GOLD KIDNEY HEALTH PLAN

Medicare Prescription Payment Plan
participation request form

The Medicare Prescription Payment Plan is a voluntary 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 may help you manage your expenses, but it doesn't 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

FIRST name:	LAST name:	MIDDLE initial (optional):
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _		
Birth date: (MM/DD/YYYY) (_____/_____/_____)	Phone number: ( )	
Permanent residence street address (don't enter a P.O. Box unless you're 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. Gold Kidney Health Plan will contact me if they need more information.**
- **I understand that signing this form means that I've read and understand the form [and the attached terms and conditions (insert if the terms and conditions are included with this form)].**
- **Gold Kidney Health Plan 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'm not a participant in the Medicare Prescription Payment Plan.**

Signature:	**Date:**

If you're completing this form for someone else, complete the section below. Your signature certifies that you're 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

Submit your completed form to:

Gold Kidney Health Plan
P.O. Box 285
Portsmouth, NH 03802

You can also call us at (888) 672-7206 to submit your request via telephone.

If you have questions or need help completing this form, call us at (888) 672-7206, 24 hours a day, 365 days a year. TTY users can call 711.

Medicare Prescription Payment Plan
Election Request Form Terms and Conditions

1. **Voluntary Participation.** Election in the Medicare Prescription Payment Plan (the "Program") is voluntary and not required to obtain prescription drugs under Medicare Part D.

2. **Medicare Part D Drugs Only**. The Program is only applicable for covered Medicare Part D drugs. The Program does not apply for drugs covered through Medicare Part A or Medicare Part B, medical benefits and/or services, or any other supplemental benefit.

3. **No Cost to Join.** The Program is completely free to join. Participants can opt-in without any upfront fees.

4. **Same Total Costs.** Election in the Program does not reduce the total cost of prescription drugs, nor does it reduce the amount of money that an individual pays in total out-of-pocket costs. Participants do not receive any discount for participating in the Program.

5. **No Interest or Additional Fees.** The Program does not include any interest or additional fees for spreading out payments.

6. **Notice of Acceptance of the Election Form.** To commence participation in the Program, the participant must receive an official "Notice to Acknowledge Acceptance of Election into the Medicare Prescription Payment Plan" via mail or electronically, depending on the participant's preferred and authorized communication method.

7. **Term of the Participation in the Program.** If the Election Form is accepted, the participant's election shall be in full force and effect for the Plan Year or remaining part of the Plan Year for which the election has been made, unless the election be previously voluntary or involuntary terminated as set forth herein.

8. **Debt Obligation.** Participation in the Program does not exempt the participant from their financial obligation. Any unpaid monthly payment remains a debt owed by the participant.

9. **Billing.** A participant opted into the Program will not pay out-of-pocket costs at the pharmacy (including mail-order and specialty pharmacies). The participant will get a bill each month from the health plan or the health plan's authorized vendor. The monthly bill is based on what the participant would have paid for any prescriptions they get, plus the previous month's balance, divided by the number of months left in the Plan Year.

10. **Monthly Payments are not fixed.** The monthly payments for a participant might change every month because new out-of-pocket drug costs get added into the monthly payment when filling a new prescription or refilling an existing prescription.

11. **Responsibility for Payments.** Participants are solely responsible for ensuring that all payments are made on time. Failure to make payments by the due date may result in termination from the Program.

12. **Grace Period.** A grace period of two months will be provided for late payments. The grace period begins on the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later.

13. **Involuntary Termination.** If payments are not made by the end of the grace period, termination from the Program will occur as of the first day of the month following the end of the grace period.

14. **Opting Out/Voluntary Termination.** Participants may opt out of the Program at any time during the Plan Year. Upon opting out, the participant will pay any new out-of-pocket costs directly to the pharmacy. The Participant will also be responsible for paying any remaining balance either by one lump sum or finishing its monthly payments.

15. **Modifications.** Participants will be notified of any changes to the payment plan terms and conditions, including any changes to payment amounts, due dates, or other relevant information. Such notifications will be provided in a timely manner.

16. **Privacy and Data Security.** All personal and payment information provided by participants will be kept confidential and used solely for the purposes of administering the Program. The privacy and security of participants' information will be treated in accordance with applicable laws and regulations.

17. **Dispute Resolution.** Any disputes arising from the Program will be resolved in accordance with the health plan's established Medicare Part D appeals and grievance procedures.

18. **Contact information.** For questions or assistance with the Program, participants should contact Member Services at (888) 672-7206. People with hearing impairments may call (TTY) 711. Operating Hours are: 24 hours a day, 365 days a year.

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Notice of Non-Discrimination

Gold Kidney Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Gold Kidney Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

GOLD KIDNEY HEALTH PLAN

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 Customer Service at 1 (844) 294-6535 (TTY 711)
If you believe that Gold Kidney Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Gold Kidney Health Plan — Appeals & Grievances
P.O. Box 285, Portsmouth, NH, 03802
1 (844) 294-6535 (TTY 711)

Fax: 1 (866) 515-7869
Attention: Gold Kidney Appeals & Grievances Department

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, call 1 (844) 294-6535 (TTY 711).

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, 1 (800) 537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/index.html

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Form Approved
OMB# 0938-1421

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 (844) 294-6535**. Someone who speaks English 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 (844) 294-6535**. 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 (844) 294-6535**。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 (844) 294-6535**。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 (844) 294-6535**. 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'assurancemédicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1 (844) 294-6535**. 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 quí vị cần thông dịch viên xin gọi **1 (844) 294-6535** sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 (844) 294-6535**. 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 (844) 294-6535** 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 (844) 294-6535**. 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 **1 (844) 294-6535**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1 (844) 294-6535** 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 (844) 294-6535**. 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 (844) 294-6535**. 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 (844) 294-6535**. 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 (844) 294-6535**. 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ございます。通訳をご用命になるには、**1 (844) 294-6535** 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。