

Exhibit 5 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan – Notification of Termination of Participation in the Medicare Prescription Payment Plan

[Instructions: The ‘Notice for Failure to Make Payments – Notification of Termination of Participation’ notifies a participant that they have been removed from the program due to their failure to pay their monthly billed amount. The notice informs participants what they still owe, instructs participants how to pay their balance, and provides details about other programs that can help lower costs, like Extra Help.]

This notice satisfies the requirement for Part D sponsors to provide a notice of removal to Part D participants who have failed to pay their outstanding balance and meets all the communication requirements outlined in Section 30.3 of the “Medicare Prescription Payment Plan: Final Part Two Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Response to Relevant Comments.” Plan sponsors may add their logos to brand this document.

The italicized blue text in square brackets is information for the plans and shouldn’t be included in the request form. The non-italicized blue text in square brackets may be inserted or used as replacement text in the request form. Use as applicable.]

[Part D sponsors may insert a title for the notice, such as “Important: Your participation in the Medicare Prescription Payment Plan has ended”]

[Member #]

[Date]

[Part D sponsors may include these additional fields:]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear [Member],

On [date of initial notification of failure to pay], we sent you a letter letting you know you missed your monthly payment for the Medicare Prescription Payment Plan. The letter explained that if you didn’t make your payment by [due date], we’d remove you from the Medicare Prescription Payment Plan.

Starting [effective date, *which should be the same date as this letter*], we’ve removed you from the Medicare Prescription Payment Plan through [plan sponsor] because we didn’t get your monthly payment. You’re still required to pay the amount you owe, \$[amount owed].

As of [effective date], you’ll pay the pharmacy directly for all new out-of-pocket drug costs.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in [plan name] for your drug coverage.

How do I pay my balance?

You owe \$[total outstanding amount].

[Plans may tailor payment options based on which payment methods are available. They may also add a mailing address for payments made through the mail.]

You can pay:

- Online at [plan's website], by credit or debit card.
- Through the mail, by check.
- *[insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)].*

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

If you have questions about your payment, call us at [phone number], [days and hours of operation]. TTY users can call [TTY number].

What if I think there's been a mistake?

If you think that we've made a mistake, call us at [phone number]. You also have the right to ask us to reconsider our decision through the grievance process in your *[insert "Member Handbook" or "Evidence of Coverage," as appropriate. Plans may also include language explaining where enrollees can find these documents]*.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe. Contact us at *[insert plan phone number or preferred contact method for someone to use in this situation]* when you're ready to start participating again.

What programs can help lower my costs?

[Plans may add their plan-specific assistance programs, if applicable. If any of these programs are not available to a plan's enrollees, they may be removed. In areas where Extra Help isn't available, plans have the option to include the following language: "Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. But there are other programs available in those areas that may help lower your costs. Call your State Medical Assistance (Medicaid) office to learn more."]

If you have limited income and resources, find out if you're eligible for one of these programs:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs. Visit ssa.gov/medicare/part-d-extra-help to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/ExtraHelp to learn more.
- **Medicare Savings Programs:** State-run programs that might help pay some or all of your Medicare premiums, deductibles, copayments, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.

- **State Pharmaceutical Assistance Programs (SPAPs):** Programs that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs (PAPs):** Programs from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit [Medicare.gov/basics/costs/help](https://www.Medicare.gov/basics/costs/help), or contact your local Social Security office to learn more. Find your local Social Security office at ssa.gov/locator/.

Note: The programs listed above may help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

[Plans may insert link to their Medicare Prescription Payment Plan website or customer service phone number for additional information.]