Abilis Health Plan

Abilis Health Community 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:

Birthdate: (MM / DD / YYYY) / /	Phone number (include 3-digit area code):

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 Abilis Health Plan (transitioning from Signature Advantage Plan, effective January 1, 2026) will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form
- **Abilis Health Plan** (formerly Signature Advantage Plan*;* transition effective January 1, 2026) **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:**

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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.	
Name:	Address (Street, City, State, ZIP code):
Phone number (include 3-digit area code):	Relationship to participant:

How To Submit This Form

Submit your completed form to:

Abilis Health Plan
Attn: Enrollment
805 N Whittington Parkway
Louisville, KY 40222

You can also complete the participation request form online at www.abilishealth.com or call us at 1-844-214-8633 to submit your request via telephone. If you have questions or need help completing this form, call us at 1-844-214-8633. Hours are 7-days a week, 8:00 a.m. to 8:00 p.m., from October 1 – March 31 (excluding Thanksgiving and Christmas) and Monday – Friday, 8:00 a.m. to 8:00 p.m., from April 1 – September 30 (excluding federal holidays). TTY call 711.

TERMS and CONDITIONS

Upon acceptance into the Medicare Prescription Payment Plan:

- Abilis Health Plan will inform your pharmacy that you're using this payment option, which will apply only to Medicare Part D covered drugs that are processed after your election is confirmed.
- When you fill a prescription for an eligible drug, you will pay zero dollars at the pharmacy, but you will still be responsible for your cost share of the drug associated with your Medicare Part D benefit under your plan.
- You will receive a monthly invoice for the amount you owe, when it's due, and information on how to make a payment.
- Your payments may change every month because your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year. However, you'll never pay more than the total amount you would have paid out of pocket or the total annual out-of-pocket maximum.
- If you miss a payment, you will receive a reminder notice. If you don't pay your bill by the date listed, you will be removed from this payment option. However, you are required to pay the amount you owe, and you may not be able to elect back into this payment option.

TERMS and CONDITIONS *continued from previous page*

- You can leave this payment option at any time without affecting your Medicare drug coverage and other Medicare benefits.
- You can do this by selecting Opt-out through the website or calling the phone number listed on the back of your member ID card. However, after you opt out, you will receive an invoice each month for the amount you owe until your balance is paid.
- You'll pay the pharmacy directly for new out-of-pocket drug costs after you leave this payment option.
- Participation in this payment option will automatically make you eligible for important relevant communications.
- If you are disenrolled from Abilis Health Plan for any reason, or you enroll in a new plan with drug coverage, your participation in this payment option will end. However, you will continue to receive a monthly invoice for the amount owed until your balance is paid in full. 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.
- While this payment option helps to manage your costs, it doesn't lower your costs. If you have limited income or resources, you can learn more about programs to help lower drug costs by visiting www.Medicare.gov.
- If you have a concern, you have the right to follow the grievance process found in your Evidence of Coverage.
- If your address is different than what is on the form, you will need to work with Abilis Health Plan to update your address.

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