Devoted
HEALTH PLANS

Broker Manual

Information and resources for selling Devoted Health plans

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How To Get Started with Devoted Health

Contracting

You can contract with Devoted Health directly as an independent broker or through your upline/agency, as long as they are one of our partners. The process is easy. To get started, email agent-support@devoted.com, or reach out to your upline to verify they are contracted with us.

Onboarding

If contracting through an agency, the agency will send you an email with instructions and a unique link to register on our onboarding portal if you are a new user. If contracting directly with Devoted Health we will send you an email with instructions and a unique registration link to register on our onboarding portal. If you've previously contracted with us, please log in to your Agent Portal account. You will have a link to access our onboarding and certification workflow.

What you need to get started:

- Must have an active health insurance license.
- Will need to complete the onboarding and certification process which includes contracting, certification, and state appointments before you can sell with us.
    - You must be licensed, and ready to sell with Devoted Health in all applicable states that you are conducting business in.
- If you have an AHIP, Pinpoint, or NABIP (formerly NAHU) certificate, you can upload your certificate to satisfy the Core Medicare Training requirement. If not, you can now complete the AHIP training by using the link in our onboarding workflow and get a $50 discount at checkout.
- The Devoted Health Certification & Assessment covers how to compliantly market and sell Devoted Health Plans.
- To continue to receive renewals, you must recertify (annually) and must be licensed and appointed per state law.
- Completion of the PY2024 Certification will also allow you to market PY2023 benefits in our current service areas.

- A face-to-face certification is not required.
- Certification can be completed in 1 hour.

Once you complete the appointment process for your respective state, you'll receive an email notification that you're "Ready to Sell" (RTS) along with additional communications on how to access our tools and resources.

Devoted Code of Conduct

At Devoted, we are building better healthcare for Medicare beneficiaries and are delivering on our promises to our members. Each of us must be committed to the highest standards of business conduct. We require all associates, officers, directors and our business partners to understand and follow these high standards while doing their jobs for Devoted. Although we are a very young company, we are built for the long term.

Our Code of Conduct reflects Devoted Health's core values. In fact, our Code, is at the very foundation of our core values:

1. We are a paragon of hypercompliance with the letter and spirit of the law.
2. Every member is family. Love for each other and for our members is at the heart of everything we do.
3. We build for a rolling 20-year time horizon.

Click here to view our entire Code of Conduct

Devoted Health's Agent Release / Transfer Policy & Timeline:

Immediate Release

- A broker or their immediate receiving / terminating upline agency (FMO/GA) may request the release & transfer(s).
- The release & transfer may be requested by:
    - A phone call into agent support, 877-764-9446.
    - A "message" within the agent portal.
    - All parties will be notified via email once the release & transfer has been processed.

- **Processing timeline for an immediate release is 7 business days**.

Delayed Release*
If an immediate release is not granted by a broker's upline, the broker will automatically be placed on the delayed release timeline as noted below.

- Receipt date of the delayed release request will start the clock for the **60 calendar days** window.*
- The broker may continue to write business during the delayed release period.
- All parties will be notified via email once the delayed release has been processed.
- ***Please reference the release timeline below for specific processing effective dates :**

Release Timeline:

Requests Received	Immediate Release Requests Effective	Delayed Release Requests Effective
8/15 - 10/8	Processed within 7 business days	Effective 12/8
10/9 - 8/14	Processed within 7 business days	60 days after request date

Devoted Health Star Sellers Program (SSP)

At Devoted Health, we strive to treat all our agents like they're part of our family. As such, **we designed a program just for you: our Devoted Health Star Sellers Program (SSP)**. This program is designed to celebrate your wins - big and small and helps us reward you for all your hard work.

Every broker who qualifies for this program will earn $100 Broker Bucks upon an initial sale. These Broker Bucks can be redeemed for items such as Devoted Health branded swag, marketing / sales materials and Personal Protective Equipment (PPEs) which are available on our **Marketing Storefront** **for use at appointment and sales/marketing events**. As brokers increase productivity with Devoted Health, this program will give them the opportunity to move to the higher tiers and will receive more Broker Bucks based on the following criteria:

Bronze (1-10 applications): initial $100 Broker Bucks
Silver (11-30 applications): additional $200 Broker Bucks
Gold (31-70 applications): additional $500 Broker Bucks
Platinum (>70 applications): additional $1,000 Broker Bucks

Broker Bucks will be loaded into agents' accounts daily (rejected and denied applications do not count toward total).

Here is how the program works:

- There are four tiers in the program: Bronze, Silver, Gold and Platinum. The tier in which you qualify for is based on the total number of CMS approved applications accrued each plan year
- As you submit more applications, you will qualify for higher tier levels which means more training, programs and Broker Bucks towards sales and marketing materials to help you sell
- Total app count is based on effective dates from 10/1 through 9/30 of each year. Program resets every plan year. This means eligible applications written for 1/1/23 are counted for this upcoming year's program!
- This Star Sellers Program replaces prior broker loyalty programs offered by Devoted Health and is subjected to change at any time with or without notice

Below are the qualifications for the program

- Broker must have a Ready to Sell (RTS) status and remain in good standing with Devoted Health
- Enrollment Applications must be approved by CMS to qualify
- Agent not employed by Devoted Health or by an e-broker agency

Getting Started:

No action is required from you for participation as long as you meet the qualifications of the program above. We will notify you via email every month to let you know your status and any new benefits you have unlocked. Here is more information for you to learn more about the program:

- **Star Sellers Program Flyer**
- **Star Sellers Program Frequently Asked Question**

Selected Frequently Asked Questions:

What does good standing with compliance mean?

To be considered in "good standing" means: the broker must be compliant with applicable laws pertaining to state licensing, appointments, and the Devoted Health certification, including training and testing requirements outlined in the Centers for Medicare & Medicaid Services (CMS) Chapter 3 of the Medicare Marketing Guidelines. The Devoted Health team will continue monitoring broker performance on a monthly basis for complaints results, rapid disenrollment rates and if recurring rapid disenrollment and/or complaint trends are identified, corrective action will be taken, possible disqualification from the program for the remainder of the plan year, or termination of your ability to sell for us.

Do sales roll over month to month?

Yes, sales are cumulative within each SSP year with application dates from 10/1 through 9/30 and it will refresh at the beginning of each SSP year on 10/1. For example:

- An application submitted on September 15th, 2023 for a 10/1/23 effective date will count towards your 2023 SSP status
- An application submitted on October 15th, 2023 for a 11/1/23 effective date will count towards your 2024 SSP status
- An application submitted on November 15th, 2023 for a 1/1/24 effective date will count towards your 2024 SSP status

What's the fine print?

- Only Brokers who are certified and appointed to market Devoted Health Plans qualify for this program
- Rejected and denied applications or plan changes do not count toward total applications
- To determine the number of applications in a calendar month, we will use the application date of an application as marked by Devoted Health
- Devoted Health reserves the right to change or eliminate benefits, tiers, eligibility criteria, or program as a whole at any time, with or without notice

Devoted Plan-to-Plan Changes

While we try to design our plans to limit the need for our members to switch plans within our suite of products, we know that needs change and we have introduced new plans that might better suit our members' needs.

- We strive to make this process as easy as possible.
- We want you, the agent, to spend more time writing new business than maintaining your existing book by spending all AEP moving them from one plan to another.
- When a member wants to switch plans, they simply call 1-800-DEVOTED and we will switch their plan for them over the phone.
- The current agent remains Agent-of-Record (AOR).
- No new commission is generated, but renewals will continue.
- It is not necessary for you, the agent, to re-write the business yourself.
- We will inform you when any of your members make a plan change.

Agent of Record Changes

Agent of record changes can be processed in the following ways:

OPTION# 1 : Members may call into member service team and request the AOR change / removal :

- Members should provide the agent's name and NPN when calling into member services

OPTION# 2 : Member may submit a signed letter request to their preferred AOR :

- Letter must indicate:
    - Member's date of birth
    - Member's address
    - Member's ID
    - New agent's full agent name
    - New agent's NPN
- Signed letters should be sent to Agent Support by the broker using Messages via the Agent Portal.

Agent Support

Questions? Need to sign up new members or check commissions?

Call us at **1-877-764-9446** during our support hours:

- Daily, 9am to 10pm Eastern (Oct 15 - Dec 7)
- Weekdays, 9am to 10pm Eastern (Dec 8 - Oct 14)

Or submit a message request through our agent portal!

We're fast and responsive. And we sweat the details (so you don't have to). Whether you're part of an FMO or on your own, work with us — we want to help your business succeed.

- 91% of calls answered within 30 seconds via dedicated support line and USA-based agents

"Working with Devoted is a breath of fresh air. I receive the same concierge service as my clients! Devoted really is about people — they make sure everyone is taken care of." - Independent Agent, Polk County

Agent Support can help you with questions around:

- Contracting & Certification inquiries
- Enrollment Status
- Member IDs
- Medicare ID Effective Date confirmations
- Low Income Subsidy (LIS) Level confirmation
- Medicaid Level
- Access to Devoted Health Agent Portals and navigation assistance
- Telephonic SOAs
- Devoted.com inquiries
- Commissions
- Marketing Portal
- Release and Transfer requests
- Pended Applications

Have member related questions? Connect with our member service guides at **800-338-6833** to assist your members with ID card replacements, prescription or benefit information, billing inquiries, and more.

Our member service guides are ready to assist our members with just about anything.

As a verified broker you can call into our Member Service Guides WITHOUT the member on the phone for the following reasons:	Member Service Guides can also help with the following as long as the member is also on the phone:
• LIS Status • Status of enrollment application • Status of combo letter, ID card or welcome kit • Member status • Request a ID card to be sent to the member	• Plan changes • PCP changes • Claim status • Booking transportation • Change address or phone number • Billing inquiries, and late enrollment penalty invoices • DME/Prescription transition or assistance • And much more!

Use this resource guide to find your local leader and their contact information - Local Broker Leader Contacts

The Devoted Health Difference

Our Mission:

Founded in 2017 by brothers, Todd and Ed Park, Devoted has built an integrated, all-in-one healthcare solution that combines Devoted Health Medicare Advantage plans, access to high-quality local providers alongside virtual and in-home care delivered by Devoted Medical, full-service member Guides, and world-class technology that powers it all. As a result of bringing all of these exceptional ingredients into one seamless offering, Devoted members find a trusted partner in Devoted to advance their health and well-being.

Member Stories — Hear what Devoted members have to say about all-in-one healthcare. Share these stories with your prospects to see what a Devoted Health membership can do for them! Dwuane, Judy, and Walter.

Here are some ways that we are different for our agents, our clients and our providers!

- Fastest growing Medicare Advantage plan in the U.S.
- Nationally ranked #3 on absolute number of net-new MA members added during 2024 AEP
- 94% first-call resolution, no time limits on calls, and consistent follow-through
- Member net promoter score of 70 and 89.4% Member Trust Score
    - Vastly higher than industry average
    - Significantly higher than iconic consumer brands like Apple, Amazon, and USAA
    - Underpinned by a phenomenal member service
- 1 in 10 members who leave for another plan come back to Devoted Health
- Strong Medicare Advantage Star ratings - for 2024 - learn more about our star ratings here.
    - Florida and Ohio: Our HMO and D-SNP plans were awarded a 5 out of 5 Star rating
    - Arizona: Our HMO plans earned a 4 out of 5 Star rating.
    - Texas: Our HMO plans both received a 4.5 out of 5 Star rating,
    - Illinois: Our HMO plans earned a 3.5 out of 5 Star Rating for their first year of eligibility.
- Leading provider service performance
    - 93%+ of claims paid within 5 days
    - 99% of providers credentialed within 21 days
    - 89% of calls answered by provider service team within 60 seconds or less
    - Average turnaround time for standard authorization is within 3 days or less and less than 1 day on average for expedited authorizations.
- Systematic improvement in member care
    - Leading to better outcomes and lower medical cost ratios for member cohorts over time — which, in turn, enables (along with our Stars performance) sustainably superior plan benefits

Learn more about how we can make all of this happen:

1. **New Medicare Advantage plan**
2. **Devoted tech platform**
3. **Partnership with local providers**
4. **Devoted Medical**
5. **The Devoted Guides**

New Medicare Advantage Plan

We may be new, but many of our employees are not new to Medicare or Healthcare. Todd and Ed Park launched Devoted Health in 2017 (our first membership came in 2019). We are building for a rolling 20-year time horizon; we are not in the business of building and selling.

Because we are new, we are agile and willing to listen to feedback. We are willing to adjust things where they need to be adjusted. We plan to stay open to change. We also truly believe we can make an impact. We believe that with clarity of thought, commitment, and persistence, we can change the world.

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." - Margaret Mead

Devoted Tech Platform

We've built claims, authorizations, credentialing, and member systems, so your clients and doctors can get:

- Fair decisions: Nearly 100% of our appeal denials have been upheld by Medicare's independent reviewer. Our appeal and dispute rates are incredibly low
- Doctor credentialing: Doctors credentialed in less than 3 weeks, on average, from contract to when they're added to our online provider search tool
- All-in-one member profiles: Member profiles give Guides a view of everything in one platform, so they can quickly and accurately answer questions

We take care of operations behind the scenes, so you don't have to!

We partner with our providers

We also strive to be the best possible plan partner for our contracted providers. To us, this means:

- Provide best-in-class service: So providers can spend less time on managing administrative tasks, and more time caring for patients
    - We process standard authorizations in 3 days or less and expedited authorizations in less than 1 day on average—view the status of your authorization requests in real time
    - We process and pay more than 93% of claims within 5 days on average
    - Our Guides help answer healthcare questions and flag potential health problems to our provider teams
        - We answer 92.5% of member service calls in under 30 seconds, and resolve 92.3% of calls on the first call. When you call, you'll speak to a real person
- Access to real-time data: Members' claims, gaps, admissions and more are all available in real time so, we can facilitate the best possible care
    - It adapts faster than legacy payors' systems
    - Real-time data is available from Day 1
    - Providers get actionable insights to help with care decisions
    - We refresh our provider directory daily

Healthy and satisfied members means high retention and less for you to worry about.

Devoted Medical and Care OnDemand

- Everything Devoted Medical does is "additive" to the PCP model, recognizing that PCPs are being asked to do more and more with less.
- Devoted Medical provides a spectrum of high-touch, high-fidelity, advanced clinical care to our patients.
- Care OnDemand provides the ultimate extension of our fully member-service oriented model; we take that further in the way we care for your members.
- Members benefit from our value-based care model because it focuses on preventative care rather than just treatment of the presenting illness.
- Our team has unique capabilities that allow us to care for members, keeping them healthier and happier, and satisfied members lead to higher retention and referral rates for you!

- Our model allows us to radically increase access to care, lower medical costs, and increase star ratings which enables us to fund our superior benefits. Translating into a significantly better experience with healthcare!

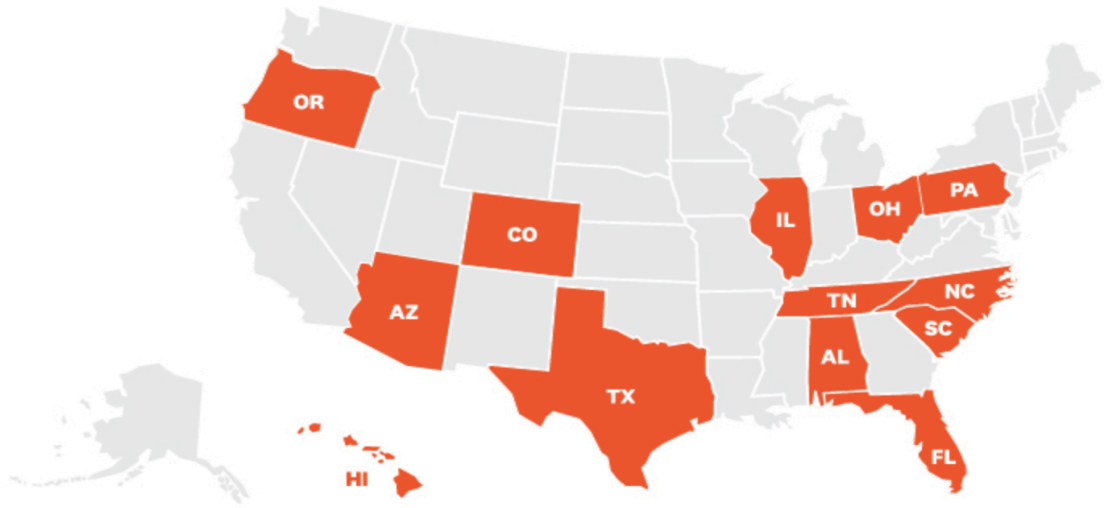
The Devoted Health Guides

We do not have a customer service department; instead, we have a team of Guides who can help our members understand their plans, see their doctors, and receive the care that we would want to offer our own family members. We do not just hire Medicare phone reps. We hire caring people with HUGE hearts! They come from many different backgrounds and work well with people. We teach them everything they need to know about answering member questions and exceeding their expectations.

Here are some ways we offer a different (better!) customer experience with our Guides:

- Navigators not Robots
    - You do not need to call different numbers or be transferred around.
    - Call one Guide and get your problem answered by that Guide. If the Guide does not know the answer right away, they will call you back with an answer.
- Problem Solvers
    - Our Guides are equipped with the tools to answer member questions.
    - They are encouraged to take each issue into their own hands and solve the problem (as long as it is compliant and legal).
- Supporters
    - The Guides are not only there to help with problems; they are also there to listen to what the member has to say.
    - They will treat each member like family, working to give them a caring and positive health care experience.

Devoted Health Plans



2024 Markets

Details on Devoted Plan Options

All plans may not be available in every market. To find out which plans are available in your market area, check the summary of benefits or visit devoted.com and enter your zip code here. This video will walk you through how to find plan documents.

In this section we will review the following plans in a deeper dive of some of these plans and how they are designed

1. **Devoted CORE HMO**
2. **Devoted PRIME/PREMIUM HMO (Select HMO in AZ)**
3. **Devoted GIVEBACK HMO**
4. **Devoted CHOICE PPO/Devoted CHOICE GIVEBACK PPO, Devoted CHOICE PLUS PPO**
5. **Devoted LIBERTY HMO and PPO**
6. **Devoted DUAL HMO D-SNP**
7. **Devoted HMO C-SNPs**

Devoted NON SNP HMOS

Devoted CORE HMO MAPD

- This is a Medicare Advantage HMO plan with a $0 monthly premium
- It provides all Medicare benefits and prescription drug coverage
- It includes competitive cost sharing and additional supplemental benefits
- Under this HMO, referrals are required* for some specialist visits and an in-network PCP must be selected upon enrollment

** Referrals are only required in Florida, Illinois, or Texas -*
https://www.devoted.com/plan-documents/2024-referral-list/

Devoted PRIME/PREMIUM HMO (SELECT HMO in AZ) MAPD

- This plan is available in many (not all) of our markets however the name in AZ is "SELECT" instead of "PRIME"
- Low monthly premium, however, 100% is allocated to Part D - Great choice for beneficiaries with 100% LIS subsidy
- Low member cost sharing
- Strong supplemental benefits are included in the plan
- Referrals are required for some specialist visits* and an in-network PCP must be selected.
- Prescription costs will vary by plan review the summary of benefits
- This plan may be a good fit for:
    - Individuals interested in more supplemental benefits or lower cost sharing and does not mind paying a low cost premium.
    - Individuals with partial Medicaid
    - Individuals with Low-Income Subsidy (LIS) (depending on subsidy level will pick up some or all of premium)
        - LIS individuals who enroll in the CORE HMO plan offering are subject to paying some higher copays than the Prime Plan offering.
        - With Devoted PRIME/PREMIUM HMO (SELECT HMO in AZ) the LIS recipient will benefit from very low copays, rich supplemental benefits, and subsidized premium and Part D benefits.
        - Prior to enrolling a prospect, make sure you confirm their LIS status and give full disclosure on premium and benefit copays with and without LIS

benefits.

** Referrals are only required in Florida, Illinois, or Texas -*
https://www.devoted.com/plan-documents/2024-referral-list/

Devoted GIVEBACK HMO MAPD

Medicare Advantage HMO plan with a Part B "giveback".

- Givebacks reduce the Part B premium that most Medicare beneficiaries are responsible for paying on a monthly basis.
    - A giveback will increase the value of a member's monthly social security check, since they are not paying as much for their Part B.
    - If an individual is not paying their Part B, they will not see an increase in their social security check.
    - If an individual is not receiving a social security check, they will see a reduction in the amount they owe monthly for their Medicare Part B.
    - **It is important to note that it may take up to 4 months for an individual's Part B reduction to show up in their social security check. Payments will be retroactive for the months that were missed. Let prospects know this at the time of sale.**
- As a result of receiving money back for their Part B premium, members will have higher cost sharing and fewer additional benefits than those offered on the other Devoted Health plans.
- Referrals for some specialists are required under this plan* and an in-network PCP must be selected upon enrollment

** Referrals are only required in Florida, Illinois, or Texas -*
https://www.devoted.com/plan-documents/2024-referral-list/

Devoted Health LIBERTY HMO (MA Only)
(Only available in Phoenix AZ)

- This is an MA **only** Part B giveback **HMO** plan without Part D coverage.
- This is a great option for beneficiaries not requiring Part D coverage by Devoted Health.
- Supplemental benefits including preventive and comprehensive dental, OTC and

much more

- **Important! The MA Only HMO plan CANNOT be combined with a stand-alone prescription drug plan.**
- The plan has a $0 premium and a Part B giveback!
    - A **giveback will increase the value of a member's monthly social security check**, since they are not paying the full Part B premium amount.
    - If an individual is not receiving a social security check, they will see a reduction in the amount they owe monthly on their Medicare Part B premium invoice.
    - It may take up to 3 months for an individual's Part B reduction to show up in their social security check. Payments will be retroactive for the months that were missed.

Devoted Health PPOs

PPO FAQ

Devoted CHOICE PPO MAPD

- This plan has a $0 plan premium
- This plan will have a list of preferred providers and staying in the network for some services may be a lower cost than going out of network. However in many markets we will have identical for in and out-of-network services, refer to the summary of benefits.
- This is a great plan option for individuals looking for flexibility and potentially looking to travel for longer periods of time.
- Referrals will not be required under this plan for individuals to see a specialist, however; it's always suggested that individuals work with their PCP to discuss specialist needs.
    - As a member of our plan, we strongly encourage our members to choose a primary care physician (PCP) from the choices listed in the Devoted Health Provider & Pharmacy Directory; however; members have the choice during enrollment to not select a PCP and choose to see an out of network PCP (at potentially a higher cost) or have an In-network PCP assigned to them. Regardless of decision, a PCP will not appear on the member's ID Card for the Devoted Health PPO plans.
- Low cost sharing for in and out of network benefits, copays vs coinsurance for services

and additional benefits like hearing, comprehensive dental, vision, gym membership and much more!

- Dental and vision benefits can be used in or out-of-network.

* Not offered in all markets

Devoted CHOICE GIVEBACK PPO MAPD

This plan is available in certain markets*

- This plan is a preferred provider organization (PPO) and the plan premium is $0 with a Part B giveback!
- Givebacks reduce the Part B premium that most Medicare beneficiaries are responsible for paying on a monthly basis.
    - A giveback will increase the value of a member's monthly social security check, since they are not paying as much for their Part B.
    - If an individual is not paying their Part B, they will not see an increase in their social security check.
    - If an individual is not receiving a social security check, they will see a reduction in the amount they owe monthly for their Medicare Part B.
    - It is important to note that it may take up to 3 months for an individual's Part B reduction to show up in their social security check. Payments will be retroactive for the months that were missed.
- As a result of receiving money back for their Part B premium, members will have higher cost sharing and fewer additional benefits than those offered on the other Devoted Health plans.
- Individuals will have the option to go in and out-of-network - This plan will have a list of preferred providers and staying in the network for some services may be a lower cost than going out of network. However in many markets we will have identical for in and out-of-network services, refer to the summary of benefits.
- Preventive Dental included with in and out-of-network coverage.

**Plan is not offered in all markets*

Devoted CHOICE PLUS (PPO) MAPD

- This plan is a preferred provider organization (PPO) with a plan premium.
- The premium will be on the Part D side of the plan, and therefore if an individual has

LIS their premium will be reduced.

- Because we have a plan premium on this plan, this plan has enhanced supplemental benefits and some lower cost sharing on services.
- This plan will have a list of preferred providers however cost-sharing for in and out-of-network services will be identical.
- This is a great plan option for individuals looking for more supplemental benefits, flexibility and potentially looking to travel for longer periods of time.
- Referrals will not be required under this plan for individuals to see a specialist, however; it's always suggested that individuals work with their PCP to discuss specialist needs.

*This plan is not available in all of our markets

Devoted LIBERTY CHOICE PPO MA ONLY

Only available in Pima County AZ

- This plan does not include prescription drug coverage
- There is no premium associated with this plan, and there is a Part B giveback
- Since this plan is a PPO we will have a list of preferred providers, however members may go out of network on this plan, but may pay a higher cost share for some out of network providers. However; most of the cost sharing is the same in and out of network.

Devoted Health C-SNPs

2023 SNP FAQ

2024 SNP FAQ

Qualifications for C-SNP

- During enrollment there will be a **pre-enrollment qualification assessment** tool to submit with the application.
- Individuals who **answer "Yes" to the qualifying questions may be eligible** to join the plan.
- Following enrollment, **Devoted will verify chronic conditions** with the individual's provider within the first two months. Devoted Medical may also become involved to assist in verification as needed.
- If after the first month of **enrollment conditions cannot be confirmed**, individuals

will receive a letter within 7 days of the following month informing them of **disenrollment by the end of month**. The agent will be notified as well.

Devoted Health BEWELL HMO C-SNP
(Only in Maricopa County and Pinal County, AZ)

- Special needs plan designed for individuals with any one of these conditions: **Diabetes, Congestive Heart Failure (CHF) or Cardiovascular disease.** (Only one condition required)

Devoted Health BEWELL PLUS HMO C-SNP
(Available in Yavapai, Coconino, Maricopa and Pinal County AZ)

- Special needs plan designed for individuals with any one of these conditions: **Diabetes, Congestive Heart Failure (CHF) or Cardiovascular disease.** (Only one condition required)
- The difference between this plan and the non PLUS plan is that it has a premium.
    - The premium is dedicated to the Part D portion of the plan, so if an individual has 100% LIS they will not pay the premium.
    - Additionally individuals with LIS will pay their LIS cost share amounts for prescriptions.
    - Check with Agent support to determine levels of LIS so you may properly discuss premium and prescription cost shares.
    - Individuals are not required to have LIS to join the plan.
- This plan has benefits and a model of care focused on these conditions.
- Qualifications for this plan are the same as the BEWELL plan.

Devoted BEWELL San Antonio - D (HMO C-SNP)
(Only in Greater San Antonio counties - Bexar, Comal, Guadalupe, Atascosa, Bandera, Kendall, Medina, Wilson, Gonzales, Karnes, Kerr, La Salle, McMullen)

- Special needs plan designed for individuals with Diabetes
- This plan has benefits and a model of care focused on this condition

Devoted BeWell PLUS Tennessee - D(HMO-CSNP)

- Available in certain counties in TN
- Special needs plan designed for individuals with Diabetes
- The plan has a premium
    - The premium is dedicated to the Part D portion of the plan, so if an individual has 100% LIS they will not pay the premium.
    - Additionally individuals with LIS will pay their LIS cost share amounts for prescriptions.

- Check with Agent support to determine levels of LIS so you may properly discuss premium and prescription cost shares.
- Individuals are not required to have LIS to join the plan.

Devoted Health D-SNP

Devoted offers D-SNP plans in AL, CO, FL, NC and OH
Learn more about the D-SNP plans and some frequently asked questions in this document.

Medicaid qualification levels will vary depending on the state and if it is a partial or full dual plan.

- Prior to enrollment, agents must confirm current Medicaid status, this can be completed through your agent portal, Details can be found here. Or for additional assistance, agents may contact Agent Support at **1-877-764-9446**.

- Refer to the plan's summary of benefits to identify which level of Medicaid is required to qualify for the plan.

- When you see the name Devoted Dual plus this is for our full duals and the Devoted Dual is for our partials (except in south florida where dual plus is for both full and partial.
  - FL except south fl - Dual Plus eligible levels include:
    - FBDE
    - QMB +
    - QMB
    - SMLB +
  - FL except south fl - Devoted Dual eligible levels include:
    - SLMB
    - QI
    - QDWI
  - South FL - Devoted Dual Plus eligibility levels include:
    - FBDE
    - QMB +
    - QMB

        - SMLB +
        - SLMB
        - QI
        - QDWI
    - AL, CO, NC, and OH - Devoted Dual Plus eligibility levels include:
        - FBDE
        - QMB +
        - QMB
        - SLMB +
    - AL, CO, NC and OH - Devoted Dual eligibility permits fulls to enroll in this plan as well, however it is strongly recommended for them to join the Plus plan.
        - FBDE
        - QMB +
        - QMB
        - SLMB +
        - SLM
        - QI
        - QDWI
- Members enrolled in this special needs plan will have little to no cost sharing for **most** covered services in the network.
    - While Full Duals will pay $0 for Medicare covered services, Partial Duals may have cost share for Medicare services.
- This plan will have a premium listed, but this premium will be reduced by the individual's subsidy.

For current enrollees, Devoted must verify continuing eligibility of full dual status at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.

- Devoted can decide to continue to provide care for an individual that no longer meets the unique eligibility criteria of the plan (i.e. Medicaid), if the individual can reasonably be expected to again meet the special needs criteria within a determined period of time.
- If the member of a SNP does not re-qualify within Devoted's period of deemed

continued eligibility, the member will be involuntarily disenrolled, with proper notice, at the end of this period.

- The period of deemed continued eligibility begins the first of the month following the month in which information regarding the loss is available to the organization and communicated to the enrollee, including cases of retroactive Medicaid terminations.
- Regardless of the date on which the beneficiary loses Medicaid, Devoted will provide the member with a 30-day advance notice of disenrollment.

SEP for Individuals Who Lose Special Needs Status

- CMS will provide an SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status.
- This SEP begins when the period of deemed continued eligibility starts, and ends when the beneficiary makes an enrollment request or within 3 calendar months after the expiration of the period of deemed continued eligibility.

Plan Eligibility

Below is a listing of the eligibility requirements that allow an individual to enroll in our plans.

✅Must live in the plan's service area

✅Must be eligible for Part A and Enrolled in Part B

✅Must have a qualifying election period

In most cases, enrollment in a Devoted Health plan will not impact an individual's enrollment in their Medicaid plan, unless it is a D-SNP plan in FL.

Additional Benefit Review

The Devoted Health plans provide all Medicare A&B benefits, prescription drug coverage, and additional benefits as outlined below. To find specific coverage information for each plan, you must review the summary of benefits or evidence of coverage.

Once someone becomes a member of our plan, they will use their Devoted Health Plan Card to get most of their benefits. If they have Medicaid, they should also bring their Medicaid card. There are some additional cards that members will receive upon enrollment depending on their plan such as a healthy food card, a dental or dental and eyewear card, gift cards for staying healthy.

Learn more about some of our extra benefits in this document here.

You can also access some more information on our extra benefits on our website here.

Below are a few more quick links to extra benefit information:

Plan-specific benefit and coverage details
www.devoted.com/find-plan-documents

Over-the-counter
www. devoted.com/otc

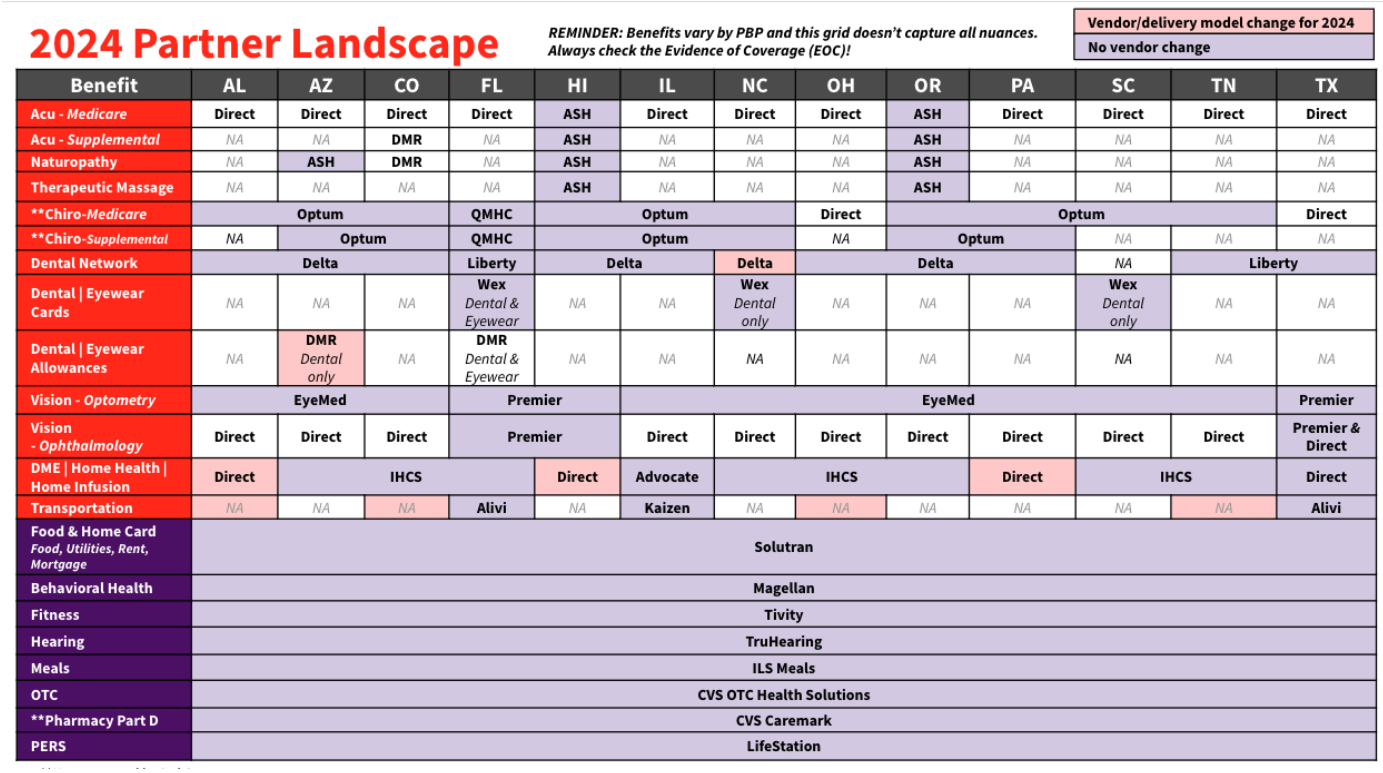
PPO plans
www.devoted.com/ppo

Grocery card
www.devoted.com/food-and-home (2024)

Dental
https://devoted.com/dental/
www.devoted.com/dental-card (NC and SC only)
www.devoted.com/dental-eyewear-card (AZ, select FL PPO only))

Devoted Dollars rewards program
https://devoted.com/devoted-dollars/

2024 Vendors for Benefits



2024 Partner Landscape

REMINDER: Benefits vary by PBP and this grid doesn't capture all nuances. Always check the Evidence of Coverage (EOC)!

Vendor/delivery model change for 2024
No vendor change

Benefit	AL	AZ	CO	FL	HI	IL	NC	OH	OR	PA	SC	TN	TX
Acu - *Medicare*	Direct	Direct	Direct	Direct	ASH	Direct	Direct	Direct	ASH	Direct	Direct	Direct	Direct
Acu - *Supplemental*	NA	NA	DMR	NA	ASH	NA	NA	NA	ASH	NA	NA	NA	NA
Naturopathy	NA	ASH	DMR	NA	ASH	NA	NA	NA	ASH	NA	NA	NA	NA
Therapeutic Massage	NA	NA	NA	NA	ASH	NA	NA	NA	ASH	NA	NA	NA	NA
**Chiro-*Medicare*	Optum			QMHC	Optum			Direct	Optum				Direct
**Chiro-*Supplemental*	NA	Optum		QMHC	Optum			NA	Optum		NA	NA	NA
Dental Network	Delta			Liberty	Delta		Delta	Delta			NA	Liberty	
Dental | Eyewear Cards	NA	NA	NA	Wex *Dental & Eyewear*	NA	NA	Wex *Dental only*	NA	NA	NA	Wex *Dental only*	NA	NA
Dental | Eyewear Allowances	NA	DMR *Dental only*	NA	DMR *Dental & Eyewear*	NA	NA	NA	NA	NA	NA	NA	NA	NA
Vision - *Optometry*	EyeMed			Premier	EyeMed								Premier
Vision - *Ophthalmology*	Direct	Direct	Direct	Premier	Direct	Direct	Direct	Direct	Direct	Direct	Direct	Direct	Premier & Direct
DME | Home Health | Home Infusion	Direct	IHCS		Direct	Advocate	IHCS		Direct	IHCS				Direct
Transportation	NA	NA	NA	Alivi	NA	Kaizen	NA	NA	NA	NA	NA	NA	Alivi
Food & Home Card *Food, Utilities, Rent, Mortgage*	Solutran												
Behavioral Health	Magellan												
Fitness	Tivity												
Hearing	TruHearing												
Meals	ILS Meals												
OTC	CVS OTC Health Solutions												
**Pharmacy Part D	CVS Caremark												
PERS	LifeStation												

Prescription Coverage

- We have a formulary (list of covered drugs) that outlines what prescriptions are covered under Part D of our plan and if there are any restrictions to using those prescriptions (such as prior authorization, step therapy or quantity limits).
    - The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.
    - On the formulary, you can determine if a prescription is a brand name (regular text) or generic (italic text), but this does not indicate its tier level.
    - Part B drugs - which are drugs typically administered by injection or infusion in a physician's office, immunosuppressive drugs, certain oral anti-cancer drugs, and a few more which can be found in the EOC.
- Our prescription lookup tool can be located on our website here: https://www.devoted.com/search-drugs and this video will walk you through how to use this tool.
- Our prescription costs vary by plan and are broken out by tier levels 1-5 and 1-6 in some plans in FL for excluded drugs.

Generic Stratified Formulary

- Tier 1: Preferred Generic
  - (**lowest cost** generics & adherence drugs)
- Tier 2: Generic
  - (**low cost** generics)
- Tier 3: Preferred Brand
  - (**middle cost** generics & brands)
- Tier 4: Non-Preferred Drug
  - (**higher cost** generics & brands)
- Tier 5: Specialty Tier
  - (**highest cost** generics & brands)

*All Markets except the ones listed for Traditional ~ **82 PBPs***

Generics all tiers & placed based on cost

Traditional Formulary

- Tier 1: Preferred Generic
  - **(lowest cost** generics & Adherence Drugs)
- Tier 2: Generic
  - **(low cost drugs)**
- Tier 3: Preferred Brand
  - (**99% are Brands**)
- Tier 4: Non-Preferred Drug
  - (**higher cost** generics & brands)
- Tier 5: Specialty Tier - (**highest cost** generics & brands)

1. *Arizona - Maricopa/Pinal*
2. *Florida - All except Pensacola*
3. *Illinois - Chicago*
4. *Texas - Greater Houston*

~ 61 PBPs

Most Generics (99%) are on Generic Tiers Tier 1 & Tier 2

- **Due to the IRA Insulin Cap, all plans now cap insulin at $35**
  - Devoted must cap the out-of-pocket member cost share of select insulin to no more than $35 for a month's supply in the following Part D phases:
    - Deductible
    - Initial Coverage
    - and Coverage Gap

- Our plans include the four levels of Medicare prescription coverage:
  - Deductible (Check the SB by plan, some plans will have a $0 deductible, while others plans will have deductible costs)
  - Initial coverage
  - Coverage gap
    - In some of our plans, we have extended the initial coverage stage, so the coverage gap will not be reached until a higher prescription cost between the member and plan has been met - this is beneficial to the member. (View the plan's summary of benefits.)
    - Devoted offers 2 different types of gap coverage
      - On some of our plans, mostly Givebacks, we offer gap coverage of some tier 1 drugs that are low-cost maintenance medications for diabetes, cholesterol, and blood pressure that are also included in the CMS star measures.
      - On some of our other plans, we offer coverage for a more expansive list of drugs that includes some drugs on both tier 1

and tier 2. The expanded list includes the same list of drugs previously mentioned plus insulin administration supplies such as syringes, needles, and alcohol swabs in addition to some drugs for important disease states such as seizure disorders, depression, acid reflux, and thyroid disorders.
        - The summary of benefits will outline this information.
    - Catastrophic coverage - which will be $0 for 2024

How do I know if someone is going to hit the coverage gap?

It is difficult to completely estimate someone's prescription costs as their prescriptions may vary throughout the year. However, we can get a pretty good idea by the prescriptions they are on now as to whether or not they are likely to hit the coverage gap. This can be done by using the Plan Finder and Prescription Lookup tools on www.Medicare.gov.

How to Estimate Drug Costs

By utilizing the Medicare website (medicare.gov), we can determine if a prospective member may end up in the donut hole based on their prescription costs. We can also determine what the retail costs of the prescriptions are, and what their likely out-of-pocket costs will look like.

Prescription Restrictions

The amount paid for Part D prescriptions does not count towards a member's medical maximum out-of-pocket (MOOP).

It is important to understand prescription restrictions. You will want to inform beneficiaries that if they see acronyms listed next to their prescription in the drug list, there may be additional plan requirements. Acronyms you may encounter will include:

- PA (prior authorization)
    - The member or provider must submit a request for approval from the plan for the prescription to be covered.
- ST (Step Therapy)
    - Encourages the member to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require the member to try Drug A first. If Drug A does not work, the plan will then cover Drug B.
- QL (Quantity Limits)
    - For certain drugs, we limit the amount of the drug that members can have by limiting how much of a drug they can get each time they fill their prescription.

- GAP COVERAGE The selected plan covers this drug through the coverage gap (donut hole), potentially with a co-pay

FAQs for Prescriptions

What if a prescription listed is not covered?
We will cover a temporary supply of the member's drug during the first 90 days of their membership in the plan if they are new, and during the first 90 days of the calendar year if they were in the plan last year and we removed the prescription from the formulary. The member can then either change to another drug, or ask for an exception. The member will also receive a text upon the transition supply fill letting them know we have filled their one time transition fill and the next steps to take.

What if a prescription is too expensive and covered at too high of a tier for the member to afford?
They can change to another drug or ask for a tier exception, which would go through a review process for approval. Note: tier exceptions are not granted for Tier 5 drugs.

Additional Prescription Policies

- Our members must use in-network pharmacies. (We contract with the big names, but you can verify that a certain pharmacy is included through the Provider Lookup tool.
- Our mail-order pharmacy is CVS Caremark - 1-800-338-6833. Members can receive a 100-day supply at a discounted rate for tiers 1-3 drugs by using this mail-order option.
- We also partner with PillPack. PillPack is a pharmacy for ongoing and chronic medications; it makes prescriptions much simpler for members to manage. The startup sends a 30-day supply of medications, divided into daily packets. Pillpack does not have extra costs, just the standard copay.
- We do not have "select or specialty pharmacies".
- Members receive an EOB of their prescription cost utilization each month.
- If a member has a Part D Late Enrollment Penalty (LEP) or Income Related Monthly Adjustment Amount (IRMAA), they may pay a higher premium for the prescription inclusion.
- If a member has LIS/Extra Help, they may pay less for their prescriptions. We have a breakdown by county, by plan, and by LIS level, describing individual prescription cost sharing available in the plan documents lookup by plan.
    - Here is a video you can watch on how to use these LIS charts.

- When speaking to a prospect, it is important to look up their prescription drugs to see if they are or are not covered under a specific plan.
- Excluded drug coverage includes:
    - Erectile Dysfunction drugs, generic brands
    - Folic acid 1mg tablets
    - B12 injections

Our Network

Devoted Health offers HMO and PPO plans

- Health Maintenance Organization (HMO), meaning we have a network of physicians that the member must use, unless it is an emergency situation. Going outside of that network could result in members incurring unnecessary out-of-pocket costs.
- Preferred Provider Organization (PPO), meaning there is a network, but beneficiaries can see any doctor or provider that accepts Medicare. On a PPO the following is true.
    - Members do not need a referral to see a specialist in or out of the Devoted network.
    - Copayment and coinsurance amounts are set by plan for in and out of network cost sharing.
    - The beneficiary will usually pay more for out-of-network care, but this is dependent on the plan.
    - This FAQ document can answer more questions about our PPO, this is for internal training use only and is not to be shared externally with clients.
    - You can direct members and providers here for more information: https://www.devoted.com/ppo/ .

We have partnered with (and hand selected) trusted doctors, hospitals, and pharmacies that individuals can use in their area. Virtually every covered service or piece of equipment can be obtained through an in-network provider.

The member's PCP will be their main doctor providing care. However, that does not mean that the member can not make changes to their PCP. Members are not locked into the PCP they choose at the time of enrollment; they can contact their Devoted Health Guide Team at any time and request to change their PCP.

> *If a member requests a **change on or before the 9th of a month** and has not yet seen their PCP that month*: the member may choose to have the change go into effect retroactive to the 1st of that month, or the 1st of the following month.

*If a member requests a **change on or after the 10th of a month** or reports that they have already seen their PCP that month*: the change will be effective the 1st day of the next month.

PCP Contracts
Below are some different types of PCP contracts that Devoted Health works with.

FFS PCP - Physicians who are paid on a visit or service basis.
This means when members see the physician or receive a service from the provider, the provider bills the health plan (based on the contracted rate), and the health plan will reimburse the provider.

Capitation PCP - Physicians paid a per-member, per-month (PMPM) rate for the services that they typically provide in a primary care office.
The rate is negotiated based on the services offered by the provider and the county average rates. If they provide those services, the physician will not bill the health plan. Instead, they will pull funds from the payment that Devoted Health has provided them up front. Covered or approved services received outside the primary care office will still be paid by the health plan.

Risk PCP - Physicians who have contracted with Devoted Health to take on some of the financial risk that is associated with the senior population and their medical needs.
Devoted Health passes a percentage of the premium they receive from CMS to the physician based on the number of members assigned to their office. Then the provider is responsible for some or all costs associated with the member in the following Medicare covered categories. This could mean they are responsible for specialist visit costs, hospital costs, drug costs, etc.

- Part A
- Part B
- Part D

Why would a PCP want to accept risk?
The payment model is aligned with comprehensive, quality care. The provider is paid a percentage of the premium, as defined in their contract, as opposed to a limited amount such as a capitation.

How does a risk strategy benefit a Devoted Health member?
Providers paid under this model benefit financially when they take care of their patients, keep them healthy, and focus on preventive services rather than acute conditions.

At Devoted Health, we believe that risk/anchor providers are important to a member's care. Whereas many healthcare plans focus on a reactive model, our model focuses on preventive care. We want to help our members get care before it gets to the point where they need to be hospitalized and placed on medications. Our risk PCPs may spend more time following up on recent issues or tests, because keeping members healthy is their goal.

Encouraging Preventive Care

We want our members to focus on preventive care, as well. We encourage our members to take their health care into their own hands, and take preventive measures to maintain good health and well-being.

As part of this focus, we emphasize PCP and out-patient treatment whenever possible. We want our members to understand the risks associated with ER visits and hospitalizations:

- Hospitals are for individuals who are extremely sick, and some individuals may be at risk of acquiring an infection if admitted to a hospital. Additionally, hospitalization may be stressful and that may impact an individual's condition.
- There is limited continued social interaction in a hospital setting. As a result, returning to the community after a long stay in a hospital may be difficult.

If our members understand the potential hazards of hospitalization, they may understand why preventive care is a much stronger approach.

For the reasons listed above, we also ask our sales staff to help their members to schedule their first visit with their PCP. This can be done during the enrollment appointment, or during their first follow-up call after the member is effective.

Specialists

Devoted Health has built a relatively large specialist network for its members.

We have built this network through collaboration with PCPs as a way to ensure that PCP-preferred specialists are included. We have chosen to work with specialists with proven, high-quality outcomes.

If a member needs to see a specialist, like an orthopedist or oncologist, they may need a referral from their PCP; this does depend on the state and plan, (check the plan's summary of benefits for more information). Referrals are just a way to make sure the PCP knows what is going on with an individual's health. Members must see specialists that are in-network.

Our referral process is easy! Our PCPs use Availity (a commonly used tool) to submit the referral. Once submitted, the referral is automatically approved.

Not all specialists require a referral, here is more information on what requires a referral and in what states

What's the difference between a referral and an authorization?
A referral helps PCPs to coordinate their patients' care. Referral requirements vary by market. Referrals are automatically approved once the PCP puts them into the Availity system.

An authorization (also known as "prior authorization") is an approval in advance in order for a member to receive certain services or drugs. Providers are responsible for obtaining prior authorization for all qualifying, non-emergent services prior to the service being scheduled or delivered.

- Average standard auths are being approved within 2 days (we have up to 14 days)
- Average expedited auths are being approved within 12 hours (we have up to 72 hours)

For a list of authorization requirements, click **here.**

Large Hospital networks
Devoted Health is committed to creating a relatively large hospital network to meet the required needs of our members and providers. Our on-line **Provider Look-up tool** has the most up-to-date in-network hospital information.

Provider lookup tool: https://www.devoted.com/search-providers

This video will walk you through how to look up doctors on the devoted website.

Summary

Devoted Health cares for its members in many ways, through their guides, additional benefits, prescription coverage, and selection of physicians. When we design our plans, we are focused on the members and how we can make their experiences with health care easier, more affordable, and a whole lot more caring.

Review this resource for some more information around our networks and how we build.

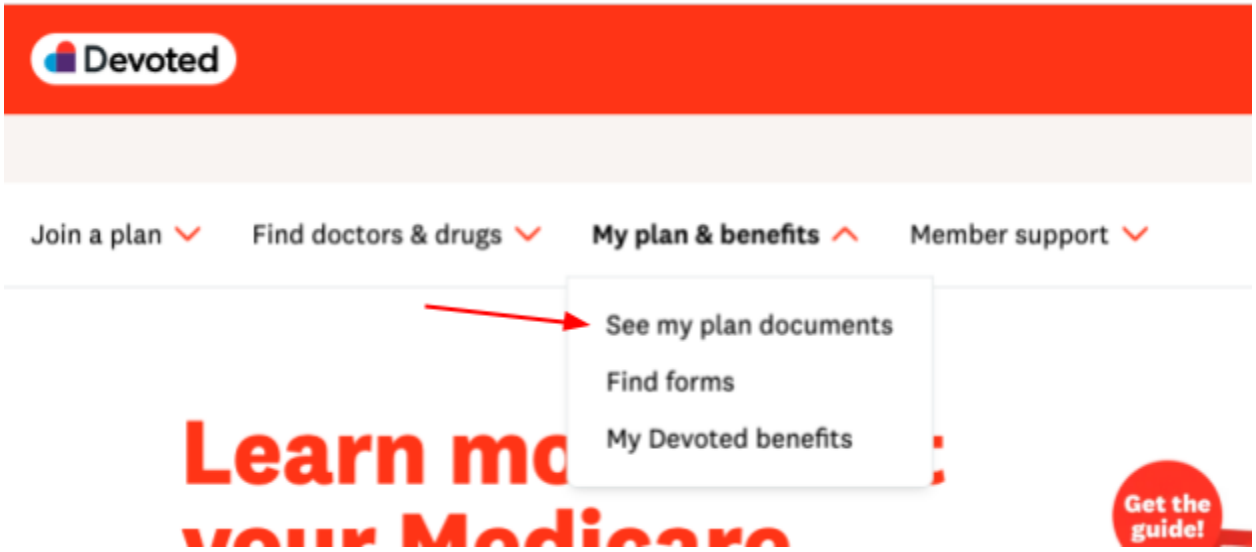
Devoted Health Website and Tools

- Devoted Health Website
- Prescription lookup tool
- Provider lookup tool
- Broker Electronic enrollment tool
- Electronic Scope of Appointment
- Broker Marketing Storefront
- Broker Commission and Application Status Portal

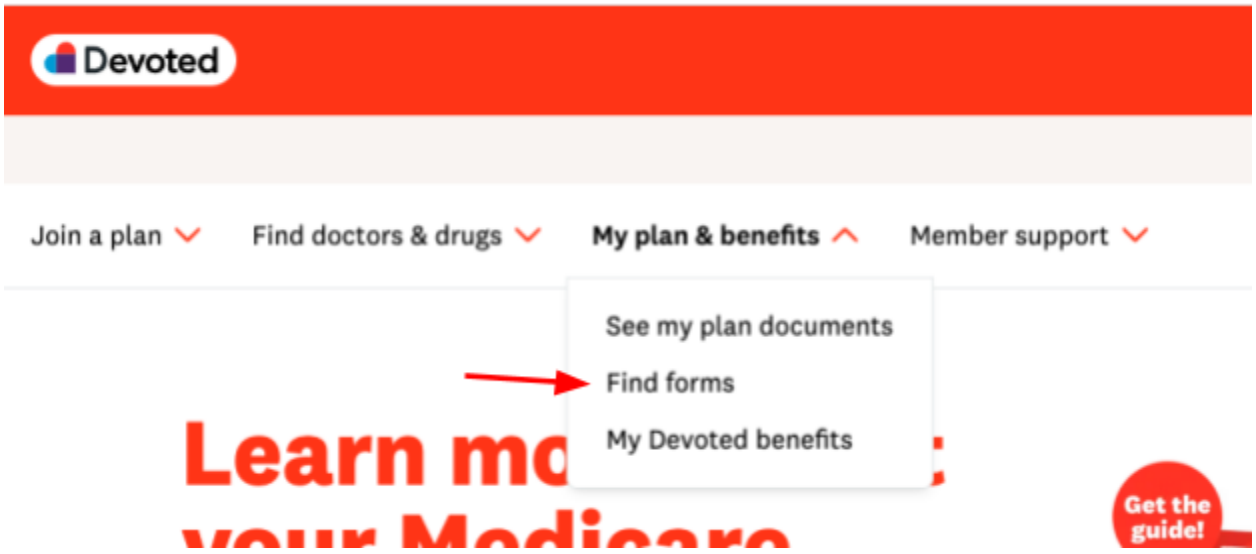
How to use the Devoted Health Website

The Devoted Health website contains forms, resources, and much more.

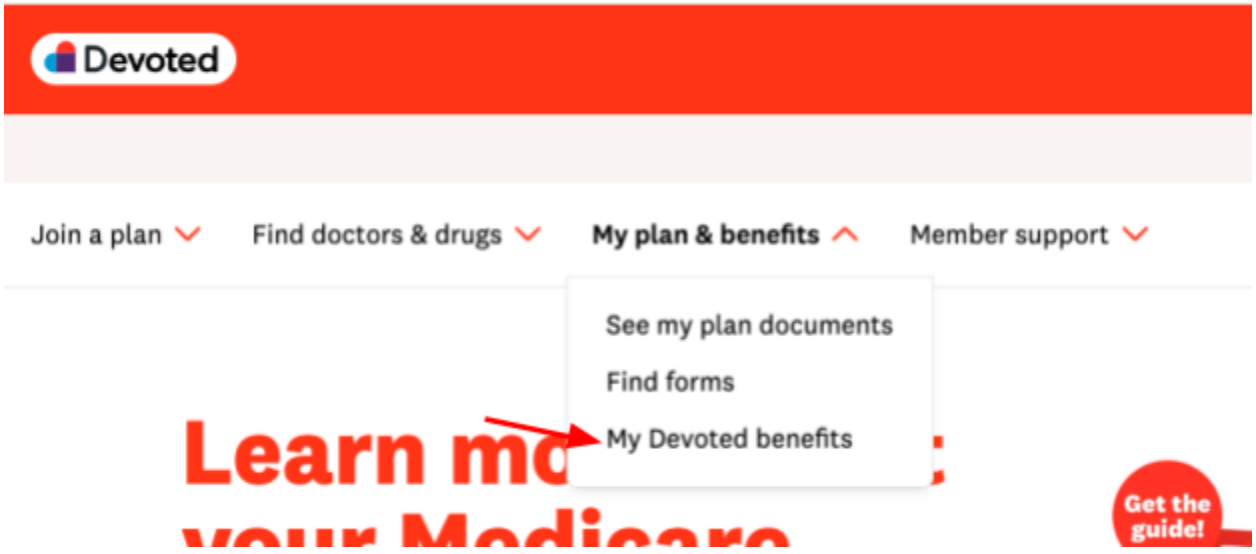
Our Summary of Benefits pages are easy to access. Go to www.devoted.com and click on “my plan & benefits” then “See my plan documents”. There are other ways to access summary of benefits and plan information - watch this video to see how easy it is!



Forms for our members including reimbursement forms, consent for release of PHI, enrollment forms and others can be found under “My plan & benefits” “ and then “Find forms”.



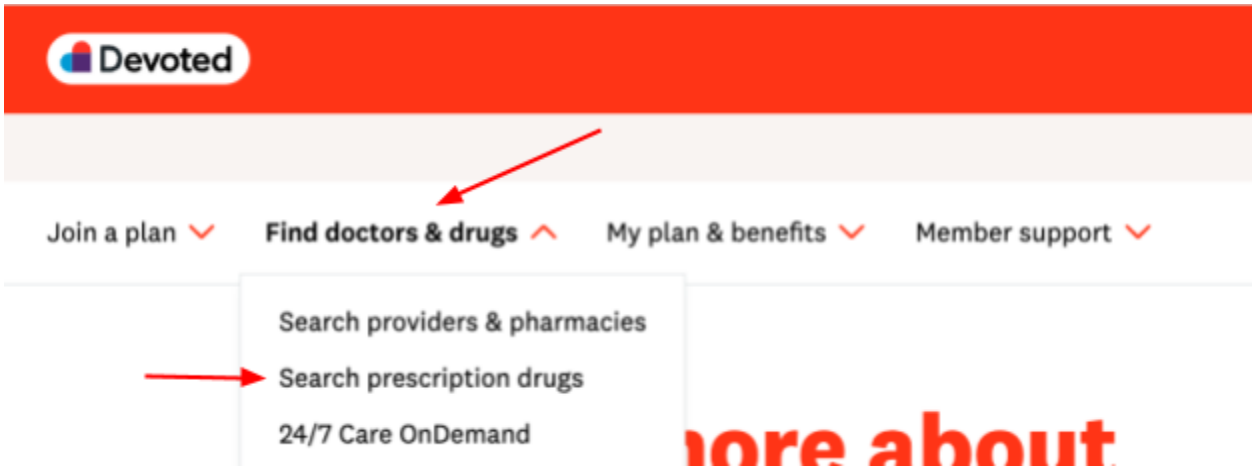
Learn about some of the great extra benefits our members receive and how they can use them under the “My Devoted benefits” tab!



Prescription Lookup

Looking up prescriptions in the Devoted Health website is easy and does not require any login. You can either use our Prescription Lookup tool or download the formulary.

Go to www.Devoted.com, click “Find doctors & drugs” and then select “Search prescription drugs”.

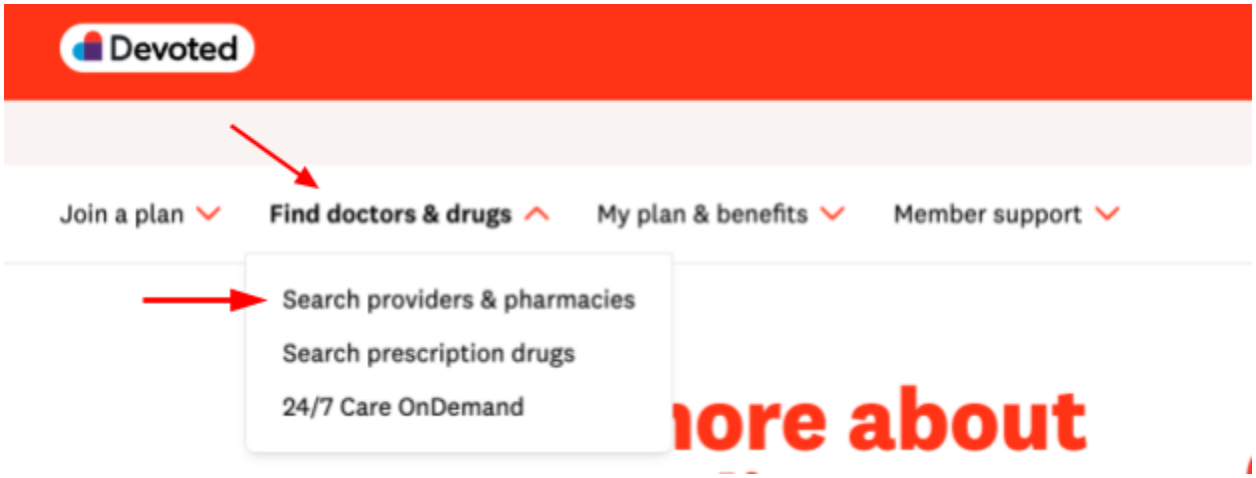


You have the ability to look up prescriptions and save a list for the prospect to reference later.
Video - How to look up prescriptions using the lookup tool

Provider Lookup

Our Provider Lookup tool makes it easy for our agents to look up doctors and facilities, and for our members to access the registry without needing to login to a member portal.

Go to www.Devoted.com and click “Find doctors & drugs” then “Search providers & pharmacies”.



This **video** will demonstrate some of the features and filters that can be used to make your searching experience even more enjoyable! (Please note, the Referral Group option for filtering is only available in certain markets.)

Broker Agent Portal

Our on-line enrollment tool is called our "Devoted Health Agent Portal" and is built from the ground up to make selling Devoted quicker and easier!

Here is a quick video on our agent portal and how you can use it!

What can I do in the agent portal?

- View your book of business and their status
- Complete an enrollment application
- Complete a scope of appointment
- Complete an HRA
- Access helpful tools and training material
- Request to host an event with Devoted
- Identify and provide status updates on appointments assigned by Devoted
- Request Help through our messages for Agent Support

How do I log in?

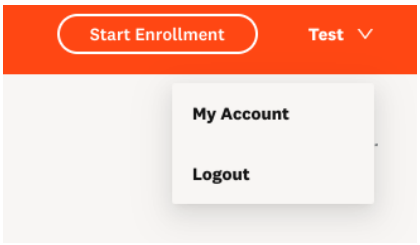
You will use your NPN as your username and the password that was set when you completed our contracting and certification workflow. If you have not completed this, please use the link sent to you by your upline to create an account or send us an email for further assistance.

You can access the portal at any time by going to https://agent.devoted.com/ and entering your username and password.

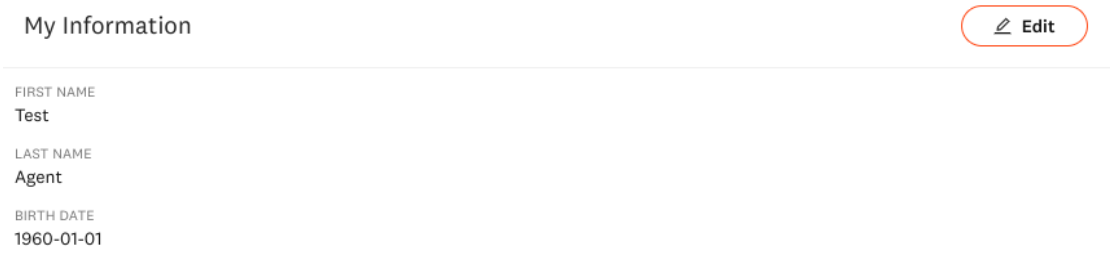
Review / Update Demographic & Financial Information

You can view and update your demographic & financial information in your Agent Portal account by following the easy steps outlined below.

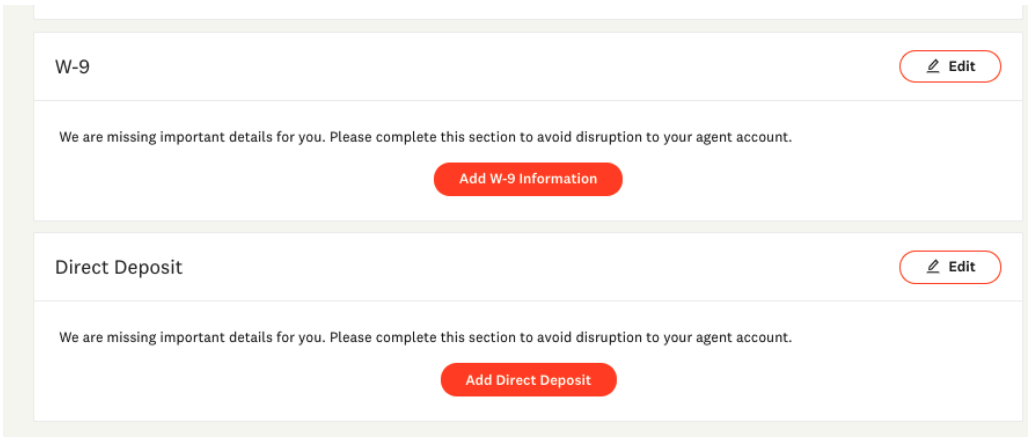
- Login to your Agent Portal account
- On the top right hand corner of the page you will see your name, select it and you will see a dropdown menu.
    - Select ***My Account***.



- This will display your demographic and financial information as seen below:
    - Click on the ***Edit*** button in the ***My Information*** section to make the necessary changes.
        - Note : Email address updates must be submitted to agent support via portal message or phone call.



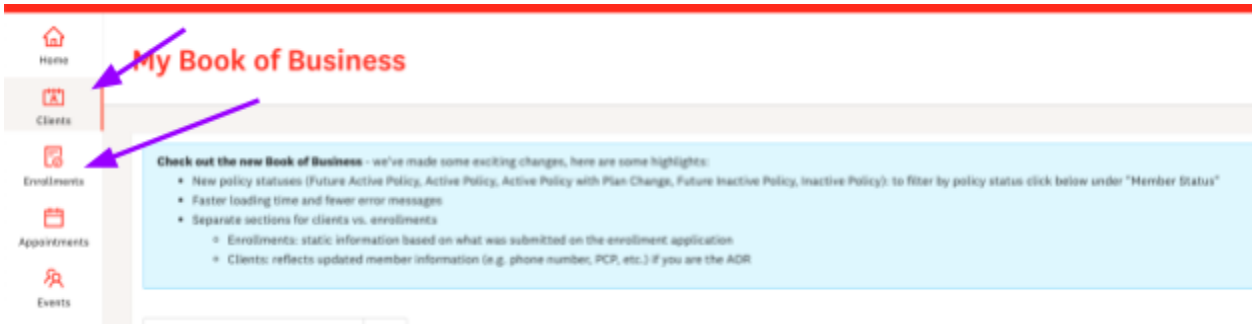
- If you need to update your financial information(***direct payees only***)
    - Click on the ***Edit*** button in the ***W9*** or ***Direct Deposit*** section to make the necessary changes.



View your book of business and client list and their status

You will see two sections for your “book of business” in the agent portal.

1. **“Clients”** this is where you can locate the individuals you have enrolled into a Devoted Health plan and it reflects the updated member information (i.e. their updated phone number and PCP) if you are the agent of record.
    a. In this page you can find your members contact information, their status in the plan, the effective date and end date, and their Member ID.
2. **“Enrollments”** this is where you will see clients that you haven’t completed an enrollment on (i.e. enrollment is drafted, but not completed) can be located, as well as submitted enrollment static information.



Complete a Scope of Appointment

Scope of appointments can be completed electronically, over the phone, by paper, or through email. (Here is an FAQ document on SOAs)

This document walks you through how to complete an SOA with Devoted Health.

This video will walk you through completing an SOA with Devoted Health

Complete an enrollment form

Can be completed electronically in person or by emailing/texting the application. More instructions can be found here.

Complete an HRA (Health Risk Assessment)

- If an application is submitted by paper or third-party enrollment vendor, HRA will be available when Devoted Health processes the application. For agent portal submissions, HRA will be available immediately.
- Here is a helpful FAQ on completing HRAs and a helpful video!

Request to host an event with Devoted

You are able to request events using our Agent portal and see once it has been approved. Step by step instructions can be found in **this file**.

View RSVPs and Attendees from events

- If you are hosting a formal marketed event with Devoted you are able to view the RSVPs in your Agent portal under the events section.
    - You can also download a list of those that attended your events.
- If you host any type of event with Devoted and submit your lead cards to your community outreach specialist a list of those that attended and requested a follow up from the event will appear in your events section of your agent portal.

Submit your post event metrics

- As we continue to look for ways to grow and improve our events, our post event metrics help!
- You are now able to submit your post event metrics right through your agent portal under your event.

Watch this video on how to do the above two actions.

Identify and provide status updates on appointments assigned by Devoted

Step by step instructions can be found in **this file**.

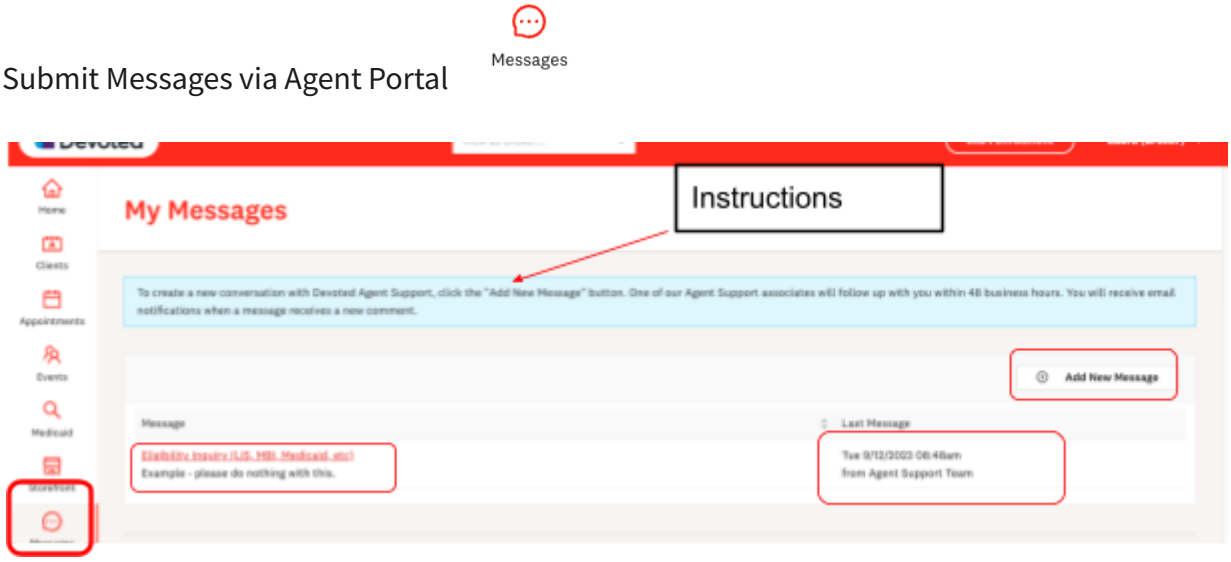
Request help through our agent support messages

You can electronically submit agent support messages and view/update prospect appointments directly in [Agent Portal](#).

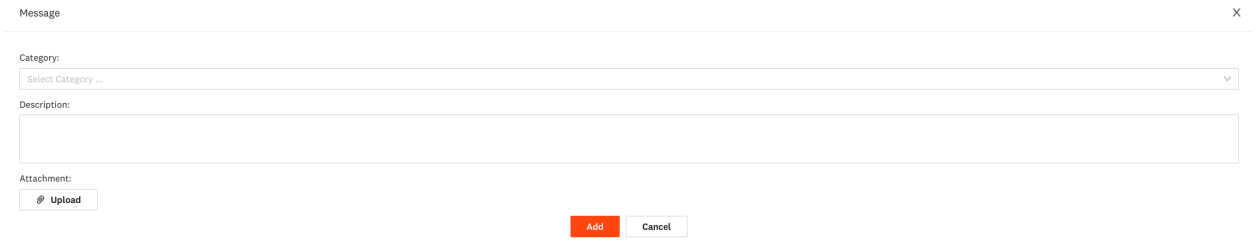
- Submit messages to our Agent Support to help answer any questions you have. Our Agent Support team will follow-up within two business days. Details can be found below
- Quickly access prospect appointments assigned from Devoted Health directly in the Agent Portal. You can edit the appointment, add relevant notes and disposition.

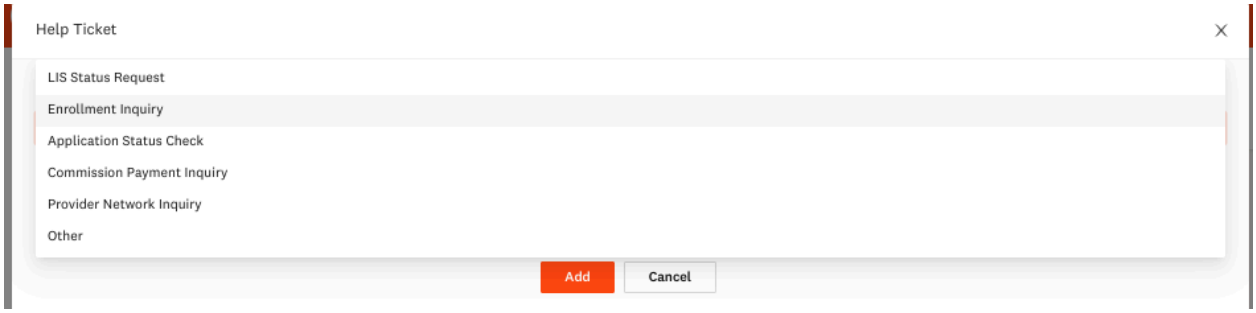
Messaging Instructions: Step by step instructions can be found in **[this file](#)**.

1. Submit Messages via Agent Portal

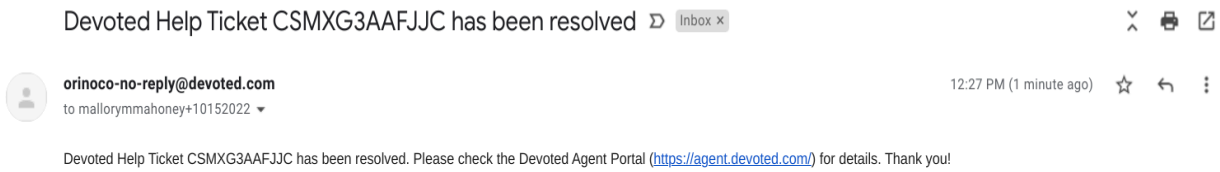


2. Select the Category of your item and add a description
3. Upload any desired documents “Attachments”
4. Hit “Add” to submit your message.





5. Receive a Messages ID and can track the progress of their message within Agent Portal as well as the Resolution. You will receive email notifications when the status of the message changes.
6. Email notification will be sent once your message has a response.

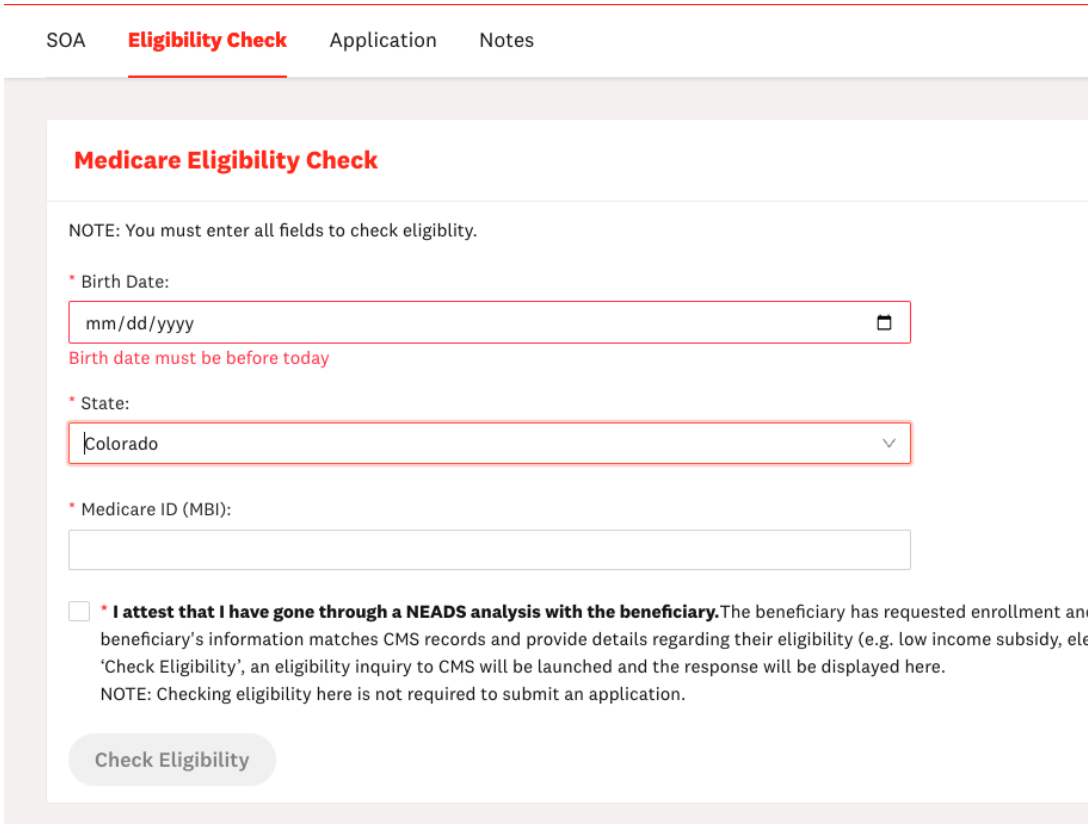


Medicaid eligibility directly in Agent Portal.

- **Lookup DSNP/Medicaid Eligibility.** You must have enrollee's first/last/DOB/gender **OR** Medicaid ID and MBI. You will receive Medicaid status, level, and more! Details can be found here. Medicaid eligibility data is available now for AL, FL, OH, CO and NC!

Medicare eligibility and LIS lookup directly in Agent Portal.

- **Lookup Medicare Eligibility and LIS levels** within the agent portal under the client. You must first be inside a client page and you must have the enrollee's verbal authorization to complete the eligibility check. Enter the required information and you will receive LIS levels, A&B effective dates, current plan, and more!



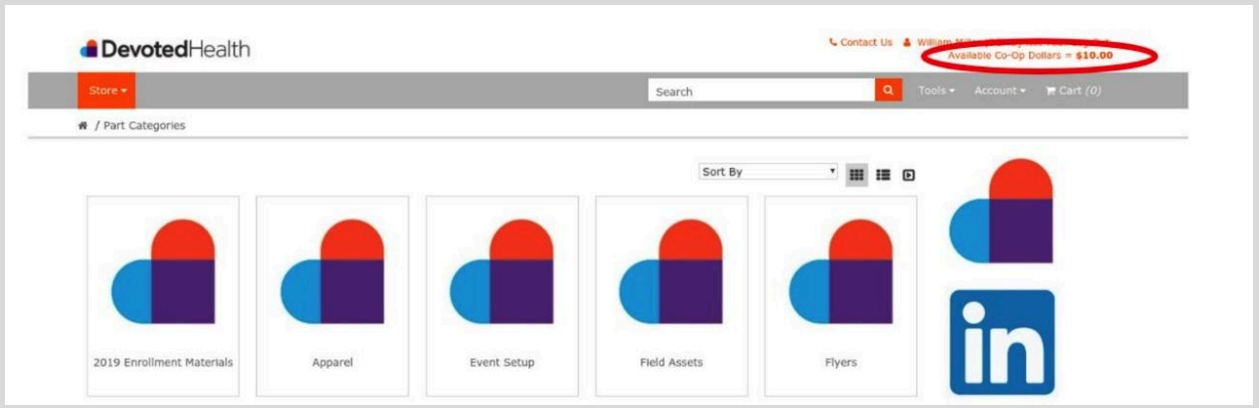
Marketing Storefront

The marketing storefront offers best in class sales, marketing and member retention tools. Brokers have access to hundreds of CMS approved customizable flyers, direct mail, banners, social media posts and so much more including broker swag and educational subscriptions.

This video has instructions for using the storefront from logging in and finding information that you need to sell.

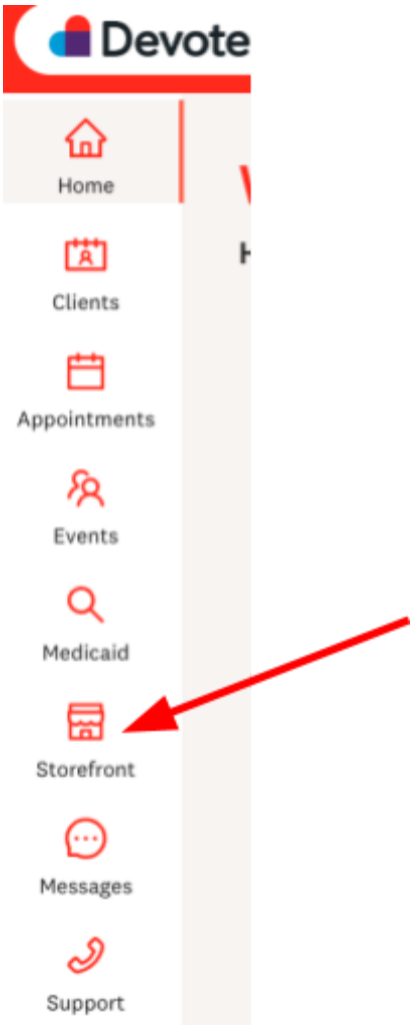
Many items in the storefront are available electronically at no cost and items in the storefront with cost can be purchased using your "Broker Bucks" earned through our Star Sellers Program or by credit card.

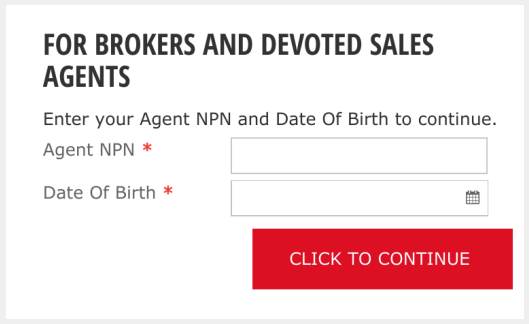
To check your Broker Bucks balance, log in to the Devoted Health Marketing Storefront (see instructions below). You will see co-op balance (available broker bucks) in the upper right corner of your screen.



Accessing the Storefront

Once a broker is appointed with Devoted Health and receives their “ready to sell” email, they will be able to register on the Marketing Storefront within 48 hours. All you will need is your NPN and Date of Birth to start your registration. You can access the storefront from the agent portal or by going directly to devoted.com/storefront.





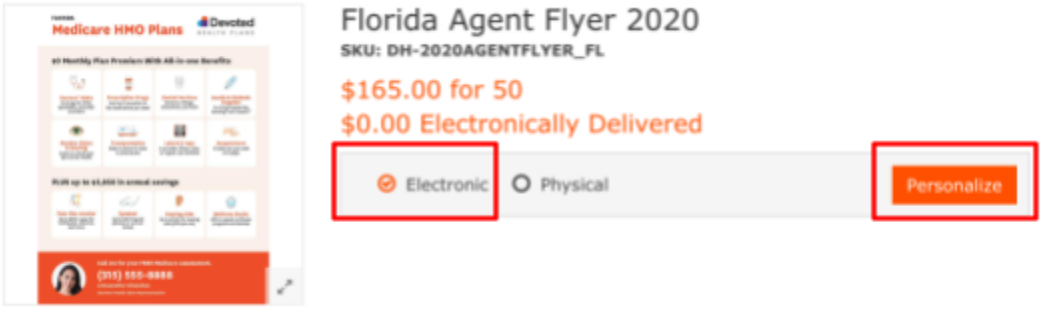
Ordering from the Storefront

Once you have access to the storefront, you will be able to customize, download and order materials, and have them shipped directly to you. Most materials are available in both English and Spanish. Before ordering an asset, please confirm that you have selected the correct language.

This guide has more information around accessing enrollment materials

To view the material closer click on the asset image. Once open click the double arrow icon in the image preview.

1. If a marketing material is available to be personalized or is available in electronic version, these options will appear before adding the item to your cart.



2. To personalize, enter the information you want to include on the marketing material. You can build a proof of your document to ensure accuracy.

3. If you are happy with the proof, click “Continue”.

4. You will then need to approve the proof with your initials and click “Accept”. The item will be added to your cart.

5. When you are ready to checkout, if there are costs associated with any of the items, these will go to your marketing dollars as explained earlier in this section.

6. Click “Checkout” and then “Place Order”. Electronic items will be sent to the email address on file. Physical items will require the individual to enter the desired shipping address.

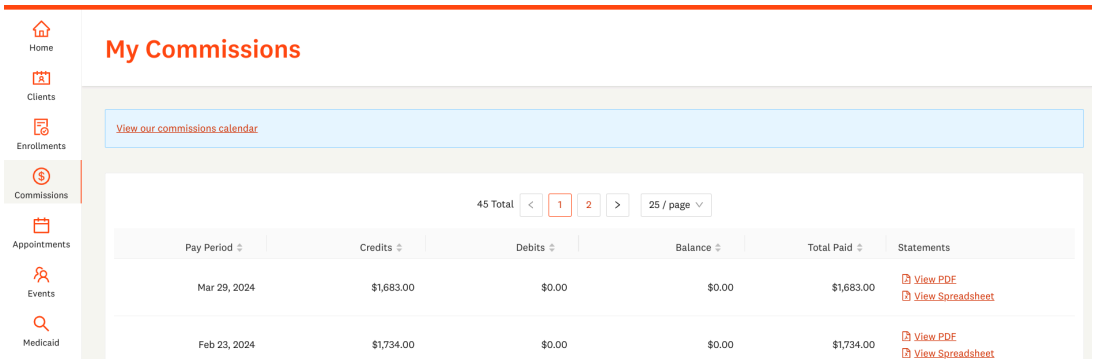
Here is a resource with some more information about our storefront and new materials available.

Commissions

Outside of applications for the following plan year, commissions are paid upon submission date weekly on Fridays and renewals and HRAs are paid at the end of the effective month. The payment date depends on the date the application is submitted.
Here you can find our payout commission calendar which identifies by submission date when you will receive payment.

Compensation year is January through December 31. New members are paid at either the initial rate or the renewal rate, depending on their Medicare Advantage status. Payments may be pro-rated depending on that status and the month of enrollment. Rapid disenrollments (enrollments for three months or less) will be recouped and will be seen as a deduction on your commission statement. If a member leaves the plan within the plan year, recoupment will occur for months the member is not in the plan.

If you are a direct payee your commissions statement is available to view in Agent Portal. Log on and click “Commissions” on the left hand panel, and view/download your statements. If you encounter an error, please try refreshing the page.



For Brokers who have been with Devoted Health for an extended period, historical commission information (before January 2021) can still be accessed through "Evolve"

For indirect payees: you will not see any statements - please contact your agency for payment information.

FAQ

Q: What does the Commission statement show?
A: In the Agent Portal, you can view the statement two ways:

1. A spreadsheet to include the member's ID, name and month they are effectively enrolled.
2. PDF to include the members HICN, Name, Effective date, Contract, Amount paid, type of enrollment and whether or not they canceled.

Q: When do commission statements appear in the agent portal
A: Commission statements appear by the end of the week that they are scheduled for payment.

Q: What if I see that I enrolled someone who was new to Medicare but only received payment for a renewing Medicare beneficiary?
A: If a member who was new to Medicare is enrolled by an agent, but the agent received the commission amount for an enrollee who is not new to Medicare, here is what may have happened: Payments are made based on the information received from CMS at the time of the enrollment. If CMS does not send any information regarding an initial status, the default non-initial rate is paid. It is not uncommon for CMS to send data late regarding a member's status. In those situations, if information regarding an initial status is sent at a later time, the difference between the previous non-initial amount and the updated initial amount is paid at the next available payment cycle.

Q: What if I have a question about a commission?
A: Please contact Agent Support by phone, 1-877-764-9446, during normal business hours, or submit a message in the Agent portal.

Q: What if my member makes a plan change from a Devoted Health MA plan to another Devoted Health MA plan?

A: If the change is made by a Devoted employee, the broker agent will remain the agent of record and continue to receive renewal payments. If the change is made by another broker, the new broker will become the agent of record and will begin receiving the renewal payments.

Q: What if I was formally an employed agent with Devoted Health and I am now a broker?
A: Former Devoted internal agents will not be compensated for any plan members they enrolled while a Devoted internal agent.

The Devoted Health Sales Process

- Scope of appointment
- Enrollment Presentation
- Finalize the sale
- Completing the Enrollment

Many of the materials you need for an appointment can be found here and this presentation checklist includes reminders of the information you must cover during your presentation based on CMS regulations.

Digital Enrollment Kits

The digital enrollment kits which include the summary of benefits and more information to include in your enrollment presentation can be found on the agent portal.

Scope of Appointment

The Scope of Appointment (SOA) form is used to document a Medicare Advantage (MA) or prescription drug plan (PDP) appointment with a potential, new, or existing beneficiary. The SOA ensures that only the types of products the beneficiary has requested are discussed. The form is intended to protect the beneficiary from being solicited for a product that he/she didn't originally express interest in.

- Agents must complete and submit SOAs to Devoted Health for all scheduled appointments. This includes "no-sale" appointments.
- The Retention Policy is 10 years (Devoted Health retains the SOAs submitted for the 10 year minimum requirement).

Here you can find more information related to SOAs.

Telephonic/Virtual Sales Requirements

When agencies indicate that their agents and brokers conduct telephonic/virtual sales and enrollment activities in the field they must follow our Non-Call Center requirements.

Here you can find more information about those requirements.

Enrollment Presentation

Review the information in the digital enrollment kit or paper enrollment kit. This will help ensure beneficiaries are provided with all the information they need to make an informed decision as part of your overall sales presentation. Any marketing, sales and/or enrollment calls completed over the phone or by web-based technology (i.e. webex, zoom, etc.) must be recorded.

1. **The warm up** - The warm up is one of the most important steps of the sale.https://assets.devoted.com/brokers/DH_Embracing-A-Growth-Mindset-Guide.pdf Most individuals make a decision if they will buy from you within 30 seconds. This has nothing to do with the benefits or the plan that you are offering, but more about you and how much they trust or like you.

2. **NEADS (Now, Enjoy Adjust, Decision Makers, Solutions) Analysis** - Understanding a prospect's needs means identifying where there is a disconnect between what they have now and what they could have with Devoted. This is your opportunity to ask questions and determine why you are meeting with them, and why they might be interested in making a change to our plan. Use the NEADS acronym to remember some important questions and discussions to have with the client. In recent CMS guidance updates have been made in requiring these questions be asked as a part of your enrollment process.
    - **N**ow - What does the prospect currently have for their healthcare coverage?
        - What are their healthcare needs? Such as durable medical equipment, physical therapy, any other specific healthcare needs?
        - What are their preferred physicians, facilities and hospitals?
        - What pharmacy do they currently use and what prescriptions do they have?
    - **E**njoy - What do they like about that coverage or why did they initially choose it?
    - **A**djust - Why are they meeting with you, what are they looking to change or add with their healthcare?
        - What kind of health plan does the beneficiary wish to enroll in? (Such as low premium and higher copay or higher copays and $0 premium)
        - Does the beneficiary require hearing, dental or vision coverage?
    - **D**ecision maker - Do they have anyone help them make their healthcare decisions?
    - **S**olution - Provide the prospect with a solution that meets their needs.

Note: ***Although it's nice to know more about an individual and their wants and needs, CMS regulations say the only information you can require an individual to provide is a zip code to pull up the available plans in an individual's area and provide a plan overview.***

3. **Devoted Health Video/Presentation** - Introduce the Devoted Health sales video/presentation. This is a quick (only seven minutes) video/presentation to show prospects. The video/presentation explains how Devoted Health works, and clarifies potential questions about Medicare.

   2024 Sales Video: English | Spanish

4. **The Enrollment Kit** - When you are ready, show the prospect the Medicare Comparison guide and Summary of benefits. Although Devoted offers multiple plans, it is important that agents decide on one plan to review with the prospect, based on the NEADS analysis. The agent should explain why there are multiple plans available and why a particular plan option is more suited to the prospect's needs.
   a. Using your plan comparison grid confirm the needs of the prospect and point out some of our highlighted benefits.
   b. Next, you should review the full Summary of Benefits for the chosen plan. Make sure to review the pre-enrollment checklist and remember to review all the plan benefits, including but not limited to:
      i. All benefit cost sharing (such as deductibles, copays, and coinsurances)
      ii. plan premium information (including Part B premium, and comparing their current premium to the new potential plan premium).
      iii. Cost limitations on dental, vision and hearing
      iv. Coverage for out of network providers and services (e.g. except in emergency or urgent situations)
      v. Review coverage outside the United States
      vi. Explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
   c. Explain any impact on the individuals current coverage
   d. **You must explain that the plan is an HMO or PPO and what that means.** Remember to discuss physicians, and offer to look up specific doctors, facilities and the preferred hospital for the beneficiary to see if they are in network or not. Show them how they can look up names themselves online.

i. For the HMO plans be sure to explain that for those physicians, facilities or hospitals that are not in network the beneficiary will need to choose a new one or they will pay out of pocket.
ii. For the PPO be sure to explain how out of network benefits work and applicable cost share.

e. When reviewing prescription benefits, you can show the new member how to look them up on their phone or computer, remember to check to see if their prescriptions are covered and their pharmacy is in network, and let them know if not they will need to choose a new pharmacy or may have to pay the full price of the prescription.
f. If the plan has a star rating, show off the star rating for that plan and explain how the star ratings are determined.
g. Explain that this is not a hearing/dental/vision "rider" but a full plan.
h. Explain that plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
i. Review how to file a complaint - if someone has a complaint, have them call 1-800-DEVOTED and we will help them with the process.
j. Review the right to cancel an enrollment as well as the specific date through which cancellation may occur which is prior to the effective date with Devoted, or during their outbound enrollment verification (OEV) window, which is listed on their OEV letter that they receive from Devoted following enrollment or they can call Devoted Health at 1-800-990-0723.
k. Review these Items only applicable to certain plan types:
i. Review need to qualify for chronic/disabling condition requirement for C-SNPs
ii. Review the need to have Medicaid to qualify for D-SNP.

Finalizing the Sale

Once you have answered all of their questions, it is time to close the sale. Refer back to the information you gathered in the beginning, and summarize why this plan will bring them value.

Don't forget to ask for referrals - After the enrollment is completed, remember to ask the member for referrals. Give them your business cards so they can give them to any friends or relatives they'd like to refer. You may ask for names and mailing addresses for referrals, but you **cannot** request phone numbers or email addresses. You may use the member-provided

referral names and mailing addresses to solicit potential new members by conventional mail only.

Completing the Enrollment

Enrollment can be completed three different ways:

1. **Paper submission:**

    a. The beneficiary must be provided with a copy of the summary of benefits
    b. Agents must conduct a full and compliant enrollment presentation using Devoted and CMS approved materials.
    c. Enrollment applications are available in the enrollment kit. Once completed, within 48 hours you must fax the application or mail to:
        - Devoted Health — Enrollment
          PO Box 211127
          Eagan, MN 55121
        - Fax number can be found on the fax cover page dependent on the state:
          Fax Cover Page: CO + FL | All other states

    For submission of paper enrollments we **require** the use of the state specific fax cover page.

    Faxing Submission Requirements - all elements can be found here.

    - Fax cover page (or document with same fields)
    - Enrollment form (included in sales kit)
    - Enrollment receipt (included in sales kit)

    Mailing Submission Requirements

    - Enrollment form
    - Enrollment receipt

    Pro Tip: Write your NPN on all enrollment form pages prior to faxing to ensure we can reach out to you if all faxed pages don't come through properly.

    The Enrollment Receipt must be submitted with all **paper** enrollment forms (carbon copy should stay with the beneficiary).

2. **Electronic in-person submission:**

    a. The beneficiary must be informed where they can access all materials on-line
    b. Agents must conduct a full and compliant enrollment presentation using Devoted and CMS approved materials.
    c. You can submit an online enrollment through our online agent portal.
    d. The member must sign the enrollment electronically by typing in their name.
    e. Here is a video on how to complete the enrollment electronically in-person.

3. **Electronic Remote Signature submission:**

    Instructions (Video on how to complete):

    a. The beneficiary must be provided with the enrollment kit.
        i. If you are not meeting with the beneficiary in person, the enrollment kits can be sent by email prior to enrollment. There are two options for doing this:
            1. Sending them a link to the Devoted plan documents webpage via email.
            2. Sending the documents as an attachment via email.
    b. If the sales presentation was already completed in-person, you may complete the electronic e-signature application with the beneficiary if they decide upon enrollment at a later date; as long as the beneficiary wants to enroll in the same plan that was presented in person. If the beneficiary has additional questions or is interested in a different plan, then another sales presentation would need to be conducted. If a Devoted health approved call center the agent may conduct a full and compliant sales presentation on a recorded line using Devoted and CMS approved materials.
    c. Choose “Electronically, Remote” as the Submission Method on Agent Portal
    d. Fill in the enrollment application
    e. Make sure the application is saved and resolve any errors
    f. Click "Check Application For Errors & Prepare to Generate Signature Link" button and resolve any errors
    g. Click “Generate Secure Application Link”. You will see a success notification in the upper right corner, and the application will automatically be moved into Awaiting Signature status
    h. A pop up window will appear. Confirm the language, phone number and/or email address. Click either the “Send SMS” or “Send Email” button.

i. Please note: Agents may NOT use their own phone number or email address to complete this step.
    i. These fields will automatically populate based on the information in the enrollment application.
    ii. You can edit the email address directly in the pop up. If you need to edit the phone number, you'll have to do it on the enrollment application.

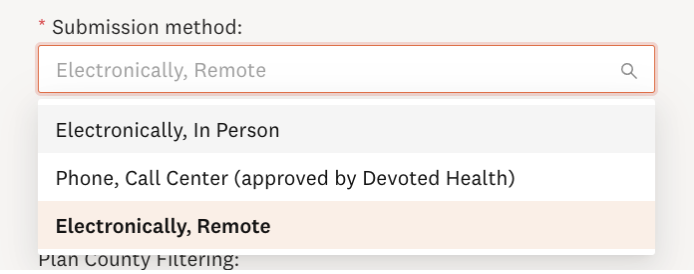
What the prospect will see:

a. Wait 1-2 minutes for them to receive their text or email, it will be titled "Finish Your Devoted Membership Application" and comes from the agent's email address or from a text code. Then they must click the link that says "complete" my application.
b. The individual will need to verify their DOB to continue to application
    i. They will see all their information for the application, the plan they chose, some disclaimers, and then they just need to type in their name and select "Sign Application and Enroll now"
c. THE APPLICATION IS NOT CONSIDERED COMPLETED UNTIL THE ENROLLEE SIGNS THE APPLICATION FROM THE LINK.

FAQs:

Q: How long is the secure link good for?
A: The secure link that is generated will only be **valid for 24 hours**. Enrollees must sign and submit the application prior to the effective date.
Q: How do I know if the prospect signed the application?
A: You will be able to see the status in the prospect file in the application and you can send them the link manually if they say they can't find it, or lost it!
Q: What if I choose "electronically remote" as the signature option and then decide to change the enrollment method?
A: Change your submission method in the application: (after you make this change the remote signature will no longer be valid)
Q: How do I resend a link?
A: From the application page, scroll down to the "Application Ready to Send for Remote Electronic Signature" section. Click the "Text/Email Application Link to Enrollee" button to open the pop up window and send the email or text message. If the original link is more than 24 hours old, you will need to generate a new link to send. You can do this by clicking the orange "Generate Secure Application Link" button.
Q:The prospect did not receive the link - what should I do?

A: For SMS links, confirm that the prospect's phone number is correct; that the phone number is for a text-enabled mobile device; and that the prospect is opted in to SMS. For email links, confirm that the prospect's email address is correct. You can also try to manually send the link from your Gmail account. From the Links section, click the Copy URL button.
Q: The prospect is not seeing the application in the correct language - what should I do?
A: The application automatically detects the language based on the prospect's computer and browser settings. If you need to override this behavior, you can have the prospect add "&lng=es" (for Spanish) or "&lng=en" (for English) to the end of the URL.



Health Risk Assessment (HRA)

An HRA will be available for broker agents to complete on any Medicare Advantage members through our agent portal upon submission/receipt of the application. Agents are asked to complete the HRA with the consumer at time of enrollment and will receive $50 for each HRA that is completed within 5 days from the date the application was completed.

- HRA is only used to help match members with Devoted Health services like managing medications, controlling chronic conditions like diabetes, or getting settled at home after a hospital stay. The HRA answers don't impact an enrollee's premium or application processing. Devoted Health will share responses with doctors to help them offer more personalized care.
- Members enrolling in one of our SNP plans will receive a Devoted Dollars gift card for completing the HRA and staying enrolled in our plan in January (refer to the summary of benefits).
- If an application is submitted by paper or third-party enrollment vendor, HRA will be available when Devoted Health processes the application. For agent portal submissions, HRA will be available immediately.
- Here is a helpful one-pager on completing HRAs and a helpful video!

Guardians or Responsible Parties

A “Responsible Party” is a person authorized under applicable law or identified in writing by an individual to act on behalf of the individual in making healthcare related decisions for a prospect. Individuals who are able to enroll a prospect into the Devoted health plan on their behalf include a power of attorney, guardian, or healthcare surrogate.

If a responsible party completes an enrollment application on an individual’s behalf into the Devoted health plan, agents cannot require documentation as evidence of Power of Attorney (POA). The POA has to attest to it on the application, and the agent then must explain that they would have to be able to present evidence of it if requested by Devoted and if they're unable to, they wouldn't be authorized to enroll the beneficiary as POA.

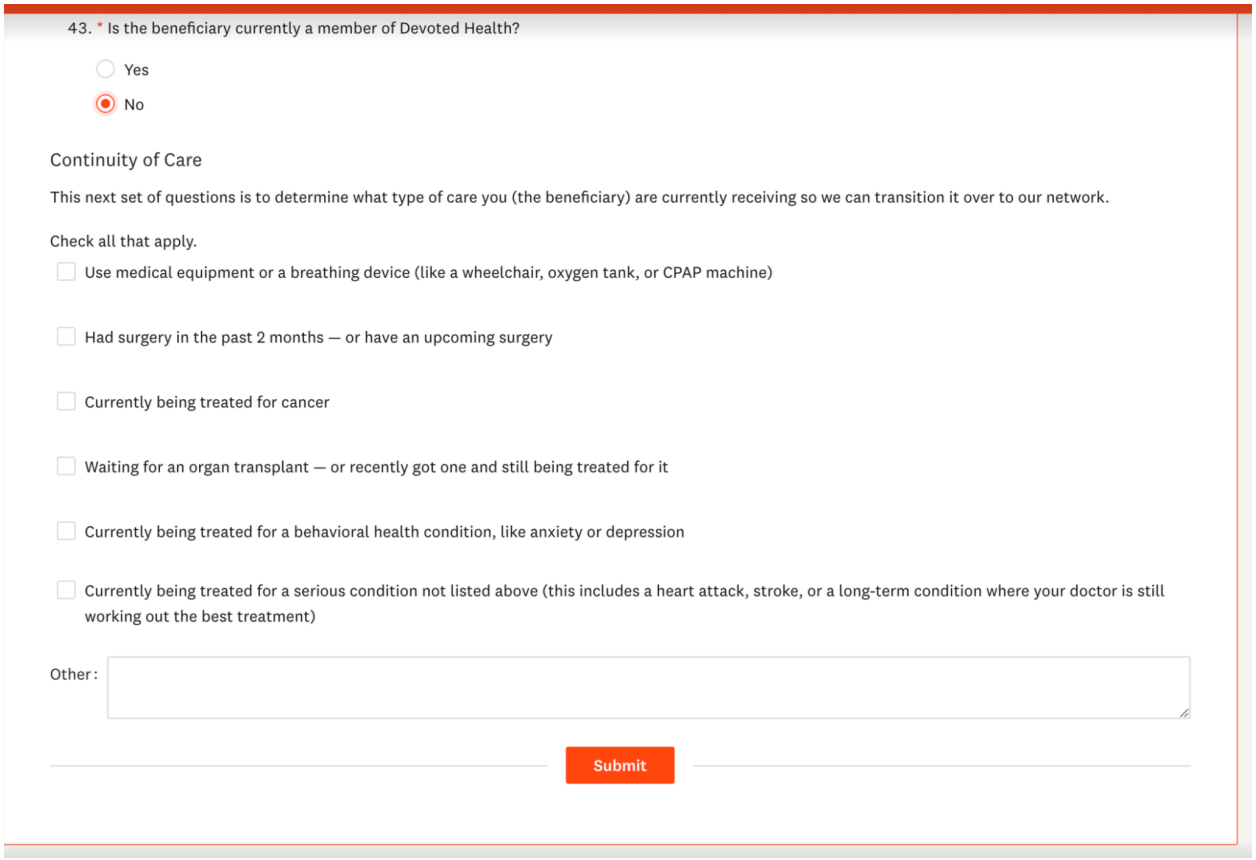
The authorized representative attestation on an enrollment form **does not** actually give the person broader authorization; to discuss PHI or take action on the member's behalf, the person needs to send us written documentation signed by the member. If the individual would like to speak on the member’s behalf, they would need to submit the copy of their advanced directive. If they are not a legal representative, they may not sign the application on the prospect’s behalf, but they may fill out an appointment of representation form (which can be found here), and send it to Devoted so they may speak with our Guide team.

- Follow these steps for submitting:
    - If completing a paper application this can be sent with the paper application.
    - If completing an electronic application we ask that the form is sent three days after the application is submitted to make sure it can be attached to a member record.
    - This can be faxed or mailed to the enrollment department at the same fax/mailing address for the enrollment application. We ask that the fax cover sheet be used and it includes the member’s name and Medicare number so we know where to assign the authorization.

FAX - 1-877-234-9988
Mail - Devoted Health
ATTN: Appointment of Representative
PO Box 211037
Eagan, MN 55121

Continuity of Care (COC)

When completing an HRA you'll reach Question #43 which asks if the member is a "new member" (Q: Is the beneficiary currently a member of Devoted Health? Yes - existing member and No - new member). If the answer is "NO," another question related to continuity of care will appear. To ensure that your member receives proper support during their transition to our plan, it is crucial to check the appropriate box (s), rather than simply typing in the "other field." By doing so, you'll initiate outreach to the member and ensure their smooth transition onto our plan."



Cancellations and Disenrollments

Members have the right to cancel an enrollment which is prior to the effective date with Devoted, or during their outbound enrollment verification (OEV) window, which is listed on their OEV letter that they receive from Devoted following enrollment or they can call Devoted Health at 1-800-990-0723.

Members are able to voluntarily disenroll from Devoted Health during a valid election period, and one of the most effective forms of doing this is by enrolling in another plan to ensure there is no lapse in Part D coverage.

At times members may be involuntarily disenrolled from their health plan, for example if they lose special needs status or move outside the service area. Members will be informed in these scenarios to help them with their transition.

What Our Members Can Expect:

Once new members are enrolled in the plan, we want to make sure their first experience with Devoted Health is positive. The below outlines some of the items they can expect within the first few weeks from Devoted Health.

This document outlines what our members can expect when they enroll with Devoted within the first few days and weeks. Also if needed here are some numbers that can help your members get access right away to their benefits once they are effective.

RX BIN and PCN

Part D

RxBIN: `004336`
RxPCN: `MEDDADV`
RxGRP: `RX8704`

Part B MA Only

RxBIN: `004336`
PCN: `PARTBADV`
Group: `RX21BZ`

Summary

We want our onboarding process for our members to be as easy and seamless as possible. If they need any additional assistance with their transition, remind them that they can always contact our Guides at 1-800-Devoted!

Want to learn more about member retention and referrals review our guide here.

Permission to Contact (PTC) Review:

Agents May:	Agents May NOT:
Make unsolicited outreach through conventional mail and other print media (e.g., advertisements, direct mail) or email (provided every email contains an opt-out option).	Conduct door-to-door solicitation, including leaving information of any kind, except that information may be left when an appointment is pre-scheduled but the beneficiary is not home.
Make unsolicited outreach through email, provided that all emails contain an opt-out function.	Approach potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.).
If an agent has a pre-scheduled appointment with a potential enrollee who is a “no-show,” they may leave information at that potential enrollee’s residence.	Send direct messages from social media platforms.
Call individuals who have given permission for a plan or sales agent to contact them. (Examples of permission include: filling out a business reply card, emailing the Plan/Part D sponsor requesting a return call, or asking a customer service representative to have an agent contact them.) Permission applies only to the entity from which the individual requested contact and for the duration and topic of that transaction.	Use telephone solicitation (that is, cold calling) robocalls, text messages, or voicemail messages, including, but not limited to, the following: ● Calls based on referrals ● Calls to former enrollees who have disenrolled or those in the process of disenrolling ● Calls to beneficiaries who attended a sales event, unless the beneficiary

	gave express permission to be contacted ● Calls to prospective enrollees to confirm receipt of mailed information
Return phone calls or messages from individuals or enrollees, as these are not considered unsolicited contacts.	Market plans for the upcoming plan year prior to October 1 under the pretense of plan business for AEP.
Contact for plan business: Call current enrollees, including those in non-Medicare products, to discuss plan business.	Make unsolicited calls about other business as a means of generating leads for Medicare plans (e.g., bait-and-switch strategies).
Call beneficiaries who submit enrollment applications to conduct business related to enrollment.	Make outbound calls based on referrals (if an individual would like to refer a friend or relative to an agent or Plan/Part D sponsor, the agent or Plan/Part D sponsor may provide contact information such as a business card that the individual could provide to a friend or relative).
Agents/brokers calling clients who are enrolled in other products they may sell, such as automotive or home insurance.	Make calls to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling.
When reaching out to a beneficiary regarding plan business, as outlined above, agents must offer the beneficiary the ability to opt out of future calls regarding plan business.	Call beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted).
	Call prospective enrollees to confirm receipt of mailed information.

Contacting Your Current Clients

You may contact your current clients from another business relationship with whom you have a current, active contract or business relationship in other products. You must be able to provide proof of a current, active relationship with the client upon request.

Contacting Current Members

If you are the Agent of Record (AOR), you may contact a Devoted Health Plan member to discuss the plan in which the member is currently enrolled, without obtaining additional PTC.

If you are NOT the AOR, you may only call an existing member if PTC has been delegated by Devoted Health Plan to the agent. Delegation of PTC occurs when Devoted Health Plan provides the member's contact information (i.e. name and phone number) to the agent. You may only use the member's Protected Health Information or Personal Identifying Information (PHI/PII) to the extent necessary to conduct business on behalf of Devoted Health. **Any other use of PHI/PII obtained through delegated PTC is prohibited.**

How to market yourself

Want to learn more best practices about how to market yourself review our guide here.

Devoted Health Educational and Sales Events:

When agents participate in a Devoted Health educational or sales event, they are representing Devoted Health. We expect them to treat prospects and members with the love and respect they deserve! Therefore, it is imperative that agents follow the CMS Title 42 Code of Federal Regulations (CFR) *§§ 422.2264* and Devoted Health policy and procedures.

When scheduling an event things to keep in mind

- **Submitting an Event:**

- Educational and Informal events need to be submitted a **minimum of 7 days** in advance of the event date.
- Formal events must be submitted a **minimum of 14 days** prior to the event date.
    - In order to be eligible for hosting a formal sales event, sales agents must have received seminar training, and completed a seminar authorization form. If you are not yet authorized to conduct formal sales seminars and would like to get started, reach out to your local sales leader.

- **Updating an event:**
    - Recommend at **least 24 hours** prior to the original scheduled date and time
    - Updates must be submitted to the local community outreach specialist

Registering an Event

Instructions: Step by step instructions on submitting events through our agent portal can be found in this file.

What Happens Next?

1. The information will go to our local market contacts who will review the information and contact you with any questions. You can watch the progress of your event under the "events" tab.
    - When first submitted it will sit in "Review" status
    - If the event is approved it will move to "Approved"
    - If the event is canceled it will move to "Canceled"
2. Once submitted you will be able to see your event in your portal and as the event moved to either approved or canceled you will receive an email notification. If you need to make a change to your event (i.e. date/time/location) please reach out directly to your local market contact.
    - You cannot conduct the event without an approval notice.
    - All agents providing information at the event must be certified and ready to sell with Devoted Health.
    - If you have an emergency and cannot make it to the event, you must provide 72-hour notice to a Devoted Health Community Outreach Specialist. Failure to do so will result in being subjected to disciplinary action.

This document outlines some of the best practices for having a successful event.

Preparing for the Event

- **Make sure you have all the materials you plan to use prior to the event.**
    - All advertisement and promotional material(s) must be approved by Devoted and CMS.
    - Pre-approved marketing material(s) can be ordered on our marketing storefront
- Confirm that the event is easily accessible for all visitors.
- Make sure there are signs directing individuals to the event location.
- Arrive **at least** 15 minutes before the event start time to set-up, and stay until the scheduled end time of the event.
- Dress in business casual attire.
- Upon arrival at the event, check in with the contact person and/or staff of the venue

- and introduce yourself.
- Have your ID at all times.
- Set up your laptop, test projector, and speakers before the start of the event.
- Make sure to test the Devoted sales presentation video, etc.
- Set up beverages, and snacks, if applicable.

During the Event

- If you have to leave the event prior to the scheduled end time, you must notify Devoted Health and your upline agency.
- If the event is a formal sales event only one plan should be represented.
- ***All Devoted Health events are subject to secret shopping by Devoted and/or CMS. You will not be notified when secret shopping occurs. If you violate any Devoted Health and/or CMS policies you will be subjected to disciplinary action.***

After the Event

If you host any type of event with Devoted and submit your lead cards to your community outreach specialist a list of those that attended and requested a follow up from the event will appear in your events section of your agent portal.

Submit your post event metrics

- As we continue to look for ways to grow and improve our events our post event metrics help!
- You are now able to submit your post event metrics right through your agent portal under your event.

Video on how to see those that attended and requested information and post event metric entry.

Cancellation Policy

- If you need to cancel your event, this must occur 3 days prior to the event by notifying your local Devoted Health community outreach specialist or local sales leader.
- In the case of an emergency, you are responsible for finding coverage for the date/time of the event.
    - Events may only be “weather permitting” if you make a note of it when you submit for scheduling.

    - In the case of extreme weather, or other federal emergencies please contact your Community Outreach Specialist to seek approval for an emergency cancellation.
    - Any changes to date/time, location, or other important issues should be reported immediately to a Devoted Community Outreach Specialist.
- In the event of a cancellation a sign is to be posted at the site indicating that the event is canceled and if the event is advertised anyone who RSVP'd must be notified of the event cancellation.
- "No show" is not acceptable.
- Failure to follow these policies may result in disciplinary action.

Marketing Sales Events Dos and Don'ts

Marketing/Sales Events are designed to steer (or attempt to steer) enrollees toward a plan. The rules in the table below apply to all marketing/sales events.

Agents May	Agents May NOT
Use sign-in sheets as long as they are clearly labeled as optional.	Use any sales scripts or presentations without them being approved by Devoted and CMS.
Conduct raffles or drawings in which individuals include their contact information, as long as the information is only used for that purpose, and prizes are of nominal value.	Conduct health screenings or other activities that may be perceived as, or used for, "cherry picking".
	Require attendees to provide contact information as a prerequisite for attending an event.

Educational Events Dos and Don'ts

Educational events are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs. The rules in the table below apply to all educational events.

Agents May	Agents May NOT
Host educational event in a public venue	Distribute or use marketing/sales materials,

and must explicitly advertise the event as educational	or enrollment forms at the event.
Include communication activities and distribution of communication materials.	Market specific MA plans or benefits.
Answer beneficiary initiated questions pertaining to MA plans.	Conduct sales or marketing presentations or distribute or accept plan applications.
Distribute business cards and contact information for beneficiaries to initiate contact.	Collecting SOAs and setting up future marketing appointments
Collect BRCs (Business Reply Cards)	Conduct a marketing/sales event immediately following an educational event in the same general location (e.g., same hotel or adjacent building)

Activities in a Healthcare Setting

Provider Initiated

What does "provider-initiated" mean?

Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient.

Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. (42 CFR §§ 422.2266)

CMS considers the following contracted provider-initiated activities to be outside the definition of marketing and, therefore, not subject to regulation as marketing:

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from https://www.medicare.gov) including in areas where care is delivered
- Providing the names of MA organizations with which they contract and/or participate
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered)

- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Office, CMS' website at https://www.medicare.gov, or 1-800-MEDICARE
- Referring patients to MA plan marketing materials available in common areas
- Providing information and assistance in applying for the LIS

Plan Initiated Provider Marketing

What does "plan-initiated" mean?

CMS defines plan-initiated activities as those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements. (CFR §§ 422.2266)

Dos and Don'ts for plan initiated provider activities

Providers May	Providers May NOT
Make available, distribute, and display communication materials, including in areas where care is being delivered.	Accept/collect scope of appointment forms or enrollment applications.
Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).	Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on provider financial interests or any other interests of the provider.
Permit health plans or agents to conduct sales activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of enrollment forms in common areas of a healthcare setting. *Common areas in a healthcare setting include, but are not limited to: common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms.*	Permit plans to market or host events in restricted areas. *Restricted areas generally include, but are not limited to: exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).*

	Offer inducements to persuade their patients to enroll in a particular MA plan or organization.
	Conduct health screenings as a marketing activity.
	Distribute marketing materials/applications in areas where care is being delivered.
	Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.
	Offer anything of value to induce enrollees to select them as their provider.
	Mail marketing materials on behalf of the MA organization

Election Periods

There are many different election periods and timeframes that are important for all agents to be familiar with. This guide outlines the different election periods available for enrollment in a Medicare advantage plan and other resources available in reviewing election periods.

Compliance Reporting Metrics

Compliance is very important to us! On a monthly basis, our sales leaders monitor rapid disenrollments, application timeliness, and agent allegations. Don't be alarmed if we contact you regarding any of these topics.

Rapid Disenrollment

A Rapid Disenrollment is when a beneficiary disenrolls within 3 months of being on the plan or before the enrollment is final. We may reach out to discuss how to prevent this from happening with future enrollments.

- During the Annual Enrollment Period if an agent has more than 20 enrollment applications for 1/1 and greater than 10% of those who have enrolled rapidly disenroll, this will be reviewed by Devoted Health.
- For the rest of the year including open enrollment period (OEP) Devoted Health reviews disenrollment rates greater than 7% if an agent has 10 or more applications.

Application Timeliness

To comply with CMS enrollment submission requirements, agents/brokers must submit 98% of their applications within 3 days of receipt date. We highly recommend using our electronic enrollment tools to avoid any processing delays.

Agent Allegation Investigation:

We investigate all complaints/grievances of agent marketing misrepresentation submitted by members and/or the member's legal authorized representative. As part of the investigation process, we may request an agent statement via email and ask that agents/brokers respond within the specified timeframe to assist in resolving the case. Case determinations fall into three categories: founded, unfounded, and inconclusive. If any improvement opportunities are identified based on the individual case findings and/or agent's overall allegation history, we will work with the agent/broker to help reduce complaints.

Note: *During all interactions with prospects, providers, community partners, etc. agents are to comply with applicable federal civil rights laws and must 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).*

Resources:

Local Broker Leader Contacts

Devoted Agent Portal

Quick links resource

Devoted Health Broker Site

Summary of Benefits and EOC

Provider Lookup Tool

Prescription Lookup Tool

Devoted Health Marketing Storefront

How to report a potential violation of this Code, Compliance concern, or potential Fraud Waste and Abuse (FWA)

At Devoted Health we want to hear any potential violations. Every agent has an obligation to report any concerns about a potential breach in the Code of Conduct, Compliance concern and potential FWA without fear of retaliation. We are a company built on openness and trust. There are multiple ways to report a violation:

- Call our hotline. You can remain anonymous - **(855) 292-7485**
- Report it directly to the Devoted Health Medicare Compliance Officer - **sokane@devoted.com**
- Report it to your local sales manager
- Email **compliance@devoted.com**