

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
PO Box 5098
Edmond, OK 73083

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. Digital 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>.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-962-7325 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-962-7325 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-962-7325 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-962-7325 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-962-7325 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-962-7325 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-962-7325 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-962-7325 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-962-7325 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-962-7325 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.

للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY 711) 1-855-962-7325 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी परश्च के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया पराप्त करने के लिए, बस हमें 1-855-962-7325 (TTY 711) पर फोन करें कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-962-7325 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-962-7325 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-962-7325 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-962-7325 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-962-7325 (TTY 711)にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。