CarePlus HEALTH PLANS®

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is an **optional** payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs 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.

Complete all fields unless marked optional

First name: _____ Last name: _____ Middle initial (optional):_____

Medicare Number: _____ -_____-_____ | CarePlus ID: _____

Birth date: (MM/DD/YYYY)
(_____ /_____ / _____)

Phone number:
(_____) _____

Permanent residence street address
(do not enter a P.O. Box unless you are experiencing homelessness)

_____

City: _____ | County (optional): _____ | State: _____ | ZIP code: _____

Mailing address, if different from your permanent address (P.O. Box allowed):

Address: _____

City: _____ State: _____ ZIP code: _____

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. CarePlus will contact me if they need more information.
- I understand that signing this form means that I have read and agree to the form and the attached Terms and Conditions.
- **CarePlus will send me a notice to 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.

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:	Address (Street, City, State, ZIP code):
_____	_____
_____	_____
Phone number: (_____) _____	Relationship to participant: _____

How to submit this form

You can complete the participation request form online by visiting **CarePlusHealthPlans.com/MPPP** or scan this QR code to opt into the program.

To submit your request via telephone, call CarePlus Member Services at **1-800-794-5907 (TTY: 711).**

For questions or help completing this form, from October 1 - March 31, we are open 7 days a week, 8 a.m. - 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

To submit this form by mail, send to:

Medicare Prescription Payment Plan
PO Box 14540
Lexington, KY 40512-4540

Medicare Prescription Payment Plan Terms and Conditions

These terms and conditions ("Terms") govern the CarePlus Medicare Prescription Payment Plan (“the Program”), including, as available, participation in the Program. By participating in the Program, you agree to be bound by these Terms. CarePlus may change these Terms based on guidelines from The Center for Medicare and Medicaid Services (“CMS”) and reserves the right to change these Terms, but will notify you of any changes, as required.

Participation

Participation in the Program is voluntary and may only extend to the end of each plan year. You will need to be an active CarePlus member with a Part D prescription drug benefit plan. You will also need to have paid any past due balances on any participation in the Program from a previous year to CarePlus if your participation in the Program was previously terminated due to past due and unpaid balances.

If you are eligible to participate in the Program, you can opt-in and opt-out at any time within the plan year.

Billing

By participating in the Program, you agree to pay all covered Part D prescription drug costs incurred up to the maximum out of pocket amount of $2000 (could be less depending on your plan), as permitted by law, spread over the remaining months of the plan year. You will only be billed once a month for Part D drug prescriptions obtained during the prior month, spread over the remaining months of the year. You understand that your payments may increase every billing cycle with each additional Part D drug that you obtain. At all times while you participate in the Program, you will no longer pay at point-of-sale at the pharmacy (including mail order and specialty pharmacies), but will be billed for the covered part D prescriptions you obtained at the pharmacy by your plan, CarePlus. If you obtained Part D drugs from the pharmacy in December, your last bill for the plan year will be received in January of the following plan year.

You will have the option to pay through a secure web portal, by phone or through the mail. Information on how to pay your balance will be provided on your monthly invoice.

Termination

Participation in the Program is not guaranteed. CarePlus will notify you if you miss a payment and will provide any past due balances on the next statement. Failure to pay the minimum balance due each month will result in a two-month grace period before you are terminated from the Program. If the minimum balance due and any past due payments are not paid within the two-month grace period, you will be terminated from the Program. Moving forward, you will pay for any additional prescriptions at point-of-sale at the pharmacy. CarePlus will notify you when your participation has been terminated and CarePlus will continue to bill you for any past due balances owed while you participated in the Program. CarePlus reserves all legal rights to collect unpaid balances from you. You may re-enter the Program with CarePlus once you pay any past due balances.

You will be removed from the Program if you switch Part D prescription drug plans during a current plan year, including if you switch plans within CarePlus. You will need to opt-in again to participate in the Program under your new Part D plan. If you switch Part D prescription

Termination (cont.)

drug plans, you will owe any outstanding balances to CarePlus owed during your participation in the Program and will need to opt-in with your new prescription drug plan if you want to continue participating in the Program. Balances are not carried over to new prescription drug plans.

If you continue to pay your required premiums, you will not be removed from your CarePlus insurance plan if you are terminated from the Program.

Communications

By participating in the Program, you agree to receive telephonic and mail communications regarding your participation status, billing statements and overdue notifications.

Disputes

If you disagree with our decisions, you have the right to ask CarePlus to review our decision. You must submit your dispute within 60 calendar days after the incident or event that caused the grievance.

Grievance and Appeals Department
P.O. Box 277810
Miramar, FL 33027
Fax number: 1-800-956-4288
Phone number: 1-800-794-5907 (TTY: 711)

Release of information:

By joining this Medicare Prescription Payment Plan (the Program), you acknowledge that CarePlus and vendors on its behalf may share your information with Medicare, who may use it to track your participation, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (See Privacy Act Statement below).

Privacy Act Statement:

The Centers for Medicare and Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange participation 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 on this form is voluntary and will not affect enrollment in your CarePlus Prescription Drug Plan. CarePlus works with a third-party supplier (“Supplier”) to help provide the Program, including to provide a website to view your account, schedule payments, make payments, and review payment history. Supplier owns the website, and grants you a non-transferable, non-exclusive, revocable, limited license to use the website. SUPPLIER PROVIDES THE WEBSITE ON AN “AS-IS” AND “AS AVAILABLE” BASIS AND EXPRESSLY DISCLAIMS ALL WARRANTIES OF ANY KIND, WHETHER EXPRESS, IMPLIED, OR STATUTORY. If you suspect that your account or password has been compromised, please promptly notify CarePlus.