DOCTORS HEALTHCARE PLANS, INC.

Medicare Prescription Payment Plan Participation Request Form

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. 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

DOCTORS HEALTHCARE PLANS, INC.

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Doctors HealthCare Plans, Inc. 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 terms and conditions.
- **Doctors HealthCare Plans, Inc. 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

You may submit this Participation Request Form to Doctors HealthCare Plans, Inc. through the mail, by calling us directly at the contact information listed below or via our website:

Submit your completed form via mail to: Doctors HealthCare Plans, Inc., 2020 Ponce de Leon Blvd., PH1, Coral Gables, FL 33134;

You may also submit a Participation Request form via telephone by calling us directly at: Doctors HealthCare Plans, Inc., Member Services, (786) 460-3427 or (833) 342-7463. Calls to this number are free. Hours of operation: 7 days a week, 8:00 a.m. – 8:00 p.m.

Or, you may complete the Participation Request Form online at www.doctorshcp.com.

If you have questions or need help completing this form, call us at (786) 460-3427 or (833) 342-7463. Calls to this number are free. Hours of operation: 7 days a week, 8:00 a.m. – 8:00 p.m. Member Services also has free language interpreter services available for non-English speakers. TTY users can call 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week, 8:00 a.m. – 8:00 p.m.

DOCTORS HEALTHCARE PLANS, INC.

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 (786) 460-3427 or (833) 342-7463. Calls to this number are free. People with hearing impairments may call (TTY) 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Operating Hours are: 7 days a week, 8:00 a.m. – 8:00 p.m.

19. As a participant of this voluntary payment option, participants will receive a monthly invoice for the amount owed for prescriptions filled.

20. Payment will be due by the date indicated on the monthly invoice.

21. Participants will be removed from the Medicare Prescription Payment Plan (involuntarily termed) if the payment for past due amounts is not received by the end of the grace period. When the participation ends, the member will be responsible for paying the pharmacy directly for all new out-of-pocket drug costs.

22. Participants can leave the Medicare Prescription Payment Plan at any time (voluntarily term). If the member still owes a balance, they are required to pay the amount owed, even though they are no longer participating in this payment option.

23. Regardless of how the participations ends, the member will continue to receive monthly invoices for prescriptions filled during their participation in the payment option until all amount owed is paid.

24. If a participant is removed from the Medicare Prescription Payment Plan, they will NOT be able to use this payment option in the future until the amount owed has been paid.

Notice of Non-Discrimination

Doctors HealthCare Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people on the basis of race, color, creed, religion, national origin, age, disability, political affiliations or beliefs, or sex (including pregnancy, sexual orientation, and gender identity).

Doctors HealthCare Plans:

- 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 Services/Civil Rights.

If you believe that Doctors HealthCare Plans has failed to provide these services or discriminated in another way, you can file a grievance with:

Doctors HealthCare Plans, Inc.
Attn: Member Services/Civil Rights
2020 Ponce De Leon Blvd, PHI
Coral Gables, FL 33134
Telephone: 833-342-7463 (TTY: 711)
Fax: 786-578-0293,
Email: civilrights@doctorshcp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services/Civil Rights, is available to help you.

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 https://www.hhs.gov/ocr/complaints/index.html.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS AND SERVICES

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids y services to provide information in accessible formats are also available free of charge. Call 833-342-7463 (TTY:711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, están disponibles servicios de asistencia lingüística gratuita para usted. También están disponibles sin carga adecuada apoyos y servicios para proporcionar información en formatos accesibles. Llame al 833-342-7463 (TTY:711) o hable con su proveedor.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 833-342-7463 (TTY:711) oswa pale avèk founisè w la.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم - (TTY: 711) (1-833-342-7463) أو تحدث إلى مقدم الخدمة".

Chinese Traditional: 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 833-342-7463 (TTY:711) 或與您的提供者討論。]

Chinese Simplified: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 833-342-7463（文本电话：(TTY:711) 或咨询您的服务提供商。

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 833-342-7463 (TTY: 711) ou parlez à votre fournisseur.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachhilfe-Dienste zur Verfügung. Angemessene Hilfsmittel und Dienste zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 833-342-7463 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.

Gujarati: ધ્ યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ ધ છે. માહહતીને સુલભ સ્ વ૦ીમાાં આપવાની યોગ્ ય સહાયક સાધનો અને સેવાઓ પણ હહન શુલ્ ક ઉપલબ્ ધ છે. 833-342-7463 (TTY:711) પર કોલ કરો અથવા તમારા પરદાતા સાથે વાત કરો.

Italian: ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti per te. Sono disponibili anche ausili e servizi appropriati per fornire informazioni in formati accessibili, anch'essi gratuiti. Chiama il 833-342-7463 (TTY:711) o parla con il tuo fornitore.

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. 833-342-7463 (TTY:711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

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 833-342-7463 (TTY:711) lub porozmawiaj ze swoim dostawcą".

Portuguese: ATENÇÃO: Se você fala Português, serviços de assistência linguística gratuitos estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 833-342-7463 (TTY:711) ou converse com seu prestador de serviços.

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 833-342-7463 (TTY:711) или обратитесь к своему поставщику услуг.

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 833-342-7463 (TTY:711) o makipag-usap sa iyong provider."

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-833-342-7463 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

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 Người khuyết tật: 833-342-7463 (TTY:711) hoặc trao đổi với người cung cấp dịch vụ của bạn."