



Blue Shield of California

An independent member of the Blue Shield Association

## 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 might 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

<b>FIRST name:</b>	<b>LAST name:</b>	<b>MIDDLE Initial (optional):</b>
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<b>Medicare Number:</b>	_____ - _____ - _____
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<b>Birth Date:</b> (MM/DD/YYYY)	____/____/____	<b>Phone Number:</b>	(____) _____
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**Permanent Residence street address**  
(don't enter a P.O. Box unless you're experiencing homelessness):

<b>City:</b>	<b>County (optional):</b>	<b>State:</b>	<b>ZIP code:</b>
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**Mailing address, if different from your permanent address (P.O. Box allowed):**

<b>Address</b>	<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>
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### Read and Sign Below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Blue Shield of California 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
- Blue Shield of California 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.

<b>Signature:</b>	<b>Date:</b>
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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.

<b>FIRST name:</b>	<b>LAST name:</b>	<b>MIDDLE Initial (optional):</b>
<b>Address (street, city, state, ZIP code):</b>		
<b>Phone Number:</b> (      )	<b>Relationship To Participant:</b>	

#### How to Submit This Form:

Submit your completed form to:

Blue Shield of California  
Mailstop: 1003  
MPPP Election Dept.  
13900 N. Harvey Ave  
Edmond, OK 73013

Fax: 440-557-6525

Email: [ElectMPPP@RxPayments.com](mailto:ElectMPPP@RxPayments.com)

You can also complete the participation request form online by logging in to your Blue Shield of California or submit your request via telephone (833) 696-2087 (TTY: 711).

If you have questions or need help completing this form, call us at (833) 696-2097, 8am-8pm, 7 days a week. TTY users can call 711.

## **Terms and Conditions for Participation in the Medicare Prescription Payment Program**

### **1. No Fees or Interest**

The Medicare Prescription Payment Program (M3P) does not charge any fees or interest, and no credit check is required to enroll in the program.

### **2. Plan Participation Confirmation**

Once Blue Shield of California reviews your Medicare Prescription Payment Program request form, we will send you a letter confirming your participation in the Medicare Prescription Payment Plan.

### **3. Notification to Pharmacy**

Upon acceptance into the Medicare Prescription Payment Program, we will inform your pharmacy that you are using this payment option.

### **4. Applicability**

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

### **5. Cost Sharing**

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

### **6. Monthly Invoices**

Each month, you will receive an invoice detailing the 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.

### **7. 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, with the expectation that the total balance will be completely paid off by January 31st of the next calendar year.

### **8. Missed Payments and Plan Termination**

If you miss a payment, you will receive a reminder notice to make your payment within 15 calendar days of the payment due date. You will be considered to have failed to pay your monthly billed amount after the conclusion of a two-month grace period. If you do not pay your bill by the end of the two-month grace period, you will be removed from the Medicare Prescription Payment Program. 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 Program. If you are removed from the Medicare Prescription Payment Plan, **you’ll still be enrolled in your Medicare health or drug plan.**

Blue Shield of California will reinstate a participant who has been terminated from the Medicare Prescription Payment Plan if the individual demonstrates good cause for failure to pay the program billed amount within the two-month grace period and pays all overdue amounts billed.

## 9. Opting Out

You can leave the Medicare Prescription Payment Plan at any time by contacting Blue Shield of California at 833-696-2087 (TTY – 711). **Leaving will not affect your Medicare drug coverage and other Medicare benefits.**

Keep in mind:

- If you still owe a balance, you are required to pay the amount you owe, even though you're no longer participating in this payment option. You will continue to receive an invoice each month for any outstanding amount until your balance is paid in full.
- You can choose to pay your balance all at once or be billed monthly.

You will pay the pharmacy directly for new out-of-pocket drug costs after you leave the Medicare Prescription Payment Plan.

## 10. Disenrollment and New Medicare Drug Plan Enrollment

If you leave or are disenrolled from your current Blue Shield of California plan for any reason, or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage), and you still owe any balances, you are required to pay the amount you owe, even though you're no longer participating in this payment option. You will continue to receive an invoice each month for any outstanding amount until your balance is paid in full. Upon disenrollment, you remain responsible for the amount due under the existing Medicare Prescription Payment Plan.

Contact your new plan if you'd like to participate in the Medicare Prescription Payment Plan through your new plan.

## 11. Address Updates

SimplicityRx administers this program on behalf of Blue Shield of California. Any contact information or communication preferences you provide during election or directly through your Medicare Prescription Payment Plan Payment Portal will only be used for your Medicare Prescription Payment Plan Program, and may not be communicated back to Blue Shield of California for use on other Blue Shield of California communications.

## 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 Program 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.



## NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California provides:

- Aids and services at no cost 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)
- 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 Blue Shield of California Customer Service using the number on the back of your member ID card.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator  
P.O. Box 5588, El Dorado Hills, CA 95762-0011  
Phone: (844) 831-4133 (TTY: 711)  
ax: (844) 696-6070  
Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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  
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

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

**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 1-800-776-4466. 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 1-800-776-4466. 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 1-800-776-4466。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 1-800-776-4466。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 panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-776-4466. 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 1-800-776-4466. 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 1-800-776-4466 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 1-800-776-4466. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-776-4466 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 1-800-776-4466. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي اسئلة تتعلق بالصحة أو جدول الادوية لدينا. للحصول

ليس عليك سوى الاتصال بنا على 1-800-776-4466. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية على مترجم فوري،

**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 1-800-776-4466 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian** E disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-776-4466. 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 1-800-776-4466. 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 1-800-776-4466. 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 1-800-776-4466. 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、1-800-776-4466 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。

**Hmong** Peb muaj cov kev pab cuam txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog ntawm peb li kev noj qab haus huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais tus kws pab cuam txhais lus, tsuas yog hu rau peb ntawm 1-800-776-4466. Muaj cov paub lus Hmoob tuaj yeem pab tau koj. Qhov no yog pab dawb.

**Ukrainian** Ми надаємо безкоштовні послуги перекладача, щоб відповісти на будь-які запитання щодо нашого плану лікування чи надання лікарських засобів. Щоб скористатися послугами перекладача, просто зателефонуйте нам за номером 1-800-776-4466. Вам може допомогти хтось, хто розмовляє Українською. Це безкоштовна послуга.

**Navajo** Díí ats'íís baa áháyá éí doodago azee' bee aa áháyá bina'ídílkidgo éí ná ata' hodoolnihíí hóló. Ata' halne'é biniyégo, kojí' 1-800-776-4466 béesh bee hodíílnih. Diné k'ehjí yákt'i níká adoolwoł. Díí t'áá jíík'eh bee aná'áwo.

**Punjabi** ਪੰਜਾਬੀ ਸਾਡੀ ਸਿਹਤ ਨਾਂ ਡਰੱਗ ਪਲਾਨ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਇੱਕ ਦੁਬਾਸ਼ੀਆ ਲੈਣ ਲਈ, ਸਾਨੂੰ 1-800-776-4466 'ਤੇ ਕਾਲ ਕਰੋ। ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਕੋਈ ਵੀ ਵਿਅਕਤੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

**Khmer** យើងមានសេវាអ្នកបកប្រែផ្តល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានាដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តល់មាត់ម្នាក់សូមទូរសព្ទមកយើងខ្ញុំតាមលេខ 1-800-776-4466។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ សេវានេះមិនគិតថ្លៃនោះទេ។

**Mien** Yie mbuo mbenc duqv maaih tengx wang-henh nzie faan waac mienh liouh dau waac bun muangx dongh nzunc baav meih maaih waac naaic taux yie mbuo gorngv taux yie nyei heng-wangc jauv-louc a'fai ndie-daan. Liouh lorx zipv longc faan waac nor, douc waac lorx taux yie mbuo yiem njiec naaiv 1-800-776-4466. Maaih mienh gorngv benx Mienh waac haih tengx nzie duqv meih. Naaiv se benx wang-henh nzie weih jauv-louc oc.

**Lao** ພວກເຮົາມີນາຍພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບຄໍາຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອໃຫ້ໄດ້ຮັບນາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-776-4466. ມີຜູ້ຮູ້ພາສາລາວ ສາມາດຊ່ວຍທ່ານ. ບໍ່ແມ່ນບໍລິການໂດຍບໍ່ເສຍຄ່າ.

**Armenian** Մեզ մոտ հասանելի են անվճար թարգմանչական ծառայություններ՝ մեր առողջապահական կազմակերպության հետ կապված Ձեր ցանկացած հարցին պատասխանելու համար: Թարգմանիչ լինելու մասին համար պարզապես զանգահարեք մեզ 1-800-776-4466  
հեռախոսապահարկով: Ձեզ կօգնի հարցերին իմացող թարգմանիչը: Ծառայությունն անվճար է:

**Farsi** ما خدمات مترجم شفاهی رایگان ارائه می‌دهیم تا به هر گونه سوالی که در مورد طرح سلامت یا داروی ما دارید پاسخ دهیم. برای داشتن مترجم شفاهی، کفایت با ما به شماره 1-800-776-4466 تماس بگیرید. کسی که فارسی صحبت می‌کند می‌تواند به شما کمک کند. این یک خدمت رایگان است.

**Thai** ภาษาไทย เรามีบริการล่ามฟรีเพื่อตอบคำถามของคุณเกี่ยวกับสุขภาพหรือแผนด้านยาของคุณ หากต้องการบริการล่าม โปรดโทรหาเราที่ 1-800-776-4466 มีคนที่สามารถพูดภาษาไทยได้เพื่อช่วยเหลือคุณ บริการนี้เป็นบริการฟรี