tests, including molecular diagnostic/genetic testing and advanced imaging such as MRI, CT scans, nuclear stress test, EKG/ECG/EEG, and PET scans	**In-network** **X-rays & Ultrasounds** **$0 copay at:** • A PCP's office • A specialist's office • An urgent care center **$0 copay at:** • A stand-alone facility **$50 copay at:** • An outpatient hospital setting **Radiation Therapy** **20% coinsurance at:** • A PCP's office • A specialist's office • A stand-alone radiology center **20% coinsurance at:** • An outpatient hospital setting **Medical Supplies** **$0 copay** **Lab Services** **$0 copay at:** • A PCP's office • A specialist's office • A stand-alone lab • An urgent care center **$0 copay at:** • An outpatient hospital setting

Services that are covered for you	What you must pay when you get these services
	Blood Services **$0 copay** **Diagnostic procedures and tests** **$0 copay at:** • A PCP's office • A specialist's office • An urgent care center • A stand-alone facility **$50 copay at:** • An outpatient hospital setting **Advanced Imaging Services** (This includes MRI, CT scans, etc.): **$0 copay at:** • A PCP's office • A specialist's office • A stand-alone imaging center **$250 copay at:** • An outpatient hospital setting If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. Prior authorization may be required for the above services. **Out-of-network** **X-rays & Ultrasounds** **$0 copay at:** • A PCP's office

Services that are covered for you	What you must pay when you get these services
	• A specialist's office • An urgent care center **$0 copay at**: • A stand-alone facility **$50 copay at:** • An outpatient hospital setting **Radiation Therapy** **40% coinsurance at:** • A PCP's office • A specialist's office • A stand-alone radiology center **40% coinsurance at:** • An outpatient hospital setting **Medical Supplies** **40% coinsurance** **Lab Services** **$0 copay at:** • A PCP's office • A specialist's office • A stand-alone lab • An urgent care center **$0 copay at:** • An outpatient hospital setting **Blood Services** **$0 copay** **Diagnostic procedures and tests** **$0 copay at:** • A PCP's office

Services that are covered for you	What you must pay when you get these services
	• A specialist's office • An urgent care center • A stand-alone facility **$50 copay at:** • An outpatient hospital setting **Advanced Imaging Services** (This includes MRI, CT scans, etc.): **$0 copay at:** • A PCP's office • A specialist's office • A stand-alone imaging center **$250 copay at:** • An outpatient hospital setting If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network** **$395 copay per stay** This is the most you will pay during an observation stay. Covered health care services provided during an observation stay will not have additional copays. **Out-of-network** **$395 copay per stay** This is the most you will pay during an observation stay. Covered health care services provided during an observation stay will not have additional copays.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network** **Diagnostic Colonoscopies:** • **$0 copay** at any in-network location **Visits to an Outpatient Hospital have a $350 copay.** Cost-sharing for certain services performed in an Outpatient Hospital setting may be lower, depending on the service performed. For detailed information, please refer to the appropriate section of this Evidence of Coverage. Emergency services: Please refer to the "Emergency Care" section in this chart. Outpatient surgery: Please refer to the "Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" section in this chart. Laboratory and diagnostic tests, X-rays, radiological services, and medical supplies: Please refer to the "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" section in this chart.

Services that are covered for you	What you must pay when you get these services
	Mental health care, partial hospitalization, and chemical dependency care: Please refer to the "Outpatient Mental Health Care", "Partial Hospitalization Services", and "Outpatient Substance Abuse Services" sections in this chart. Drugs and biologicals that you can't give yourself: Please refer to the "Medicare Part B Prescription Drugs" section in this chart. You may need prior authorization for the above services. If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. **Out-of-network** **Diagnostic Colonoscopies:** • **$0 copay** at any out-of-network location **Visits to an Outpatient Hospital have a $350 copay.** Cost-sharing for certain services performed in an Outpatient Hospital setting may be lower, depending on the service performed. For detailed information, please refer to the appropriate section of this Evidence of Coverage.

Services that are covered for you	What you must pay when you get these services
	Emergency services: Please refer to the “Emergency Care” section in this chart. Outpatient surgery: Please refer to the “Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers” section in this chart. Laboratory and diagnostic tests, X-rays, radiological services, and medical supplies: Please refer to the “Outpatient Diagnostic Tests and Therapeutic Services and Supplies” section in this chart. Mental health care, partial hospitalization, and chemical dependency care: Please refer to the "Outpatient Mental Health Care", "Partial Hospitalization Services", and "Outpatient Substance Abuse Services" sections in this chart. Drugs and biologicals that you can’t give yourself: Please refer to the “Medicare Part B Prescription Drugs” section in this chart. If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined in this section. Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care (individual and group) Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network** **Individual Therapy** **$45 copay** **Group Therapy** **$45 copay** • You may need prior authorization for the above services. • Call Magellan, our behavioral health provider, to find a network provider. You can reach them at 1-800-776-8684. **Out-of-network** **Individual Therapy** **$45 copay** **Group Therapy** **$45 copay** • Advanced determination encouraged. Contact Magellan at 1-800-776-8684 for more information.

Services that are covered for you	What you must pay when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. For Lymphedema Therapy, you will pay your specialist copay. See the "Physician/Practitioner services, including doctor's office visit" row in this chart for details. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-network** **Physical Therapy** **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting **Occupational Therapy** **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting **Speech Therapy** **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined above. **Out-of-network**

Services that are covered for you	What you must pay when you get these services
	<u>Physical Therapy</u> **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting **<u>Occupational Therapy</u>** **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting **<u>Speech Therapy</u>** **$45 copay at:** • A specialist's office • A comprehensive outpatient rehabilitation facility **$45 copay at:** • An outpatient hospital setting If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services outlined above.

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services You're covered for outpatient treatment and counseling services for substance abuse, such as drug or alcohol abuse.	**In-network** **$45 copay** • To get started, call Magellan, our behavioral health provider. You can reach them at 1-800-776-8684. **Out-of-network** **$45 copay**

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-network** **Diagnostic Colonoscopies:** • **$0 copay** at any in-network location **Outpatient Procedures/Surgery at an Ambulatory Surgical Center (ASC):** • **$295 copay** for outpatient procedures/surgery at an ASC **Outpatient Procedures/Surgery at an Outpatient Hospital:** • **$350 copay** for outpatient procedures/surgery at an Outpatient Hospital You may need prior authorization for outpatient surgery. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more. **Out-of-network** **Diagnostic Colonoscopies:** • **$0 copay** at any out-of-network location **Outpatient Procedures/Surgery at an Ambulatory Surgical Center (ASC):** • **$295 copay** for outpatient procedures/surgery at an ASC **Outpatient Procedures/Surgery at an Outpatient Hospital:**

Services that are covered for you	What you must pay when you get these services
	• **$350 copay** for outpatient procedures/surgery at an Outpatient Hospital Advanced determination encouraged. Contact us for more information.
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**In-network** **$70 copay per day** • You may need prior authorization. • Call Magellan, our behavioral health provider, to find a network provider. You can reach them at 1-800-776-8684. **Out-of-network** **$70 copay per day** • Advanced determination encouraged. Contact Magellan at 1-800-776-8684 for more information.

Services that are covered for you	What you must pay when you get these services
Personal Emergency Response System (PERS) **Your plan also pays for supplemental (extra) benefits:** A Personal Emergency Response System (PERS) is a medical alert monitoring system that provides 24/7 access to help at the push of a button. In the event of a fall or other emergency, simply press the lightweight, waterproof help button and get connected directly to LifeStation's Monitoring Center. • You must use our contracted supplier to obtain this benefit. • We offer different styles to best fit your lifestyle, including devices with fall detection and multiple mobile-enabled wearable devices. Benefit includes: • Cost of the device • Monthly monitoring fees • Fall detection (available on certain styles) • We cover one device per year. Replacement of lost or damaged devices is not covered, and you are responsible for the costs.	**$0 copay** • Call us at 1-800-DEVOTED (1-800-338-6833), TTY 711 to learn more. • There is no authorization required.

Services that are covered for you	What you must pay when you get these services
Physical exam (Routine) In addition to the Annual Wellness Visit or the Welcome to Medicare physical exam, the following exam is covered once per calendar year by Devoted Health: • Comprehensive physical examination and evaluation of chronic conditions May include history, examination, and counseling/risk factor reduction interventions. **Note:** the physical exam does not include lab tests or diagnostic tests or procedures. Any lab or diagnostic testing performed during your visit may have additional cost-sharing, as described in the "Outpatient diagnostic tests and therapeutic services and supplies" section of this chart.	**In-network** **$0 copay** **Out-of-network** **$0 copay**

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain additional telehealth services. See "Telehealth services" section in this chart. • Remote evaluation of pre-recorded video and/or images sent to your doctor • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.)	**In-network** **Visits to your Primary Care Physician (PCP):** **$0 copay** • This is the amount you will pay for each visit to your **Primary Care Physician (PCP)**. **Visits to your Specialists:** **$45 copay** • This is the amount you will pay for each visit to your **Specialists**. You do not need a prior authorization to see your PCP; however, you may need prior authorization for any medical care that your PCP or Specialist provides (e.g. diagnoses treatments, or surgeries). Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more. If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services. Cost-share for other services performed in an outpatient setting are outlined in this chapter. **Out-of-network**

Services that are covered for you	What you must pay when you get these services
	<u>Visits to your Primary Care Physician (PCP):</u> **$45 copay** • This is the amount you will pay for each visit to your **Primary Care Physician (PCP)**. **<u>Visits to your Specialists:</u>** **$45 copay** • This is the amount you will pay for each visit to your **Specialists**. If your provider bills us as part of a hospital system, you may be responsible for the outpatient hospital setting cost-share for the services. Cost-share for other services performed in an outpatient setting are outlined in this chapter. Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In-network** **Medicare-Covered Foot Care** **$45 copay** • This is the amount you will pay for podiatry services and visits covered by Medicare criteria. **Out-of-network** **Medicare-Covered Foot Care** **$45 copay** • This is the amount you will pay for podiatry services and visits covered by Medicare criteria.
🍎 **Prostate cancer screening exams** For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**There is no coinsurance, copayment, or deductible for an annual PSA test.**

Services that are covered for you	What you must pay when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more details. **Your plan also pays for supplemental (extra) benefits:** Gradient compression stockings or surgical stockings are covered for members with lower limb peripheral edema, venous insufficiency without stasis ulcers, lymphedema, symptomatic varicosities, post-thrombotic syndrome (post-phlebitic syndrome), or postural hypotension; or to prevent the reoccurrence of stasis ulcers that have healed. • Gradient compression stockings: up to 2 pairs every 6 months OR surgical stockings: up to 2 pairs every 6 months • Mastectomy sleeves for member with diagnosis of Postmastectomy lymphedema: up to 2 sleeves every 6 months Note: Devoted Health will continue to cover gradient compression stockings according to Medicare coverage guidelines for venous insufficiency with stasis ulcers. You must receive a written prescription from a network physician to obtain these items. You must use a contracted supplier to obtain covered items. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more.	**In-network** **Compression Stockings & Mastectomy Sleeves:** **$0 copay** **Ostomy Supplies & Urological Supplies:** **20% coinsurance** **All other prosthetic devices and related supplies:** **20% coinsurance** You may need prior authorization for any of the above items or related supplies. Call us at 1-800-DEVOTED (1-800-338-6833) TTY 711 to learn more. **Out-of-network** **Compression Stockings & Mastectomy Sleeves*:** **40% coinsurance** **Ostomy Supplies & Urological Supplies:** **40% coinsurance** **All other prosthetic devices and related supplies:** **40% coinsurance** Advanced determination encouraged. Contact us for more information.

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Your provider must check that you need this service — and order it for you.	**In-network** **$15 copay** **Out-of-network** **$15 copay**
🍏 **Screening and counseling to reduce alcohol misuse** We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.**

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low-dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.**

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.**

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs.	**In-network** **Kidney disease education services** **$0 copay** • Your provider must check that you need this service — and order it for you. **Renal dialysis services** **20% coinsurance** **Out-of-network** **Kidney disease education services** **$0 copay** • Your provider must check that you need this service — and order it for you. **Renal dialysis services** **20% coinsurance**

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for up to 100 days per benefit period. Unlike traditional Medicare, you **do not** need to be in the in the hospital for 3 days prior to going to an SNF. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood — including storage and administration. Coverage begins with the first pint used (including for whole blood, packed red cells and all other blood components) • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	**In-network** **You pay $0 per day for days 1 through 20** **You pay $203 per day for days 21 through 52** **You pay $0 per day for days 53 through 100** • Reminder: You'll stop paying these costs once you reach the plan's maximum out-of-pocket amount. • You are covered for up to 100 days each benefit period for inpatient services in a SNF, based on Medicare guidelines. • A benefit period starts on the first day you go to a SNF. It ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to a SNF after one benefit period has ended, a new benefit period begins. • There's no limit to the number of benefit periods you can have. • Prior authorization may be required. **Out-of-network** **40% coinsurance per stay** • Reminder: You'll stop paying these costs once you reach the plan's maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	• You are covered for up to 100 days each benefit period for inpatient services in a SNF, based on Medicare guidelines. • A benefit period starts on the first day you go to a SNF. It ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to a SNF after one benefit period has ended, a new benefit period begins. • There's no limit to the number of benefit periods you can have. • Advanced determination encouraged. Contact us for more information.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.**

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Your provider must check that you need this service — and order it for you. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-network** **$15 copay** • You don't need a prior authorization for your plan to pay for this, but you do need your provider to check that you need it — and to order it for you. **Out-of-network** **$15 copay**

Services that are covered for you	What you must pay when you get these services
Telehealth services Devoted Health will cover physician/practitioner visits performed virtually (such as over the phone or video chat) by a provider who offers the service by telehealth. • Certain telehealth services, including: • primary care visits • physician specialist visits • mental health visits (individual and group) • podiatry visits • psychiatric visits (individual and group) • physical therapy, occupational therapy, and speech language pathology services • substance abuse sessions (individual and group) • kidney disease education • diabetes self-management training • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances	**In-network** **Virtual PCP Visits** **$0 copay** **Virtual Specialist Visits** **$45 copay** **Virtual Behavioral Health Visits** **$45 copay** **Virtual Visits for Occupational, Physical, and Speech Therapy** **$45 copay** **Out-of-network** **Virtual PCP Visits** **$45 copay** **Virtual Specialist Visits** **$45 copay** **Virtual Behavioral Health Visits** **$45 copay** **Virtual Visits for Occupational, Physical, and Speech Therapy** **$45 copay**

Services that are covered for you	What you must pay when you get these services
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: • You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment This benefit may not be offered by all providers. Speak to your doctor about available telehealth options. Check directly with your provider about the availability of telehealth services.	

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Your plan also pays for supplemental (extra) benefits:** You're covered for urgently needed services worldwide. When you have an urgent care need outside of the U.S. and its territories, you have to pay the costs yourself at first. Then, you submit a claim to us so we can pay you back. • We'll cover costs up to what we pay providers in the US — if your costs are higher, you'll have to pay the difference. • You still have to pay your typical share of the costs, such as your standard copayment for an ambulance service. • If you receive urgently needed services outside the United States or its territories, you will pay your emergency care copay. See the Emergency Care section of this chart for details.	**In-network** **Urgently Needed Services at your PCP** **$0 copay** **Urgently Needed Services at an Urgent Care Center or Walk-in Retail Clinic** **$50 copay** • You pay a $50 copay for urgently needed services provided in an Urgent Care Center. • Services provided in an Emergency Room of a hospital will incur an Emergency Room copay. See the *Emergency care* section of this chart for more details. **Worldwide Urgently Needed Services (Services outside the United States)*** • Your cost-share for urgently needed services worldwide is: **$120 copay** **Out-of-network** **Urgently Needed Services at your PCP** **$45 copay** **Urgently Needed Services at an Urgent Care Center or Walk-in Retail Clinic**

Services that are covered for you	What you must pay when you get these services
For more information, please see Chapter 5 or call us at 1-800-DEVOTED (1-800-338-6833) TTY 711.	**$50 copay** • You pay a $50 copay for urgently needed services provided in an Urgent Care Center. • Services provided in an Emergency Room of a hospital will incur an Emergency Room copay. See the *Emergency care* section of this chart for more details. **Worldwide Urgently Needed Services (Services outside the United States)*** • Your cost-share for urgently needed services worldwide is: **$120 copay**

Services that are covered for you	What you must pay when you get these services
🍎 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) The services above are all covered by Medicare. **Your plan also pays for supplemental (extra) benefits:** As a member of Devoted Health, you have coverage for a routine eye exam (including refraction, if needed) and money toward eyeglasses and/or contact lenses.	**In-network** **Vision services covered by Medicare** **$45 copay** This includes visits to a specialist for diagnostic vision services, including follow-up visits after cataract surgery. **Annual Glaucoma Screening** **$0 copay** **Annual Diabetic Retinopathy Screening** **$0 copay** **Medicare-covered eyeglasses or contacts (after cataract surgery)** **$0 copay** • You are covered for two pairs of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery. **Routine eye exam** **$0 copay** • You are covered for 1 routine vision exam each year from in- or out-of-network providers. **Out-of-network** **Vision services covered by Medicare** **$45 copay**

Services that are covered for you	What you must pay when you get these services
	This includes visits to a specialist for diagnostic vision services, including follow-up visits after cataract surgery. **Annual Glaucoma Screening** **$0 copay** **Annual Diabetic Retinopathy Screening** **$0 copay** **Medicare-covered eyeglasses or contacts (after cataract surgery)** **$0 copay** • You are covered for two pairs of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery. **Routine eye exam** **$0 copay** • You are covered for 1 routine vision exam from in- and out-of-network providers each year. **In-network and Out-of-network** **Eyewear** Your plan pays up to **$350 per year** for the following: • Eyeglasses and lenses • Replacement of frames or lenses

Services that are covered for you	What you must pay when you get these services
	• Contact lenses— the contact lens fitting fee is also covered and doesn't count towards your **$350 per year** allowance. • Multiple purchases may be made, up to the annual allowance. • Allowance can be used toward the combined purchase of both eyeglasses and contact lenses. If you use an in-network provider to obtain eyewear benefits, your costs up to **$350 per year** will be applied at the point of sale. You can use Devoted Health's in-network vendors to obtain eyewear benefits, or you can get your eyewear from other out-of-network providers. If you choose to get your eyewear from an out-of-network provider, you must pay out-of-pocket and submit for reimbursement. You will be reimbursed up to your annual maximum. You can submit as many reimbursement forms as necessary but you will be responsible for all costs above your annual maximum. While services can be combined, the total amount reimbursed will not exceed your annual maximum.

Services that are covered for you	What you must pay when you get these services
	Reimbursement requests must be received by March 31, 2025. We are unable to process any 2024 reimbursements after this date. The date of service or purchase must be after your effective date with Devoted Health and must be within the 2024 plan year. Exclusions: Items or services not listed above are not covered. This includes, but is not limited to elective vision procedures (corrective surgery, etc.).
🍎 **Welcome to Medicare preventive visit** The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	**There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.**

Mandatory Supplemental Dental Benefits

Devoted Health will pay as much as $1,000 per year for covered dental services listed below.

Your plan also pays for supplemental (extra) benefits:

- You are covered for cleanings, routine exams, x-rays, and more. Please review the chart below for a list of covered services and limitations.
- **If you receive dental services from an out- of-network dentist, you will be responsible for paying the difference between the negotiated fees and the fees your dental provider charges, including any applicable cost share, even for services listed as $0.**

- If you choose to see an out-of-network provider and pay out-of-pocket, you can ask for reimbursement. For contact information, see Chapter 2.
- Prior authorization may be required for some services — meaning your dentist needs to submit a claim form before performing those services. For services that don't require prior authorization, we strongly recommend that your dentist submit a claim form before performing services.

Exclusions & Limitations:

- You are only covered for the dental services, codes and limits listed in the chart below. It is recommended that you work with your dentist to check benefit eligibility prior to obtaining dental services.
- Any dental services that are furnished that are not listed as a covered code, or if you exceed any dental benefit limitation or annual dental coverage maximum, will not be covered by Devoted Health and you will be responsible for the full cost.
- Any out-of-pocket costs or cost-sharing amount related to supplemental dental services will not count towards your medical maximum out-of-pocket amount.
- If you and your dentist are unsure of your benefits for a specific course of treatment, Devoted Health recommends that you ask for a pre-treatment estimate, also known as advanced determination. You should ask your dentist to submit the claim form in advance of performing the proposed services. Before treatment begins, you'll receive information on whether the services are covered and an estimate of your share of the cost and how much Devoted Health will pay.
- Devoted's dental partner may perform pre- and/or post-treatment clinical review of services to determine if they are appropriate and necessary based on industry standards and that they meet our dental partner's clinical criteria and guidelines for coverage. Any treatment that is determined to not be necessary or does not meet clinical criteria will not be covered by the plan, and you will be responsible for all associated costs.

CODE	SERVICE	FREQUENCY	BENEFIT DETAILS
Preventive What you pay: In network 0% coinsurance, out of network 0% coinsurance			
Exams			
D0120	Routine check-up exam	2 procedures per calendar year	Not covered within 6 months of receiving D0150 or D0180
D0140	Dental evaluation to evaluate a specific problem or complaint	2 procedures per calendar year	Not covered with any other exam code on same day
D0150	Comprehensive new patient exam	1 procedure every 3 calendar years	Not covered within 3 years of receiving D0180

CODE	SERVICE	FREQUENCY	BENEFIT DETAILS
D0180	Exam for a new or established patient with gum disease or risk factors such as smoking or diabetes	1 procedure every 3 calendar years	Not covered within 3 years of receiving D0150
D0191	Assessment of a Patient	2 procedures per calendar year	Only covered on same day as receiving D9995 or D9996. Not covered when another exam code is submitted on same day.
X-rays			
D0210	Full mouth set of X-rays	1 procedure every 3 calendar years	Not covered within 3 years of receiving D0330
D0220	X-ray of entire tooth (first image)	1 procedure per date of service	Not covered on same day as D0210 or D0330
D0230	X-ray of entire tooth (additional images)	Unlimited	Not covered on same day as D0210 or D0330
D0270 **D0272** **D0273** **D0274** **D0277**	X-ray (bitewing procedures) for diagnosing cavities between teeth in the back of the mouth	1 bitewing procedure code per calendar year	Not covered in same year as D0210
D0330	Panoramic X-ray of all the teeth and surrounding bone	1 procedure every 3 years	Not covered within 3 years of receiving D0210
D0350	2D photographic image	1 procedure per calendar year	Only covered when performed on same day as D9995 or D9996
D0801	3D dental surface scan, direct	1 of (D0801, D0802) every calendar year	
D0802	3D dental surface scan, indirect	1 of (D0801, D0802) every calendar year	
D0803	3D facial surface scan, direct	1 of (D0803, D0804) every calendar year	
D0804	3D facial surface scan, indirect	1 of (D0803, D0804) every calendar year	

CODE	SERVICE	FREQUENCY	BENEFIT DETAILS
Cleanings			
D1110	Routine adult dental cleaning	2 procedures per calendar year	Cannot be performed on the same day as another type of cleaning (D4355, D4910, D4341, D4342) or gum surgery (D4210, D4211, D4240, D4241, D4260, D4261)
Fluoride			
D1208	Topical fluoride treatment	2 procedures per calendar year	2 topical fluoride treatments (D1208) per calendar year
Other Dental Services What you pay: In network 0% coinsurance, out of network 50% coinsurance			
Fillings			
D2140 **D2150** **D2160** **D2161**	Silver-colored filling on front, middle or back teeth	Unlimited	1 procedure per surface per tooth every 2 years
D2330 **D2331** **D2332** **D2335**	White-colored filling on front teeth	Unlimited	1 procedure per surface per tooth every 2 years
D2390	White-colored filling that replaces entire outer surface of a front tooth	Unlimited	1 procedure per tooth every 5 years
D2391 **D2392** **D2393** **D2394**	White-colored filling on middle or back teeth	Unlimited	1 procedure per surface per tooth every 2 years

CODE	SERVICE	FREQUENCY	BENEFIT DETAILS
Other Gum-Related Services			
D4341 **D4342**	Deep cleaning that's performed to remove bacteria, plaque and tartar below the gumline along the tooth roots	1 deep cleaning procedure code per quadrant every 3 calendar years, not to exceed 4 unique quadrants every 3 calendar years	Not covered if another cleaning (D1110, D4355, D4910) or gum surgery procedure (D4210, D4211, D4240, D4241, D4260, D4261) is performed on same day
D4355	Cleaning that's performed when there's too much tartar on the teeth to do an effective exam	1 procedure every 3 calendar years	Not covered if another cleaning (D1110, D4910), deep cleaning (D4341, D4342), or gum surgery procedure (D4210, D4211, D4240, D4241, D4260, D4261) is performed on same day
D4910	Routine dental cleaning for an adult with a history of gum disease	3 procedures per calendar year	Only covered with previous history of receiving a deep cleaning (D4341, D4342) or gum surgery (D4210, D4211, D4240, D4241, D4260, D4261)
Extractions and Oral Surgery			
D7140 **D7210**	Routine or surgical extractions of erupted teeth or exposed roots	Unlimited	1 extraction procedure code per tooth per lifetime
Miscellaneous Services			
D9110	Minor dental procedure to relieve pain or discomfort	1 procedure per calendar year	Only covered for an in-office dental emergency visit
D9995 **D9996**	Virtual/remote dental exams	2 procedures per calendar year	Only covered if a D0140 or D0191 exam is performed on the same day

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. *Removal* of breast implants is covered when it is medically necessary, regardless of the original reason for the implants. Breast implant replacement is only covered for the two scenarios listed in the above bullet points.
Custodial care. (Care that helps with activities of daily living that does not require professional skills or training e.g. bathing and dressing.) Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
daily living, such as bathing or dressing.		
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	
Full-time nursing care in your home.	Not covered under any condition	
Home-delivered meals		Certain meals are covered as a supplemental benefit. Please see the Meals Benefit in the Medical Benefits Chart in Section 2.1 for details.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	Not covered under any condition	
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care. In addition, certain dental care services are covered as a supplemental benefit. Please see the dental services benefit in the Medical Benefits Chart in Section 2.1 for details.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition	
Private room in a hospital.		Covered only when medically necessary.
Refractions as part of a medical exam/claim	Not covered under any condition	
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	Not covered under any condition	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery as part of Medicare-covered services. Some ophthalmologists perform surgery to remove cataracts using a laser and some people need specialized lenses implanted after surgery (rather than normal intraocular lenses). Other specialty lenses like multifocal and toric lenses are considered premium options and are not covered by Medicare. If you receive this type of laser surgery and the insertion of these "premium" intraocular lenses, you will be charged for over and above the regular procedure including materials, exams, procedure, etc. Certain additional care including routine eye exams and an allowance for eyeglasses or contacts is covered as a supplemental benefit. See the *Vision Care* section of this EOC for details.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition	

CHAPTER 5 :
Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you receive care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

When you get covered care from Medicare participating providers, you are never responsible for paying more than the cost share amounts listed in this Evidence of Coverage.

- If you pay a provider upfront and submit a request for Devoted Health to pay you back, Devoted Health will pay you the Medicare Allowable amount less your cost share amount. If the provider charged you more than the Medicare Allowable amount, the provider should reimburse you the difference between that charge amount and the Medicare Allowable amount as they are not allowed to charge more than Medicare's defined fee schedule.
- If you run into issues, give us a call at 1-800-DEVOTED.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person’s enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 365 days** of the date you received the service or item. To make sure you are giving us all the information we need to make a decision, you can fill out our claim forms to make your request for payment.

- You don't have to use the forms, but it will help us process the information faster. The information required to make a decision are your name, address, proof of payment, explanation of service or item received, date of service, and the name of the provider that delivered the service/item**.**
- Either download a copy of the forms from our website (*www.devoted.com*) or call Member Services and ask for the forms.
- You may also submit your request for some Medical Services electronically through the following website https://my.devoted.com/reimbursement

Mail your request for payment together with any bills or paid receipts to us at this address:

Request for payment of Medical Services:

Devoted Health
ATTN: Member Reimbursements
P.O. Box 211524
Eagan, MN 55121

Request for payment of Dental Services

Delta Dental Insurance Company
PO Box 1809
Alpharetta, GA 30023-1809

Request for payment for Vision Care Services

EyeMed Vision Care
Attn: OON Claims
PO Box 8504, Mason, OH 45040-7111

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6 :
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in Spanish, braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, please call to file a grievance with us at 1-800-DEVOTED (1-800-338-6833) TTY 711. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Su plan debe garantizar que todos los servicios, tanto los clínicos como los no clínicos, se presten de una forma culturalmente adecuada y sean accesibles para todos los afiliados, incluidos aquellos que tienen limitaciones en inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Algunos ejemplos de cómo el plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la

prestación de servicios de traducción e interpretación, y teletipos o conexión TTY, es decir, mediante teléfono de texto o teletipo.

Nuestro plan cuenta con servicios gratuitos de interpretación disponibles para responder las preguntas de los miembros que no hablan inglés. Si lo necesita, también puede acceder a información en español, en braille, en letra grande o en otros formatos alternativos sin costo. Se le debe brindar información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para recibir información de una manera que le resulte conveniente, llame a Servicio para miembros.

Nuestro plan debe brindarles a las mujeres afiliadas la opción de acceso directo a un especialista en salud femenina dentro de la red para los servicios de atención médica de rutina y preventivos de la mujer.

Si los proveedores de una especialidad dentro de la red del plan no están disponibles, es responsabilidad del plan localizar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará los costos compartidos dentro de la red. En caso de que no haya especialistas en la red del plan que cubran un servicio que usted necesita, llame al plan para que le informen sobre dónde acudir para obtener ese servicio con un costo compartido dentro de la red.

Si tiene problemas para obtener información del plan en un formato que sea accesible y adecuado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llame al 1-800-DEVOTED (1-800-338-6833) TTY 711 para presentar una queja. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o al TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider for your care.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - We may disclose your health information to third parties to assist us in providing services to you.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others.

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Devoted LIBERTY CHOICE Arizona (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 5 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance of these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms or download the forms at www.devoted.com.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
    - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Arizona State Health Insurance Assistance Program by writing to the DES Division of Aging and Adult Services, Arizona State Health Insurance Assistance Program, 1789 W. Jefferson Street, #950A, Phoenix, AZ 85007, or by telephone at 1-800-432-4040. TTY users can call the Arizona Relay Service, for free, at 711. You can also visit the Arizona State Health Insurance Assistance Program website at: https://des.az.gov/services/older-adults/medicare-assistance.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverag*e to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you**.**
- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7 :
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to

customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. **Below are two entities that can assist you.**

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request

for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your SHIP.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.devoted.com/plan-documents/member-forms/.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.devoted.com/plan-documents/member-forms/) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon
- **Section 7** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain

how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A "fast appeal"is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 days or 7 days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a Fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.). In this case, the independent review organization will send you a letter:
  - Explaining its decision
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we

receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or

nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- Your request for an immediate appeal should be made as soon as possible, but **no later than noon the day before coverage ends**.
  - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to **Level 2** of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called *upholding the decision*.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Terms
A fast review (or fast appeal) is also called an **expedited appeal**.

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines.
- Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your

services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Terms
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. You receive a notice in writing at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a fast track appeal to request us to keep covering your care for a longer period of time.

2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it. Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Legal Terms
*A fast review (or fast appeal) is also called an **expedited appeal**.*

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Terms
The formal name for the independent review organization is the ***Independent Review Entity.*** *It is sometimes called the* ***IRE.***

Step-by-Step: Level 2 *Alternate* appeal Process During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must

continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal:	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.

  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal:	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal:	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? • Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals: you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint.

Complaint	Example
	• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Option for Fast Review of your Grievance.** You may request a fast review, and we will try to respond within a day, if your grievance concerns one of the following circumstances:
  - We have extended the timeframe for making an organization/coverage decision, and you believe you need a decision faster.
  - We denied your request for a 72-hour organization/coverage decision.
  - We denied your request for a 72-hour appeal.
  - It is best to call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711 if you want to request fast review of your grievance. If you mail your request, we will call you to let you know we received it.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Devoted LIBERTY CHOICE Arizona (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8 :
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Devoted LIBERTY CHOICE Arizona (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

OR

- Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Devoted LIBERTY CHOICE Arizona (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you**.** These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Devoted LIBERTY CHOICE Arizona (PPO) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Devoted LIBERTY CHOICE Arizona (PPO) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Devoted LIBERTY CHOICE Arizona (PPO) when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical items and services through our plan.

- **Continue to use our network providers to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Devoted LIBERTY CHOICE Arizona (PPO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Devoted LIBERTY CHOICE Arizona (PPO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Services.

Section 5.2 We <u>cannot</u> ask you to leave our plan for any health-related reason

Devoted LIBERTY CHOICE Arizona (PPO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9 :
Legal Notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Devoted Health Plan of Arizona, Inc., as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

We have the right to recover benefits paid for health care or other goods and services when a third party causes the injury or illness to the extent permitted under applicable federal and state laws and your benefit plan. You assign to us your right or your heir's or executor's right to take legal action against any responsible third party, and you agree, on behalf of yourself, heirs, executors, and other representatives to:

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you or your heirs, executors, or other representatives don't cooperate with us or our representatives, or you or they do anything that interferes with our rights, we may take legal action against you or them. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us for the costs we paid for health care or other goods and services arising out of, relating to, or incidental to such injury, illness, or condition. We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition. Our rights to reimbursement applies regardless of the amount of the judgment, settlement, or other payment and regardless if such monies are less than the amount we paid for health care or other goods and services.

SECTION 5 Notice of coordination of benefits

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other third party has already paid to you for such services. We reserve all rights afforded to us under the Medicare Program, including, without limitation, all Medicare Secondary Payer rights.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan and our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or other criteria.

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits.

Workers' compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this Evidence of Coverage for services rendered in connection with your job-related illness or injury.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under “Med Pay,” no-fault, automobile, accident, or other liability coverage are available to you, the “Med Pay,” no-fault, automobile, accident, or other liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon your receipt of any insurance proceeds, judgment, settlement, or other payment.

If you recover from a third party for medical-related expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on

a court order on the merits of the case. We will not seek recovery from any portion of an award that is appropriately designated by the court as payment for property losses; provided, however, we may pursue recovery of payments we have made if the allocation is designated as other than property losses (e.g., pain and suffering).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the Additional Notice about Subrogation (Recovery from a Third Party) section for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second - or at all - depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called “Medicare & Other Health Benefits: Your Guide to Who Pays First.” It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations. The information described in this Evidence of Coverage does not, and is not intended to, constitute legal advice. Information in this Chapter is general information regarding your rights and responsibilities. You should not act or refrain from acting based solely on the information in this Evidence of Coverage. If you do not understand your rights and obligations as generally described in this Chapter, you may want to seek the advice of a competent attorney in the state you live.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this Evidence of Coverage.

CHAPTER 10 :
Definitions of important words

Allowed Amount – This is the maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance," or "negotiated rate." It is the dollar amount assigned for a procedure, service, or supply based on various pricing maximum charge mechanisms.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Devoted LIBERTY CHOICE Arizona (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan measures your use of skilled nursing facility services in benefit periods. Our plan's definition of a benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Chronic Condition Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example, $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and

using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plan (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

"Extra Help" – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue

to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

In-Network Maximum Out Of Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

Part C – **see Medicare Advantage (MA) Plan.**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Benefit Manager – A Prescription Drug Manager or Pharmacy Benefit Manager (PBM) is a third party administrator (TPA) that processes drug benefits for insurers and/or employers.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets *prior authorization* from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of

the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Non-Discrimination Notice

Devoted Health complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Devoted Health

Provides free aids and services to people with disabilities 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

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-338-6833** (TTY 711). This is a free service. Hours are 8am to 8pm, 7 days a week from October 1 to March 31, and 8am to 8pm Monday to Friday from April 1 to September 30.

If you believe that Devoted Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Devoted Health – Appeals & Grievances
PO Box 21327
Eagan, MN 55121
Fax: 1-877-358-0711

You can file a grievance by mail, fax, or phone. If you need help filing a grievance, call us at **1-800-338-6833** (TTY 711).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-338-6833 (TTY 711). Someone who speaks English can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de interpretación para responder las preguntas que tenga sobre su plan de salud o medicamentos. Para acceder a un intérprete, solo llámenos al 1-800-338-6833 (TTY 711). Una persona que hable español podrá ayudarle. Este es un servicio gratuito.

Chinese (Traditional US/Taiwan): 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打 1-800-338-6833 (TTY 711) 聯絡我們。會說中文的人員可以協助您。此爲免費服務。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch viên miễn phí có thể trả lời mọi thắc mắc của quý vị về chương trình y tế hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-800-338-6833 (TTY 711). Một người nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

French Creole (Haitian Creole): Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan 1-800-338-6833 (TTY 711). Yon moun ki pale Kreyòl Ayisyen kapab ede w. Sa se yon sèvis ki gratis.

Korean: 의료 또는 의약품 플랜에 대해서 있을 수 있는 질문에 대답하기 위해서 무료 통역 서비스가 있습니다. 통역 서비스를 이용하기 위해서는 1-800-338-6833(TTY 711)에 전화하십시오. 한국어를 구사하는 사람이 도와드릴 것입니다. 이것은 무료 서비스입니다.

:Arabic
نوفر خدمة مترجم فوري مجانية للإجابة عن أي أسئلة قد تكون لديك بشأن خطة الرعاية الصحية أو خطة الأدوية. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم 1-800-338-6833 (الهاتف النصي 711). يمكن لشخص يتحدث اللغة العربية مساعدتك. هذه خدمة

Tagalog: Mayroon kaming libreng mga serbisyo ng interpreter para sagutin anumang tanong mo tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan kami sa 1-800-338-6833 (TTY 711) Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

Polish: Mamy do Państwa dyspozycji bezpłatne wsparcie tłumaczy, którzy odpowiedzą na wszelkie pytania na temat zdrowia lub planu przyjmowania leków. Aby uzyskać pomoc tłumacza, prosimy o kontakt pod numerem 1-800-338-6833 (TTY 711). Osoba znająca język polski pomoże Państwu. Przypominamy, że jest to usługa bezpłatna.

Russian: Мы предоставляем бесплатные услуги устного переводчика, чтобы ответить на любые вопросы, которые могут у вас возникнуть о нашем плане медицинского страхования или покрытия стоимости лекарств. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-338-6833 (TTY 711). Переводчик, владеющий русский языком, сможет вам помочь. Эта услуга предоставляется бесплатно.

French (France/International): Nous offrons des services gratuits d'interprétation pour répondre à toutes vos éventuelles questions concernant notre régime d'assurance santé ou médicaments. Pour obtenir les services d'un interprète, appelez-nous au 1-800-338-6833 (TTY 711). Une personne parlant français peut vous aider. Ce service est gratuit.

German: Wir haben einen kostenlosen Dolmetscherservice zur Beantwortung aller Fragen, die Sie möglicherweise zu Ihrem Gesundheits- oder Medikamentenplan haben. Rufen Sie uns einfach unter 1-800-338-6833 (TTY 711) an, um einen Dolmetscher zu bekommen. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist kostenlos.

Gujarati: અમારી સ્વાસ્થ્ય અથવા દવા યોજના અંગે તમને હોઇ શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે નિ:શુલ્ક દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, માત્ર અમને 1-800-338-6833 (TTY 711) પર કોલ કરો. કોઇ વ્યક્તિ જે ગુજરાતી બોલે છે તે તમારી મદદ કરી શકે છે. આ એક નિ:શુલ્ક સેવા છે.

Japanese: 当社には、健康または薬計画に関する質問に答えるための無料通訳サービスがあります。通訳を利用するには、1-800-338-6833 (TTY 711)までお電話ください。日本語話す人がお手伝いいたします。これは無料サービスです

Italian: Abbiamo servizi di interpretariato gratuiti per rispondere a qualsiasi domanda tu possa avere sul nostro piano sanitario o farmacologico. Per ottenere un interprete, chiamaci al numero 1-800-338-6833 (TTY 711). Qualcuno che parla italiano potrà aiutarti. Questo è un servizio gratuito.

Portuguese (Brazil): Contamos com serviços gratuitos de interpretação para responder a quaisquer perguntas que você possa ter sobre seu plano de saúde ou de medicamentos. Para obter um intérprete, ligue para nós pelo telefone 1-800-338-6833 (TTY 711). Alguém que fala Português poderá lhe ajudar. Este serviço é gratuito.

Hindi: हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं हैं। कोई दुभाषिया पाने के लिए, बस 1-800-338-6833 (TTY 711) पर हमें कॉल करें। हिंदी बोलने वाला कोई आपकी मदद कर सकता है। यह मुफ्त सेवा है।

Devoted LIBERTY CHOICE Arizona (PPO) Member Services

Method	Member services – Contact Information
CALL	1-800-DEVOTED (1-800-338-6833) Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30 Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am to 8pm, 7 days a week, from October 1 to March 31 8am to 8pm, Monday to Friday and 8am to 5pm, Saturday, from April 1 to September 30
FAX	1-877-234-9988
WRITE	Devoted Health, Inc. P.O. Box 211037 Eagan, MN 55121
TEXT	866-85
WEBSITE	www.devoted.com

Arizona State Health Insurance Assistance Program (SHIP)

Arizona State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Arizona State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-432-4040 Hours: 8 a.m. to 5 p.m
TTY	711
WRITE	Division of Aging and Adult Services Arizona Department of Economic Security 1789 W. Jefferson Street, #950A Phoenix, AZ 85007 contactdaas@azdes.gov
WEBSITE	https://des.az.gov/services/older-adults/medicare-assistance

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