



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.
- Already have a current AHIP, Pinpoint, or NABIP (formerly NAHU) certification? Perfect! Simply upload your certificate to meet the Core Medicare Training requirement. Don't have one yet? No worries—complete AHIP training through the [link](#) in our onboarding workflow and enjoy 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 PY2026 Certification will also allow you to market PY2025 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.

Our Code of Conduct reflects the foundation of Devoted Health's core values:

- Hypercompliant. We adhere to the letter and spirit of the law, without fail.
- Every member is family– Love for each other and for our members is at the heart of everything we do.
- We build for a rolling 20-year time horizon.

[Click here to view our entire Code of Conduct](#)

Devoted Health Agent Release & Transfer Policy & Timeline

Agent-Initiated Requirement

All Release & Transfer (R&T) requests must be **initiated by the writing agent** to confirm intent to transfer. Requests submitted by an agency on behalf of an agent will not be processed.

The writing agent may submit a request by:

- Calling Agent Support at **877-764-9446**
- Submitting a **message through the Agent Portal**

Immediate Release

An Immediate Release will be approved when one of the following occurs:

- The agent provides a signed release letter from their current upline
 - Release letters should be submitted with their Agent Portal message at the time of request.
- The current upline provides approval via the R&T notification email

Once request to transfer has been received:

- All parties (agent, releasing upline, and receiving upline) will be notified via email
- Standard processing timeline is 7 business days

Delayed Release

If an Immediate Release is not approved, the request will be placed on a Delayed Release timeline.

- The receipt date of the agent's request starts the 60-calendar-day clock
- The agent may continue to write business during this period
- If approval is received from the current upline during the delay period, the request will be converted to an Immediate Release effective the date of approval
- All parties will be notified via email once the transfer is completed

Release Processing Timeline

Please reference the timeline below for specific effective dates based on when the request is received:

Request Received	Immediate Release	Delayed Release Effective Date
8/15 - 10/8	Processed within 7 business days	Effective 12/8
10/9 - 8/14	Processed within 7 business days	60 days from request receipt

Changing Agency Affiliation (Contracting Links vs. Release & Transfer Process)

Agents who are already registered with Devoted or currently contracted under an existing upline cannot use another agency's contracting link to change their affiliation.

- If an agent attempts to use a new agency contracting link, the system will display the following error message: "Someone with this NPN has already registered / exists."
- The agent will also be directed to contact Agent Support at 877-764-9446.
- In these situations, the agent must follow the Release & Transfer (R&T) process to change their affiliation.

The screenshot shows the 'Tell us who you are' registration form in the Devoted Agent Portal. On the left, a sidebar titled 'Welcome to our Agent Portal' lists features: 'Register to sell Devoted Health', 'Submit applications online', 'Track your clients' status', and 'See your commissions'. Below this is a box for 'SALES AGENCY' with 'Indirect Payee' listed. The main form area contains fields for Agency, First Name, Last Name, National Producer Number, Birth Date, Email, and Zip. A red oval highlights an error message at the bottom: 'Someone with this NPN has already registered. Log in to your account or contact Agent Support at 1-877-764-9446 for help.' A 'Submit' button is also visible within the oval. An illustration of a woman sitting in a chair is on the left side of the form.

Key Guidance:

- Agency contracting links are intended for new agents only
- Contracting links cannot be used to change upline hierarchy or affiliation
- All affiliation changes must be completed through the R&T process initiated by the agent

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 on their first CMS approved app for that SSP year, excluding plan changes. These Broker Bucks can be redeemed for items such as Devoted Health branded swag, marketing / sales materials and branded apparel 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 (1-15 applications):** initial \$100 Broker Bucks
- **Silver (16 - 35 applications):** additional \$200 Broker Bucks
- **Gold (36- 75 applications):** additional \$300 Broker Bucks + annual subsidy to cover full cost of AHIP
- **Platinum (>76 applications):** additional \$500 Broker Bucks + annual subsidy to cover full cost of AHIP + personalized note from CEO and item to showcase your achievement

Broker Bucks will be loaded into agents' accounts daily.

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
- Rejected, denied, canceled and/or plan change applications don't count toward total application count.
- Applications that result in a plan change, where the beneficiary is currently enrolled in a Devoted Health plan and is switching to a different Devoted Health plan, are ineligible for SSP

- 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 application dates from 10/1 through 9/30 of each year. Program resets every SSP year
- You must reach the Gold or Platinum tier by June 15 to be eligible for the AHIP code that covers the full cost. AHIP codes must be used by August 15 and will expire on that day.
- This Star Sellers Program is subjected to change at any time with or without notice

Do Broker Bucks expire?

Broker Bucks will expire 15 months after the beginning of a specific SSP year.

- For example, if you accrue \$1,800 in broker bucks in the 2025 SSP year (apps written on 10/1/25 through 9/30/26), then any unused funds will expire on 1/1/27
- This is subject to change at any time

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
- Agents at certain agencies (e.g., e-brokers and other call centers) may not be eligible for the program

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 when you enter into a new tier and any and notify you of the additional benefits you have unlocked. Here is more information for you to learn more about the program:

- [Star Sellers Program Flyer](#)
- [Stars Sellers FAQ](#)

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 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!

>80% of calls answered within 30 seconds or less ¹ via dedicated support line and USA-based agents

¹ Devoted Health internal data, 2024–2025.

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!

Find your local leader and contact information here - [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.

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

- **93%** first-call resolution, no time limits on calls, and consistent follow-through¹
- Member net promoter score of **70**² and **94%** Member Trust Score¹
 - Vastly higher than industry average
 - Significantly higher than iconic consumer brands like Apple, Amazon, and USAA

- Underpinned by a phenomenal member service
- **96%** of brokers say that Devoted is keeping our promise to take care of their members and treat every member like family.³
- Leading provider service performance
 - Claims paid in days, not weeks. **80%+** of claims paid in 7 days¹
 - Providers credentialed in weeks, not months. **90%+** of providers credentialed in 3 weeks²
 - **86%** of calls answered by provider service team within 1 minute or less³
 - Average turnaround time of 15 hours for expedited authorizations⁴

Learn more about how we can make all of this happen

Newer Medicare Advantage Plan

We may be newer, 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.

Devoted Health launched in 2019, and served just 2.3K members in 1 state. In that short time, we've grown rapidly to serve over 200K members across 20 states.

Because we are newer, 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

1 Devoted Health internal data, 2024–2025

2 Devoted Health internal data, 2024–2025

3 Devoted Health internal data, 2024–2025

4 Devoted Health internal data, 2024–2025

Devoted Tech Platform

We've built claims, authorizations, credentialing, and member systems, so your clients can talk to our guides and it is easy for them to help with 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
- 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
- Healthy and satisfied members means high retention and less for you to worry about.

Devoted Medical and Care OnDemand

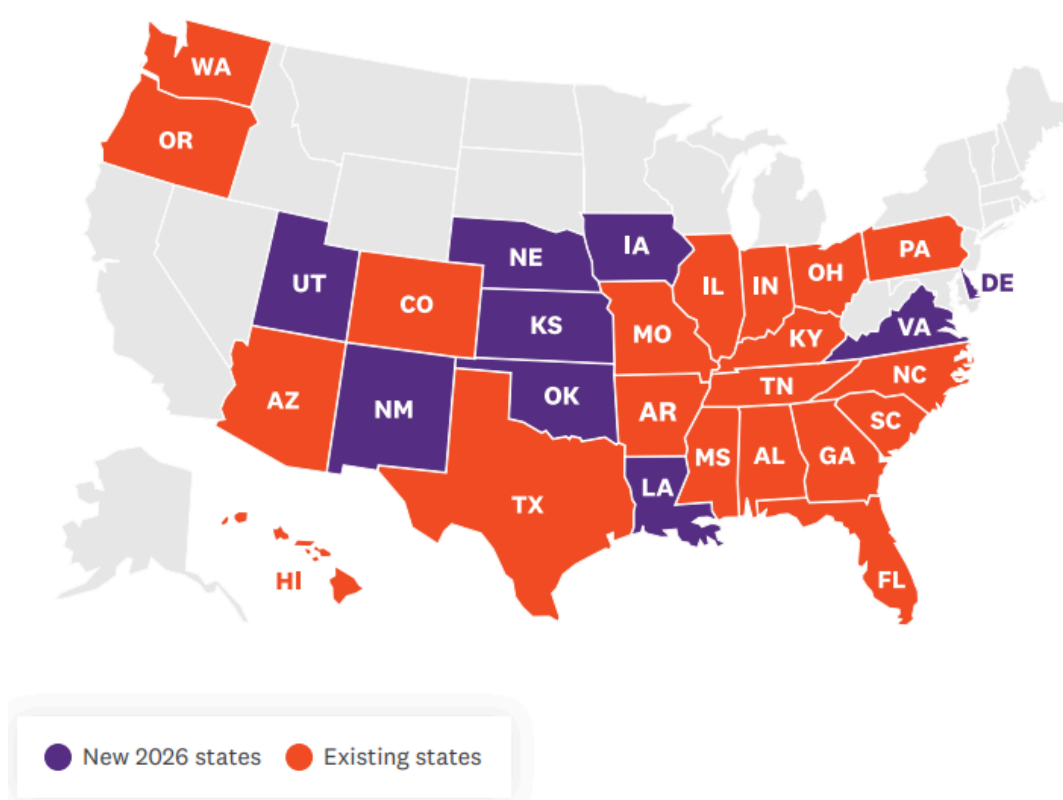
- Everything Devoted Medical does is “additive” to the PCP model, recognizing that PCPs are being asked to do more and more with less.
- Devoted Medical provides a spectrum of high-touch, high-fidelity, advanced clinical care to our patients.
- Care OnDemand provides the ultimate extension of our fully 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 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; rather, we have a dedicated team of Guides who help our members understand their plans, see their doctors, and receive the care that we would want to offer our own family members.

All of our guides are located in the U.S. and we do not just hire Medicare phone representatives we hire caring people with HUGE hearts!

Devoted Health Footprint 2026



- **Sustainable strategy;** We have a 3-year view on growth to ensure that the right decisions are made for the long haul.

- **Intentional plan design;** We keep members at the center of everything, with benefits they'll actually use and savings they will *actually* get.
- **Strong partnership;** We are dedicated to building long-term partnerships with our brokers and providers.

2026: National Plan Types Overview

\$0 Premium	Well-rounded \$0 premium plan with balanced medical and prescription drug costs and supplemental dental and eyewear benefits.
Giveback	Saver-focused \$0 premium plan with Part B premium reduction to lower monthly costs — offset by higher medical and prescription drug cost-share amounts and more modest supplemental benefits.
Dual Full	Benefit-rich full dual-only plan loaded with supplemental benefits, including a Food & Home Card (for chronically ill members who meet certain eligibility requirements*), OTC allowance, and comprehensive dental, eyewear, and vision care.
Dual Plus	Benefit-rich QMB or full dual plan loaded with supplemental benefits, including a Food & Home Card (for chronically ill members who meet certain eligibility requirements*), OTC allowance, and comprehensive dental, eyewear, and vision care.
Dual	Balanced D-SNP designed for partial duals, with most plans offering fixed copays and supplemental benefits, including a Food & Home Card (for chronically ill members who meet certain eligibility requirements*), OTC allowance, and comprehensive dental, eyewear, and vision care. Some dual plans also allow full duals to enroll.
C-SNP Plus	Robust C-SNP with primarily coinsurance-based medical benefits; \$0 premium for members with Extra Help; and rich supplemental benefits, including a generous Food & Home Card allowance (for members who qualify*), OTC allowance, and comprehensive dental, eyewear, and vision care.
C-SNP Premium	Balanced C-SNP with primarily copay-based medical benefits \$0 premium for members with Extra Help; and strong supplemental benefits, including a Food & Home Card (for members who qualify*), OTC allowance, and comprehensive dental, eyewear, and vision care.
C-SNP Zero	Flexible C-SNP with balanced medical and prescription drug costs and supplemental dental and eyewear benefits.
MA-Only Giveback	\$0 premium plan with NO Part D drug coverage. Includes supplemental dental and eyewear, and a Part B premium reduction to lower monthly costs.
Premium	Comprehensive premium plan with reasonable medical and prescription drug costs, supplemental dental and eyewear benefits, and a premium that is lower or \$0 for members with Extra Help.

2026: National Special Needs Plans Overview

	Eligibility criteria	Who might be a good fit
Dual Full	Must have a qualifying full dual-eligible status (QMB+, SLMB+, or FBDE).	All members who qualify. This plan typically has the richest supplemental benefits in the Devoted D-SNP portfolio.
Dual Plus	Must have a qualifying dual-eligible status (QMB only, QMB+, SLMB+, or FBDE).	Members who qualify for this plan and do not qualify for a Dual Full plan (if one is available in their market).
Dual	Must have a qualifying dual-eligible status (usually QI, QDWI, or SLMB). Note: Some dual plans also permit QMB and full duals to enroll.	Members who get Extra Help and are partially dual eligible (QI, QDWI, or SLMB). Note: For members who also qualify for a Dual Full or Dual Plus plan, that other plan is usually the better choice.
C-SNP Plus	Group 4 - diabetes, CHF, cardiovascular disorders.	Qualifying members who also receive Medicaid cost share assistance for Medicare services (QMB only, QMB+, SLMB+, or FBDE Medicaid status). With the richest supplemental benefits in the Devoted C-SNP portfolio, this plan is specifically designed to offer comprehensive coverage to QMB and full dual members seeking additional support managing their chronic conditions.
C-SNP Premium	Group 4 - diabetes, CHF, cardiovascular disorders.	Qualifying members who also get Extra Help and are seeking additional support to manage their chronic conditions. Note: For members who receive Medicaid cost share assistance for Medicare services (QMB only or full dual eligible) and have a C-SNP Plus plan available in their market, C-SNP Plus is usually the better choice.
C-SNP Zero	Group 4 - diabetes, CHF, cardiovascular disorders.	Qualifying members who want a \$0 premium plan designed to meet the needs of those with chronic conditions. Note: For members who get Medicaid or Extra Help and have a C-SNP Premium or C-SNP Plus plan available to them, one of those other plans is usually the better choice.

2026 Benefit Highlights

- **Winning Part B Givebacks**
 - Part B givebacks, on select HMOs and PPOs
- **Highly competitive Chronic & Dual Special Needs Plans**
- **Food & Home Card⁵**
 - Monthly card-based allowance that covers healthy foods, rent, mortgage and utility costs
- **Over-The-Counter**
 - Quarterly allowance can be used, at CVS, on all eligible over-the-counter items like toothpaste, vitamins, pain relievers and more
- **Dental⁶**
 - Included on all plans
- **Vision**
 - Included on ALL plans

Click this link to view additional details [2026 Extra Benefit FAQs](#)

View our 2026 Plans

This link will take you to our [2026 plans](#)

- Links to all plan documents are available on [Devoted.com](#)
- Digital enrollment kits with summary of benefits and more plan information available through the agent portal - [this guide](#) provides more details.
- Why sell Devoted Health [2026 Hot Sheet](#)

⁵The Food & Home Card is a special supplemental benefit offered on certain plans and available only to chronically ill members with conditions like diabetes, high blood pressure, high cholesterol, heart problems, stroke. All applicable plan coverage criteria must be met and other conditions are eligible. Not all members qualify. Benefits, premiums, and cost sharing may vary by plan.

⁶Members may have cost sharing on select services. DMR and card based benefits does not include implants, cosmetic dental services, and maxillofacial prosthetics
Benefits, premiums, and cost sharing may vary by plan. Dental limitations may apply. Dental coverage may be in the form of a card, allowance, or reimbursement-based benefit.

- Have questions on our products for 2026?
 - [2026 PPO FAQ](#)
 - [2026 Benefit FAQ](#)
 - [2026 CSNP FAQ](#)
 - [2026 DSNP FAQ](#)

- Other helpful member facing websites
 - Food & Home Card
 - www.devoted.com/food-and-home (2026)
 - PPO plans
 - www.devoted.com/ppo
 - Dental
 - <https://devoted.com/dental/>
 - [2026 FL Medicaid Dental](#) (FL D-SNPs only)
 - www.devoted.com/dental-card (Select plans)
 - Devoted Dollars
 - <https://devoted.com/devoted-dollars/>

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](#) (starting 10/1).

In this section we will review our different plans and how they are designed, benefits and cost sharing will vary by market. .

Devoted Health HMO 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.

Under our HMO, referrals are only required in **Florida, Illinois, or Texas** for certain specialists. All other states do not require a referral however we suggest our members talk to their doctors about their specialty care. Review [here](#) to learn more about what conditions require a referral and in what states.

Devoted Health PPO Plans

Beneficiaries have the option to go out of network and seek care; many services have the same cost sharing whether the individual seeks care with a Devoted network physician or out of network, but it is important to check the summary of benefits. Many times a PCP visit out of network will have a \$5 copay vs in-network.

Referrals may 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.

Devoted Health Giveback plans

- 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 premium.
 - If an individual is not paying their Part B premium, they will not see an increase in their Social Security check.
 - Therefore if an individual is having their Part B premium paid for them by the state this plan option will not be a good fit.
 - If an individual is not receiving a Social Security check, they will see a reduction in the amount they owe for their Medicare Part B premium.
 - ***IMPORTANT:** There can be a 4 month delay for the reduction to start from their Social Security check but the amount will be retroed back to the start date of the plan. It is crucial to set the expectation at the time of sale that this delay may occur. During this time the member will need to continue to pay their Part B premium to ensure they do not lose their Part B status.
- Learn more about givebacks with our [Guide to Givebacks](#), [Giveback Workbook](#) and NEW for PY26 our [Understanding Givebacks](#) video.

Special Needs Plans (SNPs)

Special Needs Plans (SNPs) are Medicare Advantage plans available exclusively to individuals who meet specific eligibility requirements. These plans are designed to deliver targeted benefits, enhanced support, and coordinated care.

Key features of SNPs include:

- **Targeted Benefits:** SNPs may provide supplemental benefits tailored to the unique health care needs of eligible members, such as Food & Home Cards and other plan-specific offerings.
- **Coordinated Support:** SNP members receive individualized care management through Health Risk Assessments (HRAs) and the development of personalized Individual Care Plans (ICPs).

Devoted offers two types of Special Needs Plans (SNPs):

- **Dual Eligible SNP (D-SNP):** For individuals who qualify for both Medicare and Medicaid. These plans include additional coordination to support members with Medicaid/Medicare navigation, care transitions, and disease management.
- **Chronic Condition SNP (C-SNP):** For individuals with certain chronic conditions. All Devoted C-SNPs are classified as *Group 4*, which is available to individuals with one or more qualifying chronic conditions, including diabetes mellitus, chronic heart failure, or specific cardiovascular disorders.

Devoted Health C-SNP Resources

We've created resources to assist you, including the [2026 C-SNP FAQ](#) and videos about specific plans like [C-SNP Plus](#).

Qualifications for C-SNP

- During enrollment there will be a pre-enrollment qualification assessment tool to submit with the application. This is available in the enrollment kits, and when completing applications electronically through our agent portal, connecture, or sunfire.

- Individuals who answer “Yes” to the qualifying questions may be eligible to join the plan.
- Following enrollment, Devoted will need to verify chronic conditions with the individual’s current 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 in their agent portal.

Qualifying questions for a Group 4 CSNP

Congestive or chronic heart failure

- ☐ I have cardiomyopathy, pulmonary hypertension, or low heart function
- ☐ I have another type of congestive or chronic heart failure
- ☐ I have a defibrillator for low heart function
- ☐ I get swelling in my legs or fluid in my lungs due to a heart problem

Cardiac arrhythmias (irregular heartbeat)

- ☐ I have atrial fibrillation or AFib
- ☐ I have an abnormally slow or fast heart rate
- ☐ I have a defibrillator or pacemaker for cardiac arrhythmia

Coronary artery disease (narrow or blocked heart arteries)

- ☐ I have angina, atherosclerosis, arteriosclerosis, or another type of coronary artery disease
- ☐ I’ve had a heart attack (myocardial infarction)
- ☐ I have a stent in my heart arteries
- ☐ I have had heart bypass surgery

Valvular heart disease (problems with heart valves)

- ☐ I have aortic, tricuspid, or mitral regurgitation
- ☐ I have aortic or mitral stenosis
- ☐ I have narrowing of my heart valves or leaky heart valves
- ☐ I have another type of valvular heart disease
- ☐ I have had a valve replacement or valve procedure

Peripheral vascular disease or chronic thromboembolic disorder

- ☐ I have problems with blood flow in my legs
- ☐ I often get blood clots

Medications for heart conditions or for history of clots

- ☐ I take one or more of the following medications:
 - ☐ Plavix (Clopidogrel)
 - ☐ Effient (Prasugrel)
 - ☐ Brilinta (Ticagrelor)
 - ☐ Coumadin (Warfarin)
 - ☐ Pradaxa (Dabigatran)
 - ☐ Xarelto (Rivaroxaban)
 - ☐ Eliquis (Apixaban)
 - ☐ Entresto (Sacubitril/Valsartan)

Diabetes

- ☐ I have diabetes (high blood sugar)
- ☐ I take one or more of the following types of medication to control my blood sugar:
 - ☐ Insulin
 - ☐ Metformin (Glucophage)
 - ☐ Prandin or Repaglinide
 - ☐ Acarbose
 - ☐ Actos, Avandia, Pioglitazone, or Rosiglitazone
 - ☐ Glipizide, Glimepiride, or Glyburide
 - ☐ GLP1 medications: Byetta, Ozempic, Trulicity, Rybelsus, or Victoza
 - ☐ SGLT2 medications: Invokana, Farxiga, or Jardiance
 - ☐ DPP4 medications: Januvia or Tradjenta

*Note: Pre-diabetes does not qualify an individual for this plan.

Devoted Health D-SNP plans

View this document to learn more about our chronic special needs plans and commonly asked questions - [2026 D-SNP FAQs](#)

Qualifications for D-SNPs

D-SNP qualifications vary by state. It is important to ensure your client resides in a qualifying service area before selecting a plan.

For current enrollees, Devoted must verify continuing Medicaid eligibility 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.
- Prior to enrollment, agents must confirm current Medicaid status. For assistance, agents may contact Agent Support at 1-877-764-9446 or check the Medicaid status using our Agent Portal.

Special Election Period (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.

Finding your plans by market

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.

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
- ✓ If it is a SNP must have the qualifying condition or medicaid level

Prescription Coverage

We know there were many changes for 2025 when it comes to prescriptions. Last year we built out this [Part D inflation reduction act \(IRA\) FAQ](#) which also includes information on M3P and the three stages for 2025 (and beyond) drug coverage.

When it comes to prescription drug coverage, many of our plans do include drug coverage, however we do have plans without drug coverage as well. These are known as MA only plans and you can identify them through Devoted Health as “Liberty” plans.

For our plans with prescription drug 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.
- Due to the IRA Insulin Cap, insulin is capped at \$35 or less in all stages
- Our prescription lookup tool can be located on our website here: [Prescription Lookup Tool](#) 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.
- There are different types of formulary offerings depending on the market and plan, which is why it is so important when looking up drugs that you look them up for the plan in which the individual is interested in enrolling into.

How to estimate drug costs throughout the different stages and identify if someone is likely to hit the catastrophic coverage?

While it's hard to predict exactly how a member's prescriptions might change during the year, we can use their current medications to get a solid idea of whether they'll likely hit that catastrophic \$2,100 cap. This can be done by using the Plan Finder and Prescription Lookup tools on www.Medicare.gov. [This video](#) and [this guide](#) will walk you through using this tool.

Part D [prescription](#) costs **do not** count toward a member's medical Maximum Out-of-Pocket (MOOP). Instead, Part D acts independently: members pay their deductible (if applicable) and co-pays until they hit a **\$2,100 out-of-pocket maximum**. Once that cap is reached, the member pays **\$0** for all covered drugs for the rest of the year.

When reviewing the drug list with beneficiaries, watch for acronyms next to certain prescriptions. These indicate requirements that must be met before the plan provides coverage:

- PA (prior authorization)
 - The member or provider must submit a request and receive approval from the plan before the prescription can be covered.
- ST (Step Therapy)
 - The plan encourages the member to try a lower-cost, effective medication (Step 1) before "stepping up" to a more expensive drug (Step 2)
- QL (Quantity Limits)
 - For certain drugs, we limit the amount of the drug that members can receive per fill or over a specific period (e.g., 30 tablets per 30 days).

FAQs for Prescriptions

Q: What if a prescription listed is not covered?

A: 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.

Q: What if a prescription is too expensive and covered at too high of a tier for the member to afford?

A: 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.
- Excluded drug coverage includes:
 - Erectile Dysfunction drugs, generic brands
 - Folic acid 1mg tablets

- B12 injections

M3P

The Medicare Prescription Payment Plan is a payment option in the [prescription drug law](#) that works with your member's current drug coverage to help them manage their out-of-pocket costs for drugs covered by their plan by spreading them across the calendar year (January–December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option.

For more information refer to the [Devoted M3P website](#)

Our Network

Devoted Health offers HMO and PPO plans

HMO

- 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.
- Under our HMO, referrals are only required in **Florida, Illinois, or Texas** for certain specialists. All other states do not require a referral however we suggest our members talk to their doctors about their specialty care. Review [here](#) to learn more about what conditions require a referral and in what states.
- An in-network PCP must be selected upon enrollment. If the member does not have an in-network PCP, Devoted Health will auto assign one for the member.

PPO

- Preferred Provider Organization (PPO), meaning there is a network, but beneficiaries can see any doctor or provider that accepts Medicare.
- Copayment and coinsurance amounts are set by plan for in and out of network cost sharing.

- Beneficiaries will have the option to go out of network and seek care; many services have the same cost sharing whether the individual seeks care with a Devoted network physician or out of network.
- 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 choose an in-network PCP, not select a PCP, or choose to see an out-of-network PCP. Regardless of the decision, a PCP will not appear on the member's ID Card for the Devoted Health PPO plans.
- [This FAQ document](#) can answer more questions about our PPO, this is for broker 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.

All PCP change requests will be processed with an effective date of the first day of the following month.

There are limited exceptions to this standard timeline. These should be treated as exceptions, not the norm, and include the following scenarios:

- The assigned PCP's panel is closed and the member should not have been assigned
- The PCP is no longer available (e.g., termed, left the practice, or deceased)
- The newly requested PCP is unreasonably far from the member
- The member is unable to obtain an appointment with the assigned PCP
- The PCP change is within the same provider group

- There were challenges selecting the PCP during the enrollment process for brand new members; during the first month these can be retro'd back to the beginning of the month

Any retro change request must be processed through member services and will be evaluated as meeting the above criteria

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

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, review [here](#) to learn more about what conditions require 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.

Virtual-only primary care

Virtual-only primary care is designed to improve access to care for patients by delivering primary care services through convenient phone and video visits. Devoted Medical is currently the only virtual-only option and aims to integrate care fully for patients. Learn more about Devoted Medical virtual PCP [here](#).

To locate virtual only PCPs, you can use the provider lookup tool. Search for primary care then elect the “online only” filter and Devoted Medical's PCPs will show up!

Devoted

Need Help? Call Us. 1-800-990-0723 TTY 711

For Providers For Brokers Español

Join a plan Find doctors & drugs My plan & benefits Member support

Member Login

Find a Provider or Pharmacy

Searching 2025 AL HMO in 35005 [edit](#)

Find

primary care

Doctors and Specialists Places Other Healthcare Services Referral Groups

Browse by:

Online Only

2 results

Clear Search

Stephanie Diane Ten Eyck, NP-C
Virtual Office AI

Family Practice
Nurse Practitioner

Devoted PCP ID: LX4J99-AA
NPI: 1487043093

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.

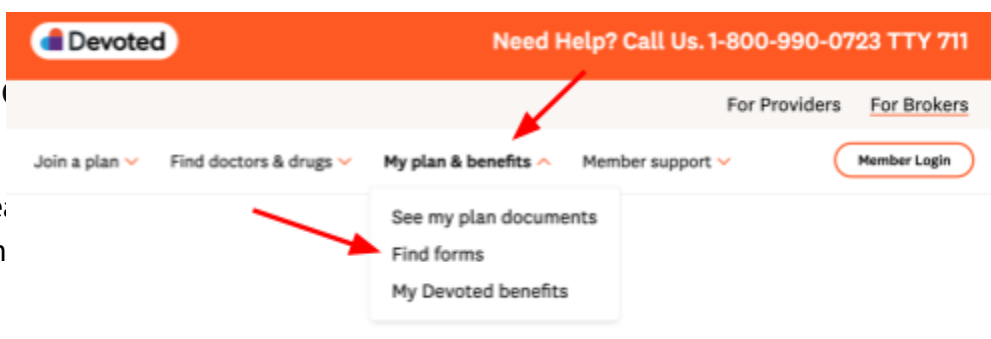
Our Summary of Benefits pages are easy to access. Go to www.devoted.com and click on “my plan & benefits” then “See my plan documents”. There are other ways to access summary of benefits and plan information - watch this [video](#) to see how easy it is!

Forms Lookup

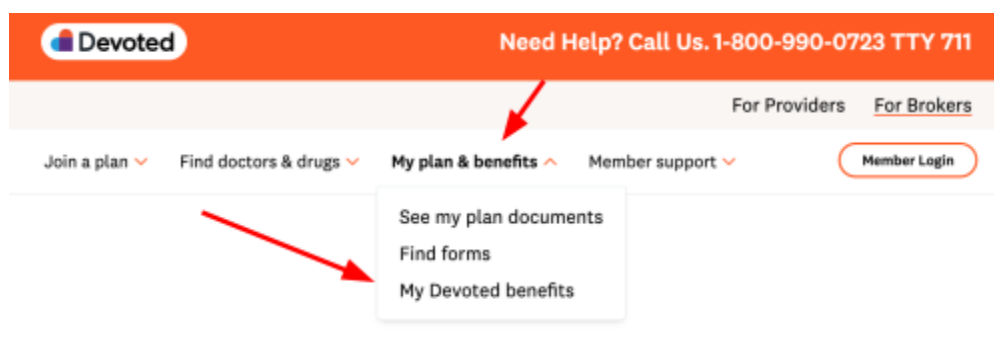
Forms for our members including reimbursement forms, consent for release of PHI, enrollment forms and others can be found under “My plan & benefits” “ and then “Find forms”.

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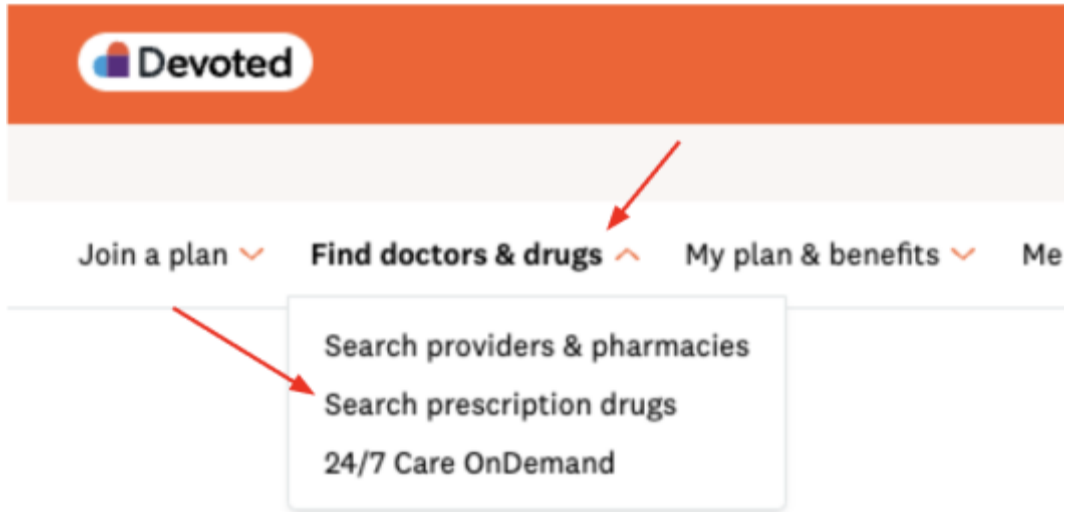


ey can use them



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”.



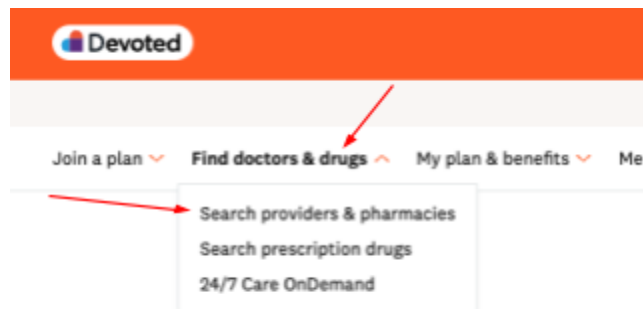
You have the ability to look up prescriptions and save a list for the prospect to reference later. [Video on how to use the prescription lookup tool.](#)

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.)



Your Devoted Agent Portal

The Agent Portal was conceptualized, strategically designed, and built with one primary goal: to provide you, our trusted partners, with a centralized suite of tools that help optimize your time and productivity! From managing your book of business to servicing clients with

confidence, the portal is designed to keep you informed, empowered, and focused. Here are just a few examples of the new and enhanced tools waiting for you in the Agent Portal:

- **Book of Business Dashboard.** Monitor your book, track new enrollment applications, and review commission details right in your portal!
- **Eligibility Tool.** This tool helps you quickly verify Medicare and Medicaid/D-SNP Eligibility. Additionally, you can also verify *applicable* LIS levels- *if applicable*.
- **Direct Connect Agent Support.** Reach out directly to our Agent Support team through the portal's messaging feature. Whether you need clarification or assistance, help is just a click away.
- **Training Materials & Resource Library** Stay informed with updated guides, reference documents, and various creatives designed to inspire/enhance senior engagement for both newer and seasoned agents, alike!

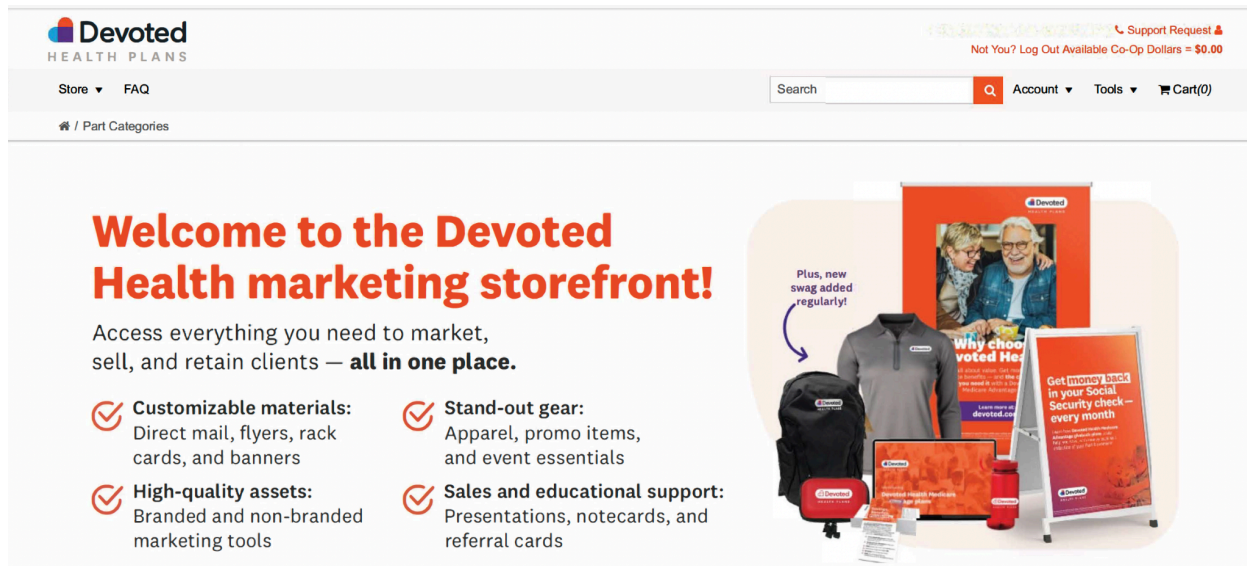
This [guide](#) will provide all the information around our Agent Portal and how to access all the tools.

Marketing Storefront

The marketing storefront offers best-in-class sales, marketing and member retention tools. Brokers have access to a large toolkit of CMS approved assets including customizable banners, direct mail, flyers, print ads, rack cards and non-branded assets. Plus, branded apparel updated seasonally, event and field tools, promos and broker swag.

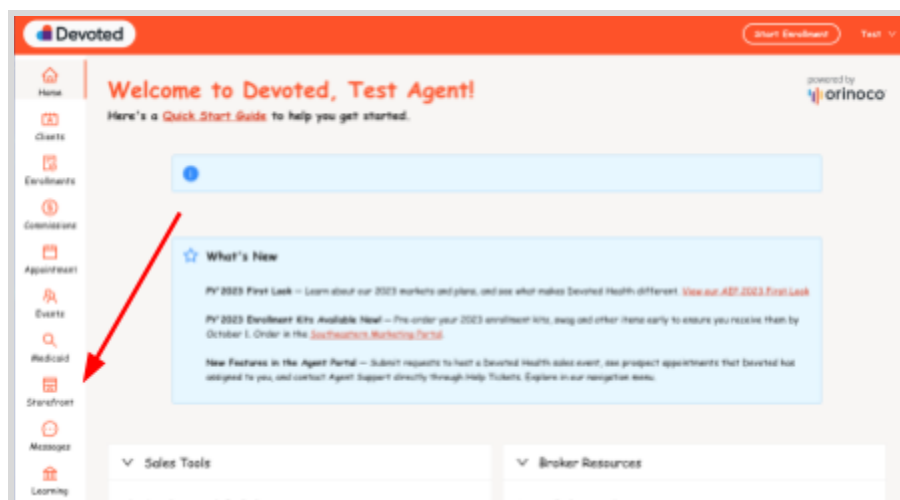
Many items in the storefront are available electronically at no cost and items in the storefront with cost can be purchased using your “Broker Bucks” earned through our [Star Seller Program](#) or by credit card.

To check your Broker Bucks balance, log in to the Marketing Storefront (see instructions below). Brokers can check their 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.



FOR BROKERS AND DEVOTED SALES AGENTS

Enter your Agent NPN and Date Of Birth to continue.

Agent NPN *

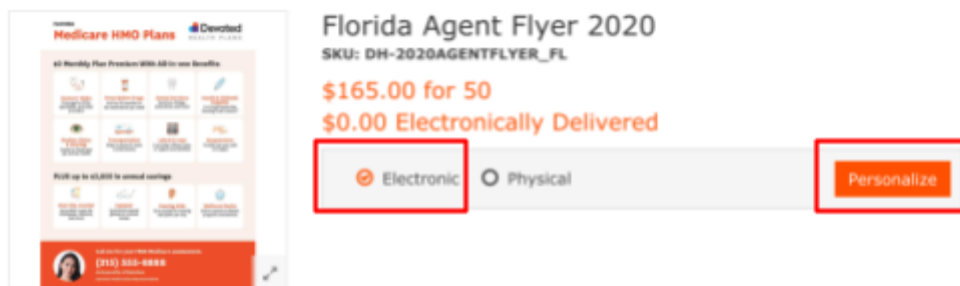
Date Of Birth *

CLICK TO CONTINUE

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 or delivered to your email. Most materials are available in both English and Spanish. Before ordering an asset, please confirm that you have selected the correct language.

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 broker bucks as explained earlier in this section. If you do not have broker bucks you can utilize a credit card at your discretion.

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.

Commissions

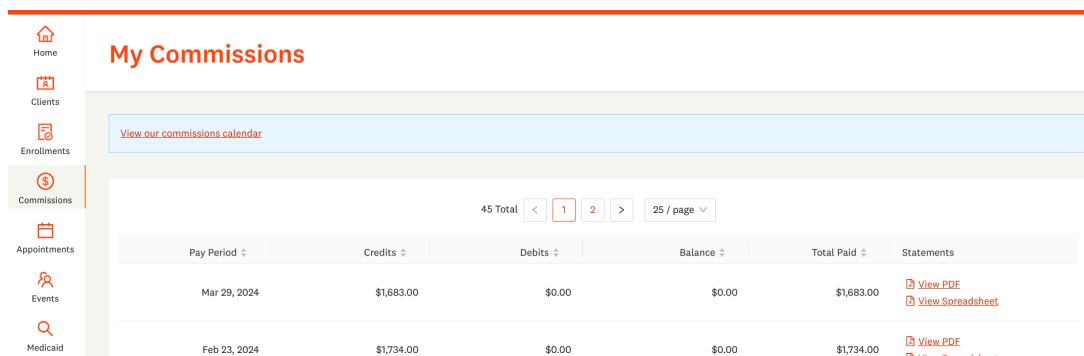
Outside of applications for the following plan year, commissions are paid upon submission date weekly on Fridays and renewals and SNP HRAs are paid at the end of the effective month. The payment date depends on the date the application is submitted.

Our [2026 payout commission calendar](#) 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.

The Sales Agent Comp table goes out to every agency at the time of contracting, and updates are sent on an annual basis (around September).

If you are a direct payee your commission statement is available to view in your [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.



My Commissions						
View our commissions calendar						
45 Total < 1 2 > 25 / page						
Pay Period	Credits	Debits	Balance	Total Paid	Statements	
Mar 29, 2024	\$1,683.00	\$0.00	\$0.00	\$1,683.00	View PDF View Spreadsheet	
Feb 23, 2024	\$1,734.00	\$0.00	\$0.00	\$1,734.00	View PDF View Spreadsheet	

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

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

FAQs

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.

Q: How is the agency of record determined regarding the payment structure?

A: The payment structure in place at the time the enrollment was initiated will determine and hold the agency of record going forward.

Q: What happens to the payment structure if an agent moves from one agency to another?

A: When an agent moves from one agency to another, compensation remains tied to the structure in place at the time the applications were submitted.

- If the agent was a **direct** payee at the time of application — Payments continue to route through the original agency, even after the agent moves.
 - Agency overrides continue to be paid to the original agency.
 - The agent continues to receive their earned compensation.
- If the agent was **indirect** under the original agency, the original payment structure remains unchanged and all payments will be made to the original agency.

Q: Does the original payment structure still apply if there are plan changes?

A: Yes. Compensation remains tied to the **initial** agency, even if the member changes plans. Plan changes do not alter the original payment structure or the agency of record.

Q: What situations can cause a break in the compensation chain?

A: Certain events can disrupt the original writing hierarchy and end compensation under the original structure:

- An agent of record change that breaks the original writing agent chain.
- A member leaving or disenrolling from the plan.

Q: Will a correction be made if an enrollment was mistakenly marked as direct instead of indirect due to an agency mistake?

A: No. Corrections are only made when the error is on our side.

Q: Who is responsible for providing the correct payment links to agents?

A: Agencies choose whether to operate with direct, indirect, or both payment options. The agency is responsible for sending agents the correct direct or indirect payee link. These options and their implications are clearly outlined during agency contracting.

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.

Enrollment Materials

Enrollment materials are available in two formats- digital enrollment kits and custom paper enrollment kits. [This guide](#) has detailed information around accessing enrollment materials.

Digital Enrollment Kits

The digital enrollment kits are the fastest and easiest way to get enrollment materials. They can be instantly accessed and downloaded in our agent portal. Kits are available in English and Spanish, and are packaged as a zip folder of PDF materials including Summary of benefits, Broker Plans at a Glance (B-PAG), Enrollment Form, Scope of Appointment form, and more.

We recommend you download digital enrollment kits for all the markets in which you are licensed to sell in. Watch this video for a quick tutorial on how to download your digital enrollment kits.

Custom Paper Enrollment Kits

Custom paper enrollment kits can be ordered in our [Marketing Storefront](#) and are directly shipped to you. These custom kits are an a-la-carte experience where agents will be able to select the specific kit components that they need. Kit components include: Summary of benefits, bundles of forms, star rating inserts, and C-SNP verification forms.

We recommend ordering from the state where you primarily conduct ‘live’ meetings to ensure you have the right paper materials for in-person sales. Watch [this video](#) for a quick tutorial on how to order your custom paper enrollment kits.

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 completing a scope of appointment with Devoted.

Here are some answers to frequently asked questions around SOAs:

What am I responsible for?

You’re responsible for complying with all CMS requirements and maintaining your own records, including SOAs.

When does the 48-hour rule apply?

You must secure a scope of appointment (SOA) at least 48 hours before the scheduled personal marketing appointment with a prospect. This includes any outbound call you’re making when responding to a business reply card (BRC).

Do I really have to wait 48 hours, or is 2 days the general rule?

Yes, you really have to wait the full 48 hours. If you collect an SOA from a prospect at 3pm on Monday, the appointment must be scheduled after 3pm on Wednesday.

What can I do during the 48 hours before meeting with the prospect?

Send them materials to review before your appointment.

When does the 48-hour rule not apply?

- During the last 4 days of a valid enrollment period

- Walk-in appointments (e.g., sales events)
- Inbound calls made by a prospect to conduct a telephonic presentation or enrollment.

How does the new SOA regulation impact educational events?

You can't collect SOAs at an educational event or hold sales events after an educational event.

Can I call a prospect in response to a BRC?

Yes, you can call a prospect to set up an appointment and complete an SOA, but the appointment must be set up at least 48 hours from completion of the SOA. DO NOT use the prospect-initiated call as a loop-hole to get around the 48-hour rule.

What if I'm speaking with a prospect (e.g., at an educational event or the grocery store) and they really want to have the appointment right away because they're traveling?

No, not unless the scenario falls into one of the exceptions provided above.

What about prospects who attend a sales event? Do I need to wait 48 hours to talk with them?

At the event, you can meet with prospects and collect SOAs and enrollment forms in person as is currently permitted at sales events. If you want to meet after the event, you will need to collect an SOA and schedule the meeting 48 hours after collecting that SOA.

Do I need to submit an SOA as part of Devoted Health's application process?

No, we don't require it, but it is a good practice to submit it with the application.

Can I fill out SOAs electronically?

We have electronic in-person and remote email/text and phone SOA options currently available.

Do you accept other plans' SOAs or general SOAs?

We accept other plans' or general SOAs as long as they represent Medicare Advantage plans (with or without prescription coverage).

How long is an SOA good for?

12 months

Important reminder about record retention Devoted does not require the SOA to be submitted with the application. Sales agents/ agencies are required to keep and maintain any records, in accordance with their contract and CMS requirements.

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 and make sure all calls are recorded.

[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.

[This document](#) will walk you through requirements for a full presentation and [here is a checklist](#) you can keep with you.

To help with part of your presentation we offer sales videos and presentations:

Agents do not need to use both, you can use the method you prefer.

- 2026 Sales Presentation: [English](#) | [Spanish](#)
- 2026 Sales Video: [English](#) | [Spanish](#)

Completing the Enrollment

Enrollment can be completed five 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:
 - i. Devoted Health — Enrollment
PO Box 211127
Eagan, MN 55121
 1. Mailing submission requirements
 - a. Enrollment form
 - b. Enrollment receipt
 - ii. Fax number: 1-877-264-3859
 1. Faxing submission requirements
 - a. Fax cover page (or document with same fields) Fax Cover Page can be found [here](#).

- b. Enrollment form (included in sales kit)

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

For instructions on how to complete the application via email or text with your prospect review the [instructions](#) here.

[FAQs](#)

Q: How long is the secured link good for?

A: The secured 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 electronic HRA is available through our agent portal for all Medicare Advantage members upon submission of an enrollment application. We ask brokers to complete the HRA with the consumer at the time of enrollment to help us shape future plan benefits and coordinate care. For any application written on or following March 1, 2026, a **\$50 HRA reward** will be paid for all new SNP (C-SNP or D-SNP) enrollments across all markets when the HRA is submitted within **5** calendar days of the application.

- The HRA is used solely to match members with services like medication management, chronic condition support (such as diabetes care), or post-hospitalization assistance. HRA responses do not impact an enrollee’s premium or application processing; however, we share this information with the member's providers to help them offer more personalized care.
- Members enrolling in one of our C-SNP or D-SNP plans will also receive a Devoted Dollars gift card for completing the HRA and remaining enrolled through January (please refer to the Summary of Benefits for details).
- If an application is submitted in the Devoted health agent portal, Sunfire or Connecture, the HRA will appear for immediate completion.

- If an application is completed by a paper application or third-party enrollment platform that does not have the HRA integrated, the HRA will be available for submission when Devoted Health processes the application in the agent portal. (This may take 1-2 days for availability.)
- Review the [2026 Commissions Calendar](#) for payment flows
 - Note: AEP commissions are paid out in January
- 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 through [agent.devoted.com](#) this can be uploaded as an attachment with the application.
 - If completing an electronic application through a third party (i.e. sunfire, connecture) we ask that the form is sent (via fax or mail, only) 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)

Once the member's application has been submitted the Continuity of Care (COC) form will need to be completed. To ensure that your member receives proper support during their transition to our plan, it is crucial to check all the boxes that apply for the member. By doing so, you'll initiate an SMS outreach to the member and ensure their smooth transition onto our plan."

Success! The application was submitted on 8/26/2024

Your confirmation code is EAX229CYF2R.

Continuity of Care

▼ This form is only to be completed for new members joining the Devoted Health plan.

This set of questions is used to determine what type of **active** care an individual is currently receiving so we can help make the transition process into the new health plan as seamless as possible. **If any of the boxes are checked or the member has questions, please reach out to one of our service guides at 1-800-338-6833** to get information on transitioning care.

Check all that apply.

☐ I use **rented medical equipment**, like a wheelchair or CPAP
I use **medical supplies**, like catheters or diabetes testing supplies
I use an **oxygen** concentrator or oxygen tanks

☐ I'm getting **home health** or home infusion services

☐ I have a **specialist visit** booked for after my new plan starts

☐ I had **surgery** recently, or I have a surgery coming up soon

☐ I'm getting treatment for a serious **health condition**, like cancer, heart attack, or stroke

☐ I'm getting **behavioral health treatment** for a condition like anxiety or depression

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 a new member joins the plan, we want their first experience with Devoted Health to feel warm, welcoming and positive. When you're completing an enrollment application, you'll see a few options that help set the stage for that:

[This document](#) outlines what our members can expect in their first few days and weeks with Devoted. It also includes a few helpful numbers you can share so members can start using their benefits as soon as they're effective.

We offer communications in a variety of delivery and format options so every member can get information in the way that works best for them.

Standard mail and accessible formats

Regular print doesn't work for everyone, so we offer materials in large print, audio CD, and braille. This ensures every member can receive the information they need in a format that fits their situation.

Paperless option

A good fit for members who prefer less mail or want instant access to their plan materials. Even when a member chooses paperless, they will still receive their ID cards, welcome kits, and any documents that require action through regular mail.

Paperless is also a good option for members who use a screen reader and want quick, easy access to their documents. Interested in paperless communications — click [here](#) to learn more!

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	Conduct door-to-door solicitation, including leaving information of any kind, except that information may be left when an

(provided every email contains an opt-out option).	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

Marketing yourself is important because it helps potential customers and others in your broader community understand who you are, what you do, and how you can help them.

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 the [event submission guide](#).

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 available

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.

Here is a [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, notify 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.
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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 and must explicitly advertise the event as educational	Distribute or use marketing/sales materials, 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 Marketing

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	Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a

the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).	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. <i>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.</i>	Permit plans to market or host events in restricted areas. <i>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).</i>
	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).

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 to your local sales manager
- Email [**compliance@devoted.com**](mailto:compliance@devoted.com)

Resources

- [Local Broker Leader Contacts](#)
- [Devoted Agent Portal](#)
- [Broker learning center](#)
- [Quick links resource](#)
- [Devoted Health Marketing Storefront](#)
- [Devoted Health Broker Site](#)
- [Summary of Benefits and EOC](#)
- [Eligibility and Enrollment Period Guide](#)
- [Provider Lookup Tool](#)
- [Prescription Lookup Tool](#)
- [How to Estimate Drug Costs](#)
- [Plan Lookup Tool](#)

Confidential. For broker use only. Not for distribution to Medicare beneficiaries. To enroll in a Devoted Health plan you must meet certain eligibility requirements and reside in the plan's CMS-approved service area.