2023 Devoted Health Medicare Advantage Plan Information

Thank you for your interest in applying for the Devoted Health Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Devoted Health within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating: HMO / PPO
Download Application
Summary of Benefits: Choice Oregon (PPO) / Core Oregon (HMO) / Choice Plus Oregon (PPO)
Pharmacy & Provider Search
Formulary

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-oregon.com/

Y0062_MULTIPLAN_CDA INSURANCE Oregon 2023 Pending

Section 1

All fields on this page and the next page are required (unless marked optional).

Devoted HEALTH PLANS

FILL IN THE PLAN YOU WANT TO JOIN

Plan name (located on the front cover of Summary of Benefits):

Plan Number (PBP/Segment): H _ _ _ _ - _ _ _ - _ _ _

County:

First name:

Last name:

M.I. (optional):

Preferred first name (optional):

Birth date: _ _ / _ _ / _ _ _ _

Sex*:

- Male
- Female

Provide your cell phone number below if you wish to receive text messages from Devoted Health (86685)**

Primary phone:

Secondary phone (optional):

Email address (optional):

Permanent residence street address (where you live - not a PO box):

City:

State:

Zip:

Mailing address, if different from your permanent address (where you live — not a PO box):

City:

State:

Zip:

YOUR MEDICARE INFORMATION

Medicare number: _ _ _ _ - _ _ _ - _ _ _ _

*Please choose the sex that Social Security has on file for you.
**By providing my cell phone number, I consent to receiving text messages regarding my plan and care from Devoted Health and its related medical practices. Msg frequency varies. Msg & data rates may apply. Reply STOP to cancel messages and HELP for help. devoted.com/terms-of-use and devoted.com/privacy-policy

LET'S CHECK IF YOU CAN JOIN A PLAN RIGHT NOW

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on ____ / ____ / ____.
- ☐ I recently was released from incarceration. I was released on ____ / ____ / ____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____ / ____ / ____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on ____ / ____ / ____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____ / ____ / ____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ____ / ____ / ____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on ____ / ____ / ____.
- ☐ I recently left a PACE program on ____ / ____ / ____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____ / ____ / ____.
- ☐ I am leaving employer or union coverage on ____ / ____ / ____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ____ / ____ / ____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ____ / ____ / ____.
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (Be sure to check the other statement that applied to you).
- ☐ I signed up for Medicare coverage between January 1 and March 31 during the General Enrollment Period (GEP). My Medicare coverage will begin July 1.
- ☐ I have a chronic condition(s) and qualify to enroll in a Special Needs Plan (SNP) that serves the condition(s). This is my first enrollment into a chronic care SNP.

If none of these statements applies to you or you're not sure, please contact Devoted Health at **1-800-385-0916** (TTY 711) to see if you are eligible to enroll. We are open 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

ANSWER THESE IMPORTANT QUESTIONS

Are you a veteran? ☐ Yes ☐ No

Will you have other prescription drug coverage (like VA, TRICARE) in addition to your Devoted Health plan? ☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, what is your Medicaid number?:

IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Devoted Health.
- By joining this Medicare Advantage Plan, I acknowledge that Devoted Health will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Devoted Health coverage begins, I must get all of my Medicare medical benefits (and prescription drug benefits, if applicable) from Devoted Health. Benefits and services provided by Devoted Health and contained in my Devoted Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Devoted Health will pay for benefits or services that my Devoted Health plan doesn't cover.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare

Signature:

Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Devoted HEALTH PLANS

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ **No, not of Hispanic, Latino/a, or Spanish origin**
- ☐ **Yes, Mexican, Mexican American, Chicano/a**
- ☐ **Yes, Puerto Rican**
- ☐ **Yes, Cuban**
- ☐ **Yes, another Hispanic, Latino/a, or Spanish origin**
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ **White**
- ☐ **Black or African American**
- ☐ **American Indian or Alaska Native**
- ☐ **Asian Indian**
- ☐ **Chinese**
- ☐ **Filipino**
- ☐ **Guamanian or Chamorro**
- ☐ **Japanese**
- ☐ **Korean**
- ☐ **Native Hawaiian**
- ☐ **Other Asian**
- ☐ **Other Pacific Islander**
- ☐ **Samoan**
- ☐ **Vietnamese**
- ☐ **Some other race**
- ☐ **I choose not to answer**

If you need materials from us in a language other than English, select your language:

- ☐ **Spanish**

Do you need one of the following accessibility accommodations? (choose only one)

- ☐ **None**
- ☐ **Braille**
- ☐ **Audio tape**
- ☐ **Large print**

Please contact Devoted Health at **1-800-385-0916** (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8am to 8pm, Monday to Friday (from October 1 to March 31, 8am to 8pm, 7 days a week).

Do you work? ☐ **Yes** ☐ **No** **If you're married, does your spouse work?** ☐ **Yes** ☐ **No**

Primary Care Provider (PCP): This is the main doctor you see for your care. Please tell us who you want to be your PCP. If you leave this section blank or list an out-of-network provider, we'll choose a PCP for you.

Full name:

Address:

PCP ID number:

Are you currently a patient?

☐ **Yes** ☐ **No**

PAYING YOUR PLAN PREMIUMS

If your plan has a monthly premium (including any late enrollment penalty you may owe), you can pay it by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Devoted Health the Part D-IRMAA.

How would you like to pay? Only choose one. If you don't select an option below, we'll send a monthly bill.

- [ ] **Send me a monthly bill**
- [ ] **Take it out of my monthly Social Security check***
- [ ] **Take it out of my monthly Railroad Retirement Board (RRB) check***

*It may take at least 2 months for your premium to start coming out of your check.

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

TO BE COMPLETED BY A LICENSED SALES REPRESENTATIVE / AGENT ONLY

☐ New member ☐ Plan change

Licensed sales agent full name: Tiffany Jackson	**Initial receipt date:**
Licensed sales agent NPN: 14254716	**Proposed effective date:**
Licensed sales agent phone: 541-434-9613	

Method of contact:

☐ Agent generated ☐ Marketing campaign ☐ Business or community partner
☐ Sales seminar ☐ Family or friend referral ☐ Search engine
☐ Community event ☐ Provider office ☐ Other

Select enrollment period:

☐ AEP ☐ SEP (losing coverage) ☐ SEP (moved coverage area)
☐ MA OEP ☐ SEP (Dual eligible) ☐ SEP (non-renewal)
☐ ICEP (MA enrollees) ☐ SEP (LIS) ☐ SEP (other)
☐ IEP (MA-PD enrollees) ☐ OEPI

SEP reason:	**SEP eligibility date:**

Licensed sales rep signature (required)**:**

Please send your completed form to:

Mail
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

Fax
1-833-434-0535

Devoted Health is an HMO and PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

2019
Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please place a check mark in the box next to the type of product(s) you want the agent to discuss. (See helpful descriptions on the next page.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
  Medicare Health Maintenance Organization (HMO), Medicare Preferred Provider Organization (PPO) Plan, Medicare Private Fee-For-Service (PFFS) Plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) Plan, or Medicare Cost Plan
- ☐ **Other Health-Related Plans**
  Dental/Vision/Hearing Products, Supplemental Health Products, Medicare Supplement (Medigap) Products

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ Date: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: Tiffany Jackson	Agent Phone: 541-434-9613
Agent Address: 2160 W 11th Ave Ste D, Eugene OR 97402	
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date of Appointment:	
Provide explanation why SOA was not documented prior to meeting (if applicable):	

ATENCIÓN: Si usted habla español u otros idiomas, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-866-235-5660 (TTY: 711)

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

AGENT: FAX THIS SIDE