PeakAdvantage MEDICARE PLANS

Medicare Prescription Payment Plan Participation Request Form

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan by spreading them across the calendar year (January-December). **This payment option might help you manage your expenses, but it does not save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

NAME First	**Last**	**MI** (Optional)
Medicare Number		

Birth Date (MM/DD/YYYY)		**Phone Number**	

Permanent Residence Street Address (PO Box not allowed, unless experiencing homelessness)	**County** (Optional)

Apt #	**City**	**State**	**ZIP**

Mailing Address, if different from your permanent address (PO Box allowed)			
Apt #	**City**	**State**	**ZIP**

Plan Year Selection

I want to participate in the Medicare Prescription Payment Plan for the:

☐ Current Plan Year ☐ Upcoming Plan Year

Important Note: If “Current Plan Year” is selected then your participation will begin immediately and will automatically renew for the upcoming plan year If you stay in the same health or drug plan.

Read and Sign Below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Peak Health will contact me if they need more information.
- I understand that signing this form means that I have read and understand the form and the attached terms and conditions.
- **Peak Health will let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I am not a participant in the Medicare Prescription Payment Plan.
- I understand that if I stay in the same health or drug plan, Peak Health will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Peak Health to opt out.

Signature	**Date**

If you are completing this form for someone else, complete the section below. Your signature certifies that you are authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

NAME First	**Last**	**MI**

Address			
Apt #	**City**	**State**	**ZIP**

Phone Number		**Relationship to Participant**	

How to Submit This Form

Submit your completed form to:

Peak Health
Mailstop: 1002
MPPP Election Dept.
13900 N. Harvey Ave
Edmond, OK 73013

Fax: 440-557-6525
Email: ElectMPPP@RxPayments.com

You can also complete the participation request form online at Activate.RxPayments.com, or call us at 833-554-4466 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-554-4466, 8AM to 11PM EST 7 days a week from Dec 8 - Mar 31, 8AM to 11PM EST Mon – Fri from Apr 1 – Sept 30, 8AM to 1AM EST 7 days a week from Oct 1 - Dec 7. TTY users can call 711.

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Terms and Conditions for Participation in the Medicare Prescription Payment Plan

The Terms and Conditions listed below outline your rights, responsibilities, and the rules governing participation in the Medicare Prescription Payment Plan program. By agreeing to these Terms and Conditions-either online, over the phone or by signing and returning the election form-you confirm that you understand and accept the provisions of the program.

1. **No Fees or Interest**
   The Medicare Prescription Payment Plan does not charge any fees or interest, and no credit check is required to enroll in the Program.

2. **Notification to Pharmacy**
   Upon acceptance into the Medicare Prescription Payment Plan, we will inform your pharmacy that you are using this payment option.

3. **Applicability**
   This payment option applies only to Medicare Part D covered drugs processed after your election is confirmed.

4. **Cost Sharing**
   When you fill a prescription for an eligible Part D drug, you will pay zero dollars at the pharmacy. However, you will still be responsible to pay your cost share of the drug associated with your Medicare Part D benefit under your plan that can be paid through a monthly invoice.

5. **Monthly Invoices**
   Each month, you will receive an invoice detailing the out-of-pocket amount you owe, the due date, and information on how to make a payment. Monthly payments are required while you carry a balance, but you can pay the balance in full at any time.

6. **Calculation of Monthly Payments**
   The formula for calculating the minimum monthly payment (referred to as the “maximum monthly cap”) differs for the first month of participation versus the remaining months of the year. The maximum monthly cap calculations include specifics of a participant’s Part D drug costs (previously incurred costs and new out-of-pocket costs), as well as the number of months remaining in the plan year and the amount outstanding. As such, the amount can vary from person to person and month to month, and the total outstanding balance will be completely paid off by February 1st of the next calendar year.

7. **Missed Payments**
   If you miss a payment, you will receive a *Notice of Failure to Pay*. If you do not pay the outstanding amount due by the date listed in the reminder notice, you will be removed from the Medicare Prescription Payment Plan. However, you will still be required to pay the amount you owe and may not be able to re-enroll in the Medicare Prescription Payment Plan.

8. **Opting Out**
   You can leave the Medicare Prescription Payment Plan at any time by selecting the opt-out option through the website or by calling the phone number provided to you in the *Notice of Election Approval* letter, which will be sent to you by your plan after successful election into the program. After you opt out, you will continue to receive an invoice each month for the amount you owe until your balance is paid in full.

9. **Communications and Notifications**
   If you provide an email, participation in this Program will automatically make you eligible for important emails containing information related to the Medicare Prescription Payment Plan.

10. **Disenrollment and New Plan Enrollment**
    If you are disenrolled from your plan for any reason and/or enroll in a new plan with drug coverage, your participation in the Medicare Prescription Payment Plan through your current plan will end. However, you will continue to receive an invoice each month for any outstanding amounts until your balance is paid in full. You remain responsible for the amount due under this Medicare Prescription Payment Plan. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.

11. **Address Updates**
    Any contact information or communication preferences you provide during election or directly through your Medicare Prescription Payment Plan online portal will only be used for your Medicare Prescription Payment Plan, and may not be communicated to your Medicare Part D plan. If you also need to make an address update for your Part D coverage then you will need to provide those directly to your Plan.

12. **Communications**
    By providing us with your contact information, you consent to our contacting you by any means you have provided regarding important information about your Medicare Prescription Payment Plan account. This consent allows us to use text messaging for informational and account service calls, but not for telemarketing or sales calls. This may also include contact from companies working on our behalf to service your account.

13. **Automatic Participation Renewal**
    Your participation in the Medicare Prescription Payment Plan will automatically renew for the following calendar year, unless you are enrolling in a new Medicare Part D plan or have opted out of the program prior to the beginning of the calendar year.

Discrimination is Against the Law

Peak Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Peak Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Peak Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Service Phone Number on the front of you Member ID.

If you believe that Peak Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Peak Health
ATTN: Appeals and Grievances Department
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

1.855.962.7325
TTY Users Call: 711
Fax: (304) 974-3191

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Service Phone Number on the front of you Member ID.

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

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

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

PeakHealth

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-962-7325 or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-962-7325 o hable con su proveedor.

Chinese: 注意：如果您使用[插入语言]，我们提供免费的语言协助服务。此外，我们还免费提供相应的辅助工具和服务，以无障碍格式提供信息。请致电 1-855-962-7325 或联系您的服务提供商。

Arabic: تنبيه: عربية كما تتوفر وسائل مساعدة وخدما إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. أو تحدث إلى مقدم الخدمة".1-855-962-7325 اتصل على الرقم مناسبةلتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-962-7325 hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-962-7325 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Japanese: **注：**日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-962-7325 までお電話ください。または、ご利用の事業者にご相談ください

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-962-7325 o makipag-usap sa iyong provider.

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-855-962-7325 หรือปรึกษาผู้ให้บริการของคุณ

Nepali: सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-962-7325 मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-962-7325 или обратитесь к своему поставщику услуг.

Italian: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'11-855-962-7325 o parla con il tuo fornitore

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-962-7325 પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો

Polish: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-962-7325 lub porozmawiaj ze swoim dostawcą

French: ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-962-7325 ou parlez à votre fournisseur.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen 1-855-962-7325 an oder sprechen Sie mit Ihrem Provider.