

Revised Model Part D Explanation of Benefits

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I. General instructions for plans

[Instructions for plans:

- *This is a model EOB. In order to qualify for a 10-day review, your EOB must include all model language exactly as provided.*
 - *Minor grammar or punctuation changes, as well as changes in font type or color, are permissible.*
 - *References to a specific plan name in brackets may be replaced with generic language such as “our plan.”*
 - *References to Member Services can be changed to the appropriate name your plan uses.*
 - *References to the plan’s Supplemental Drug Coverage can be changed to the appropriate name your plan uses.*
 - *References to “cost-sharing tiers” may be expanded to include additional description, including the standardized names of the tiers used by the plan.*
- *Italicized blue text in square brackets is information for the plans. Do not include in EOB.*
- *Non-italicized blue text in square brackets is text that can be inserted or used as replacement text in the EOB. Use it as applicable.*
- *References to “TrOOP” mean the total of all drug costs paid by the enrollee, the LIS subsidy, and all others whose payments count toward the enrollee’s out-of-pocket costs.*
- *References to “Total Drug Costs” mean “Gross Drug Spend,” i.e., the total of all drug costs paid, including by the plan, the enrollee, the LIS subsidy, and all others who paid on the enrollee’s behalf.*
- *All pages are to be formatted in landscape orientation. To keep line lengths easy to read, the cover page and sections 3 through 7 are to be formatted as two-column text.*
- *Charts that continue from one page to the next should be marked with “continue” at the bottom on the page that continues. In an actual EOB, rows of a chart should not break across the page (in the model language in this document, rows sometimes break across a page because of the instructions and substitution text).*
- *For examples that show versions of the cover page and each section of the EOB, see Exhibits A through F in the Appendix. These exhibits will help you visualize what the document will look like when substitution text is applied for various situations. In addition, Appendix G shows an example of a complete EOB.]*

II. Model language for the cover page

[For an example of this cover page, see Exhibit A in the Appendix.]

[Insert plan name and/or logo.]

[Insert date.]

To:

[Insert beneficiary name.]

[Insert beneficiary mailing address.]

[Insert member ID numbers and/or other numbers for reference. Plans may include one or more of these identifiers in a header to this document, together with the month and year and the page number.]

For languages other than English:

[Use this space to show phone numbers and/or other contact information for members who need information in a language other than English. Include the languages that are most commonly used by the plan's members. For an example of this paragraph, see Exhibit A in the Appendix.]

Do you need large print or another format?

To get this material in other formats, including large type, Braille, and translation into other languages, call *[insert plan name]* at the number shown on this page.

[Insert plan name and/or sponsor name and full mailing address.]

Your Monthly Prescription Drug Summary For *[insert month, year, e.g., "January 2011"]*

This summary is your "Explanation of Benefits" (EOB) for your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. (This is *not* a bill.)

Here are the sections in this summary:

- SECTION 1. Your prescriptions during the past month
- SECTION 2. Which "drug payment stage" are you in?
- SECTION 3. Your "out-of-pocket costs" and "total drug costs" (amounts and definitions)
- SECTION 4. Updates to the plan's Drug List that will affect drugs you take
- SECTION 5. If you see mistakes on this summary or have questions, what should you do?
- SECTION 6. Important things to know about your drug coverage and your rights

***[insert plan name]* Member Services**

If you have questions or need help, call us. We are available *[insert days of week and calling hours]*. Calls to these numbers are free.

[Insert phone number; plan may add local phone number if desired.]

TTY users call: *[insert TTY number]*

Or visit our website: *[insert URL]*

III. Model language for Section 1

SECTION 1. Your prescriptions during the past month

- Chart 1 shows your prescriptions for covered Part D drugs for the past month. *[If member has filled prescriptions for drugs covered by the plan's supplemental drug coverage during the past month, include Chart 2 in the EOB and add the following sentence here: (Prescriptions for drugs covered by our plan's Supplemental Drug Coverage are shown separately in Chart 2.)]*
- **Please look over this information about your prescriptions to be sure it is correct.** If you have any questions or think there is a mistake, Section 5 tells what you should do.

CHART 1. Your prescriptions for covered Part D drugs <i>[insert month and year]</i>	Plan paid	You paid	Other payments (made by programs or organizations; see Section 3)
<p><i>[Insert name of drug followed by description of strength and form, e.g., "25 mg tabs"]</i></p> <p><i>[Insert date filled]. [Plans may add the name of the pharmacy, location of the pharmacy, and other additional pharmacy information if desired, such as "non-network pharmacy."]</i></p> <p><i>[Insert prescription number], [Insert amount dispensed, e.g., "30 days supply." [Plans may add additional information about the prescription if desired.]</i></p> <p><i>[If Section 4 on changes to the formulary contains a change that applies to a drug listed in Chart 1, plans should insert a note here to alert the member that this change has taken place. Use the following example as a guide for the text to be used in this note. Also, see the examples of other notes in Example 5 of Exhibit B in the Appendix. "NOTE: Beginning on January 1, 2012, step therapy will be required for this drug. See Section 4 for details."]</i></p> <p><i>[If the member changes from one payment stage to</i></p>	<p><i>[Insert amount. Use \$0.00 if applicable.]</i></p>	<p><i>[Insert amount. Use \$0.00 if applicable.]</i></p>	<p><i>[Insert amount. Use \$0.00 if applicable. For each payment, identify the payer, e.g.: "\$5.00 (paid by "Extra Help") \$10.00 (paid by Veteran's Administration)". For an illustration, see Example 2 in Exhibit B in the Appendix.]</i></p>

CHART 1.

Your prescriptions for covered Part D drugs

[insert month and year]

	Plan paid	You paid	Other payments (made by programs or organizations; see Section 3)
<p><i>another during this month, plans should insert a note that informs the member about this change. Use the following example as a model for the text to be used in this note. Also, see Example 3 in Exhibit B in the Appendix. “NOTE: With this prescription payment, your year-to-date total for “out-of-pocket costs” has reached \$xx, the amount of your deductible for our plan. This means that you have moved from the Deductible drug payment stage to the Initial Coverage drug payment stage (see Section 2).”]</i></p> <p><i>[If desired, plans may add additional notes that give members other information related to a prescription, such as notes that explain when a payment for a drug does not count toward out-of-pocket costs or suggest lower-cost alternatives that a member and their doctor might want to consider.</i></p>			
<p>TOTALS for the month of <i>[insert month and year]</i>:</p> <p>Your “out-of-pocket costs” amount is \$<i>[insert TrOOP for the month]</i>. Use “\$0.00” if applicable]. (This is the amount you paid this month (<i>[insert total paid by member for the month]</i>. Use “\$0.00” if applicable]) plus the amount of “other payments” made this month that count toward your “out-of-pocket costs” (<i>[insert total of “other payments” made that count toward the member’s out-of-pocket costs]</i>. Use “\$0.00” if applicable]). See definitions in Section 3.)</p> <p>Your “total drug costs” amount is \$<i>[insert Total Drug Costs for the month]</i>; use “\$0.00” if</p>	<p><i>[Insert total amount paid by the plan this month; use \$0.00 if applicable.]</i> (total for the month)</p> <p><i>[If the member moved from one drug payment stage to another during the month, plans should insert a note here to explain why the pattern of payments made by the plan changed during the month. Here is an</i></p>	<p><i>[Insert total amount paid by member this month; use \$0.00 if applicable.]</i> (total for the month)</p> <p><i>[If any of this total does not count toward out-of-pocket costs, insert: (Of this amount, \$<i>[insert amount paid that does count toward out-of-pocket costs]</i> counts toward your out-</i></p>	<p><i>[Insert total amount of “other payments” for the month; use \$0.00 if applicable.]</i> (total for the month)</p> <p><i>[If there are any payments that do not count toward out-of-pocket costs, add the following text: (Of this amount, \$<i>[insert amount that does count toward out-of-pocket costs]</i></i></p>

CHART 1.

Your prescriptions for covered Part D drugs

[insert month and year]

Plan paid	You paid	Other payments (made by programs or organizations; see Section 3)
<p>applicable]. (This is the total for this month of all payments made for your drugs by the plan (<i>[insert total paid by plan for the month. Use "\$0.00" if applicable]</i>) and you (<i>[insert total paid by member for the month; use "\$0.00" if applicable]</i>) plus "other payments" (<i>[insert total of "other payments for the month; use "\$0.00" if applicable].</i>))</p>	<p><i>example: "NOTE: Earlier this month, during the time you were in the Coverage Gap payment stage, the plan did not make payments for your drugs. Once you moved to the Catastrophic Coverage payment stage, the plan made payments. See Section 2.)"</i></p>	<p>of-pocket costs.)]</p>
<p>counts toward your "out-of-pocket costs." The payment(s) made by <i>[insert name(s) of payers that made payments this month that do not count toward the member's out-of-pocket costs]</i> totaling \$ <i>[insert total of "other payments" that do not count toward out-of-pocket costs]</i> do <u>not</u> count toward your out-of-pocket costs. See definitions in Section 3.)]</p>		

Year-to-date totals as of <i>[insert date for end of month]</i>	Plan paid	You paid	Other payments (made by programs or organizations; see Section 3)
<p>Your year-to-date amount for “out-of-pocket costs” is \$<i>[insert year-to-date TrOOP; use “\$0.00” if applicable]</i>. (This is the amount you have paid since <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> (<i>[insert year-to-date total paid by member; use “\$0.00” if applicable]</i>) plus the amount of “other payments” made since <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> that count toward your “out-of-pocket costs” (<i>[insert total of “other payments” that count toward “out-of-pocket costs”; use “\$0.00” if applicable]</i>). See definitions in Section 3.)</p> <p>Your year-to-date amount for “total drug costs” is \$<i>[insert year-to-date Total Drug Costs; use “\$0.00” if applicable]</i>. (This is the total of all payments made for your drugs since <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> by the plan (<i>[insert total year-to-date amount paid by plan; use “\$0.00” if applicable]</i>) and you (<i>[insert total year-to-date paid by member; use “\$0.00” if applicable]</i>) plus “other payments” (<i>[insert year-to-date total of “other payments”; use “\$0.00” if applicable]</i>.)</p> <p><i>[If the member was enrolled in a different plan for Part D coverage earlier in the year, plans should add a one-time “NOTE:” here to tell the member that these year-to-date totals include payments made for their prescriptions since the beginning of the year (or other appropriate date), including those from their previous plan.]</i></p>	<p><i>[Insert year-to-date amount of payments made by the plan; use \$0.00 if applicable.]</i></p> <p>(total for <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> through <i>[insert ending date for the month]</i>)</p>	<p><i>[Insert year-to-date amount paid by the member; use \$0.00 if applicable.]</i></p> <p>(total for <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> through <i>[insert ending date for the month]</i>)</p> <p><i>[If any of this total does <u>not</u> count toward out-of-pocket costs, insert: (Of this amount, \$<i>[insert amount paid that <u>does</u> count toward out-of-pocket costs]</i> counts toward your out-of-pocket costs.)]</i></p>	<p><i>[Insert year-to-date total for “other payments”; use \$0.00 if applicable]</i></p> <p>(total for <i>[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”]</i> through <i>[insert ending date for the month]</i>)</p> <p><i>[If there are any payments that do <u>not</u> count toward out-of-pocket costs, add the following text: (Of this amount, \$<i>[insert amount that <u>does</u> count toward out-of-pocket costs]</i> counts toward your “out-of-pocket costs.” See definitions in Section 3.)]</i></p>

<p><i>[Optional: Plans may add a "NOTE:" here to explain corrections that have been made to previous monthly summaries.]</i></p>			
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[Include Chart 2 only if the EOB is for a plan member who has filled at least one prescription during the month for a drug that is covered by the plan's Supplemental Drug Coverage. If applicable, plans should replace the term "Supplemental Drug Coverage" with the name they use for this coverage.]

CHART 2.

Your prescriptions for drugs covered by our plan's **Supplemental Drug Coverage**

[insert month, year]

- This chart shows your prescriptions for drugs that are not generally covered by Medicare.
- These drugs are covered for you under our plan's Supplemental Drug Coverage.

	Plan paid	You paid	Other payments (made by programs or organizations; see Section 3)
<p><i>[Insert name of drug followed by description of strength and form, e.g., "25 mg tabs"]</i></p> <p><i>[Insert date filled]. [Plans may add the name of the pharmacy, location of the pharmacy, and other additional pharmacy information if desired, such as "non-network pharmacy."]</i></p> <p><i>[Insert prescription number], [Insert amount dispensed, e.g., "30 days supply."]</i> <i>[Plans may add additional information about the prescription if desired]</i></p>	<i>[Insert amount. Use \$0.00 if applicable.]</i>	<i>[Insert amount. Use \$0.00 if applicable.]</i>	<i>[Insert amount. Use \$0.00 if applicable. For each payment, identify the payer.]</i>
<p>Totals for the month of <i>[insert month, year]</i></p>	<p><i>[Insert totals for the month under each column. Use \$0.00 if applicable]</i></p> <p>These payments do <u>not</u> count toward your "out-of-pocket costs" or your "total drug costs" because they are for drugs that are not generally covered by Medicare. (See definitions in Section 3.)</p>		

IV. Model language for Section 2

[NOTE TO PLANS ABOUT SECTION 2:

Language in Section 2 is customized to fit the payment stage the member is in. Within each stage, there are wording variations. These include variations for plan design (e.g., deductible vs. non-deductible, partial coverage during the Coverage Gap) and for LIS (non-LIS, partial LIS, full LIS).

To make the substitution text easier to follow, this model document presents different versions of Section 2 for each payment stage, with separate versions for LIS and non-LIS. Versions of Section 2 for non-LIS are shown first, followed by those for LIS.

In addition, for a quick overview of how the language and formatting accents change from one stage to the next, for non-LIS and LIS, see the examples of Section 2 in Exhibit C in the Appendix.]

[If your plan has a deductible, use this version of Section 2 for members without LIS who are in the deductible stage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

You are in this stage:

STAGE 1

Yearly Deductible

- You began in this payment stage when you filled your first prescription of the calendar year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You will stay in this stage **until you (or others on your behalf) have paid \$[insert deductible amount]** for your drugs (\$[insert deductible amount] is the amount of your deductible).
- As of *[insert end date for the month]* you have paid \$*[insert year-to-date Total Drug Costs]* for your drugs.

What happens next?

Once you (or others on your behalf) have paid **an additional \$[insert additional amount needed to satisfy the deductible]** for your drugs, you will move to the next payment stage

STAGE 2

Initial Coverage

- Once you are in this payment stage, the plan will pay its share of the cost of your drugs and you (or others on your behalf) will pay your share of the cost.
- Once you are in this payment stage, you will stay in it until the amount of your year-to-date “total drug costs” (see Section 3) reaches \$*[insert initial coverage limit]*. When this happens, you will move to payment stage 3, Coverage Gap.

STAGE 3

Coverage Gap

- Once you are in this payment stage, *[Insert either: you (or others on your behalf) will pay the full cost of your drugs. OR the plan will provide limited coverage.]*
- Once you are in this payment stage, you will stay in it until the amount of your year-to-date “out-of-pocket costs” (see Section 3) reaches \$*[insert TrOOP limit]*. When this happens, you will move to payment stage 4, Catastrophic Coverage.

STAGE 4

Catastrophic Coverage

- Once you are in this payment stage, the plan will pay most of the cost for your covered drugs.
- Once you are in this payment stage, you will stay in it for the rest of the calendar year (through December 31, *[insert year]*).

(stage 2, Initial Coverage).

[Use the following version of Section 2 for members without LIS who are in the initial coverage stage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

Yearly Deductible

[If the plan has no deductible, replace the text in this cell with: (Because there is no deductible for the plan, this payment stage does not apply to you.)]

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf) paid the full cost of your drugs.
- You stayed in this stage until you had paid *[\$insert deductible amount]* for your drugs (*[\$insert deductible amount]* is the amount of your deductible). Then you moved to payment stage 2, Initial Coverage.

You are in this stage:

STAGE 2

Initial Coverage

- *[Insert either: You began in this payment stage when you filled your first prescription of the year. While OR Now that]* you are in this payment stage, the plan pays its share of the cost of your drugs and you (or others on your behalf) pay your share of the cost.
- You will stay in this payment stage **until the amount of your year-to-date “total drug costs” reaches *[\$insert initial coverage limit]***. As of *[insert end date of month]*, your year-to-date “total drug costs” was *[\$insert year-to-date Total Drug Costs]*. (See definitions in Section 3.)

What happens next?

STAGE 3

Coverage Gap

- Once you are in this payment stage, *[Insert either: you (or others on your behalf) will pay the full cost of your drugs. OR the plan will provide limited coverage.]*
- Once you are in this payment stage, you will stay in it until the amount of your year-to-date “out-of-pocket costs” (see Section 3) reaches *[\$insert TrOOP limit]*. When this happens, you will move to payment stage 4, Catastrophic Coverage.

STAGE 4

Catastrophic Coverage

- Once you are in this payment stage, the plan will pay most of the cost for your covered drugs.
- Once you are in this payment stage, you will stay in it for the rest of the calendar year (through December 31, *[insert year]*).

Once you have **an additional** *\$[insert amount needed in additional Total Drug Costs to meet the initial coverage limit]* in **“total drug costs,”** you will move to the next payment stage (stage 3, Coverage Gap).

[Use the following version of Section 2 for members without LIS who are in the coverage gap]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

Yearly Deductible

[If the plan has no deductible, replace the text in this cell with: (Because there is no deductible for the plan, this payment stage does not apply to you.)]

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf) paid the full cost of your drugs.
- You stayed in this stage until you had paid \$*[insert deductible amount]* for your drugs (\$*[insert deductible amount]* is the amount of your deductible). Then you moved to payment stage 2, Initial Coverage.

STAGE 2

Initial Coverage

- While you were in this payment stage, the plan paid its share of the cost of your drugs and you (or others on your behalf) paid your share of the cost.
- You stayed in this stage until the amount of your year-to-date “total drug costs” reached \$*[insert initial coverage limit]*. Then you moved to payment stage 3, Coverage Gap.

You are in this stage:

STAGE 3

Coverage Gap

- Now that you are in this payment stage, *[Insert either: you (or others on your behalf) will pay the full cost of your drugs. OR the plan will provide limited coverage. Plans that offer limited coverage may insert a very brief description of this limited coverage, if desired.]*
- You will stay in this payment stage **until the amount of your year-to-date “out-of-pocket costs” reaches \$*[insert TrOOP limit]***. As of *[insert end date of month]* your year-to-date “out-of-pocket costs” was \$*[insert year-to-date TrOOP]* (see Section 3).

STAGE 4

Catastrophic Coverage

- Once you are in this payment stage, the plan will pay most of the cost for your covered drugs.
- Once you are in this payment stage, you will stay in it for the rest of the calendar year (through December 31, *[insert year]*).

What happens next?

Once you (or others on your behalf) have paid **an additional**

\$/insert amount needed in additional TrOOP to meet the TrOOP limit] in “out-of-pocket costs,” you will move to the next payment stage (stage 4, Catastrophic Coverage).

[Use the following version of Section 2 for members without LIS who are in catastrophic coverage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

Yearly Deductible

[If the plan has no deductible, replace the text in this cell with: (Because there is no deductible for the plan, this payment stage does not apply to you.)]

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf) paid the full cost of your drugs.
- You stayed in this stage until you had paid \$*[insert deductible amount]* for your drugs (\$*[insert deductible amount]* is the amount of your deductible). Then you moved to payment stage 2, Initial Coverage.

STAGE 2

Initial Coverage

- While you were in this payment stage, the plan paid its share of the cost of your drugs and you (or others on your behalf) paid your share of the cost.
- You stayed in this stage until the amount of your year-to-date “total drug costs” reached \$*[insert initial coverage limit]*. Then you moved to payment stage 3, Coverage Gap.

STAGE 3

Coverage Gap

- While you were in this payment stage, *[Insert either: you (or others on your behalf) paid the full cost of your drugs. OR the plan provided limited coverage.*
- You stayed in this stage until the amount of your year-to-date “out-of-pocket costs” reached \$*[insert TrOOP limit]*. Then you moved to payment stage 4, Catastrophic Coverage.

You are in this stage:

STAGE 4

Catastrophic Coverage

- Now that you are in this stage, the plan will pay most of the cost for your covered drugs.
- *[Plans should insert a brief explanation of what the member pays during this stage. For example: “For each prescription, you will pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called “coinsurance”), or a copayment (\$2.40 for a generic drug or a drug that is treated like a generic, \$6.00 for all other drugs)”].*

What happens next?

You will stay in this payment stage, Catastrophic Coverage, for

the rest of the calendar year
(through December 31, *[insert
year]*).

[If the plan has a deductible, use the following version of Section 2 for members with partial LIS who are in the yearly deductible stage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

You are in this stage:

STAGE 1

Yearly Deductible

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You will stay in this stage **until you (or others on your behalf) have paid \$[insert appropriate deductible amount for member with partial LIS]** for your drugs. *[Only insert if deductible is more than the partial subsidy deductible limit: (The plan deductible is usually \$[insert usual plan deductible], but you pay \$ [insert appropriate deductible amount for member with partial LIS] because you are receiving “Extra Help” from Medicare.)]*
- As of *[insert end date of month]* you have paid **\$[insert year-to-date Total Drug Costs]** for your drugs.

What happens next?

Once you (or others on your behalf) have paid **an additional \$[insert additional amount needed to satisfy the deductible]** for your drugs, you will move to the next

STAGE 2

Initial Coverage

- Once you are in this payment stage, the plan will pay its share of the cost of your drugs and you (or others on your behalf, including “Extra Help” from Medicare) will pay your share of the cost.
- Once you are in this payment stage, you will stay in it until the amount of your year-to-date “out-of-pocket costs” reaches **\$[insert TrOOP limit]**. When this happens, you will move to payment stage 4, Catastrophic Coverage.

STAGE 3

Coverage Gap

(Because you are receiving “Extra Help” from Medicare, this payment stage does not apply to you.)

STAGE 4

Catastrophic Coverage

- Once you are in this payment stage, the plan will pay most of the cost for your covered drugs.
- Once you are in this payment stage, you will stay in it for the rest of the calendar year (through December 31, *[insert year]*).

payment stage (stage 2, Initial Coverage).

[Use the following version of Section 2 for members with LIS who are in the initial payment stage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

Yearly Deductible

[If the plan has no deductible, insert the following text as a replacement for the other text in this cell: (Because there is no deductible for the plan, this payment stage does not apply to you.)]

[If the plan has a deductible and the EOB is for a member with full LIS, insert the following text as a replacement for the other text in this cell: (Because you are receiving “Extra Help” from Medicare, this payment stage does not apply to you.)]

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf) paid the full cost of your drugs.
- You stayed in this stage until you (or others on your behalf)

You are in this stage:

STAGE 2

Initial Coverage

- *[Insert either: You began in this payment stage when you filled your first prescription of the year. While OR Now that]* you are in this payment stage, the plan will pay its share of the cost of your drugs and you (or others on your behalf, including “Extra Help” from Medicare) will pay your share of the cost.
- You will stay in this stage **until the amount of your year-to-date “out-of-pocket costs” reaches \$[insert TrOOP limit]**. As of [insert end date of month] your year-to-date “out-of-pocket costs” was **\$[insert year-to-date TrOOP]** (see definitions in Section 3).

STAGE 3

Coverage Gap

(Because you are receiving “Extra Help” from Medicare, this payment stage does not apply to you.)

STAGE 4

Catastrophic Coverage

- Once you are in this payment stage, the plan will pay most of the cost for your covered drugs.
- Once you are in this payment stage, you will stay in it for the rest of the calendar year (through December 31, *[insert year]*).

had paid \$*[insert appropriate deductible amount for member with partial LIS]* for your drugs (\$*[insert appropriate deductible amount for member with partial LIS]* is the amount of your deductible). Then you moved to payment stage 2, Initial Coverage.

What happens next?

Once you (or others on your behalf) have paid **an additional** \$*[insert amount needed in additional TrOOP to meet the TrOOP limit]* in “out-of-pocket costs” for your drugs, you will move to the next payment stage (stage 4, Catastrophic Coverage).



[Use the following version of Section 2 for members with LIS who are in catastrophic coverage]

SECTION 2. Which “drug payment stage” are you in?

As shown below, your prescription drug coverage has “drug payment stages.” How much you pay for a prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

Yearly Deductible

[If the plan has no deductible, insert the following text as a replacement for the other text in this cell: (Because there is no deductible for the plan, this payment stage does not apply to you.)]

[If the plan has a deductible and the EOB is for a member with full LIS, insert the following text as a replacement for the other text in this cell: (Because you are receiving “Extra Help” from Medicare, this payment stage does not apply to you.)]

- You began in this payment stage when you filled your first prescription of the year. During this stage, you (or others on your behalf)

STAGE 2

Initial Coverage

- While you were in this payment stage, the plan paid its share of the cost of your drugs and you (or others on your behalf) paid your share of the cost.
- You stayed in this stage until the amount of your “out-of-pocket costs” reached \$*[insert TrOOP limit]*. Then you moved to payment stage 4, Catastrophic Coverage.

STAGE 3

Coverage Gap

(Because you are receiving “Extra Help” from Medicare, this payment stage does not apply to you.)

You are in this stage:

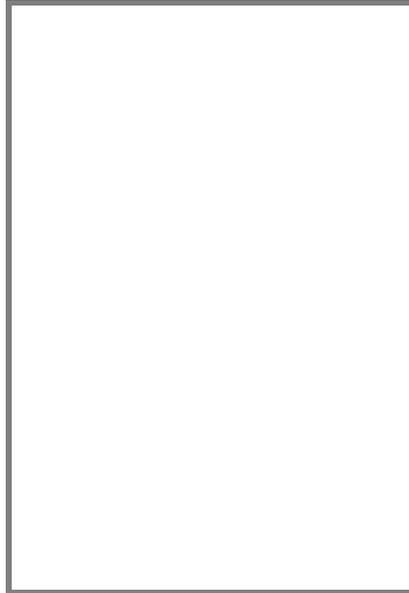
STAGE 4

Catastrophic Coverage

- Now that you are in this stage, the plan will pay most of the cost for your covered drugs.
- *[Plans should insert a brief explanation of what the member pays during this stage. For example: “For each prescription, you will pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called “coinsurance”), or a copayment (\$2.40 for a generic drug or a drug that is treated like a generic, \$6.00 for all other drugs)”].*

paid the full cost of your drugs.

- You stayed in this stage until you (or others on your behalf) had paid \$*[insert appropriate deductible amount for member with partial LIS]* for your drugs (\$*[insert appropriate deductible amount for member with partial LIS]* is the amount of your deductible). Then you moved to payment stage 2, Initial Coverage.



What happens next?

You will stay in this payment stage, Catastrophic Coverage, for the rest of the calendar year (through December 31, *[insert year]*).

V. Model language for Section 3

[Note to plans: For an example of this page that shows formatting of the totals, see Exhibit D in the Appendix.]

SECTION 3. Your “out-of-pocket costs” and “total drug costs” (amounts and definitions)

We’re including this Section to help you keep track of your “out-of-pocket costs” and “total drug costs” because these costs determine which drug payment stage you are in. And, as explained in Section 2, the payment stage you are in determines how much you pay for your prescriptions.

Your “out-of-pocket costs”

[\$insert TrOOP for month] month of ***[insert name of month]***,
[insert year]

[\$insert year-to-date TrOOP] year-to-date (since ***[insert January, [year] or other date if applicable]***)

DEFINITION:

“Out of pocket costs” includes:

- What you pay when you fill or refill a prescription for a covered Part D drug. (This includes payments for your drugs, if any, that are made by family or friends.)
- Payments made for your drugs by any of the following programs or organizations: “Extra Help” from Medicare, most charities, and most State Pharmaceutical Assistance Programs (SPAPs).

It does not include:

- Payments made for: a) plan premiums, b) drugs not covered by our plan, c) non-Part D drugs (such as drugs you receive during a hospital stay), ***[insert if applicable: d) drugs covered by our plan’s Supplemental Drug Coverage,] e) drugs obtained at a non-network pharmacy that does not meet our out-of-network pharmacy access policy.***

Your “total drug costs”

[\$insert Total Drug Costs for month]
month of ***[insert name of month]***, ***[insert year]***

[\$insert year-to-date Total Drug Costs]
year-to-date (since ***[insert January, [year] or other date if applicable]***)

DEFINITION:

“Total drug costs” is the total of all payments made for your covered Part D drugs. It includes:

- What the plan pays.
- What you pay.
- What others (programs or organizations) pay for your drugs. (All of these payments are included in your “total drug costs.”)

[Insert only if the plan offers coverage of supplemental drugs as part of an enhanced alternative benefit: NOTE: Our plan offers Supplemental Drug Coverage for some drugs not generally covered by Medicare. If you have filled

- Payments made for your drugs by any of the following programs or organizations: a) employer or union health plans, b) some government-funded programs (including TRICARE, Veteran’s Administration, Indian Health Service), c) AIDS Drug Assistance Programs, d) Worker’s Compensation, and some other programs.

any prescriptions for these drugs this month, they are listed in a separate chart (Chart 2) in Section 1. The amounts paid for these drugs do not count toward your out-of-pocket costs or total drug costs.]

Learn more. Medicare has made the rules about which types of payments count and do not count toward “out-of-pocket costs” and “total drug costs.” The definitions on this page give you only the main rules. For details, including more about “covered Part D drugs,” see the *Evidence of Coverage*, our benefits booklet (for more about the *Evidence of Coverage*, see Section 6).

VI. Model language for Section 4

[Note to plans: For an example of this Section, see Exhibit E in the Appendix.]

SECTION 4. Updates to the plan’s Drug List that will affect drugs you take

[Use this section to give formulary updates that affect drugs the member is taking, i.e., any plan-covered drugs for which the member filled a prescription during the current calendar year while a member of the plan. Include updates only if they affect drugs the member is taking. If there are no updates, insert the following as a replacement for all of the text that follows in this section: At this time, there are no upcoming changes to our Drug List that will affect the coverage or cost of drugs you take. (By “drugs you take,” we mean any plan-covered drugs for which you filled prescriptions in [insert year] as a member of our plan.)]

About the Drug List and our updates

[Insert plan name] has a “List of Covered Drugs (Formulary)” – or “Drug List” for short. If you need a copy, the Drug List on our website (*[insert website URL]*) is always the most current. Or call *[insert plan name]* Member Services (phone numbers are on the cover of this summary).

The Drug List tells which Part D prescription drugs are covered by the plan. It also tells which of the *[insert number of cost-sharing tiers]* “cost-sharing tiers” each drug is in and whether there are any restrictions on coverage for a drug.

During the year, with Medicare approval, we may make changes to our Drug List.

- We may add new drugs, remove drugs, and add or remove restrictions on coverage for drugs. We are also allowed to change drugs from one cost-sharing tier to another.

- You will have at least 60 days notice before any changes take effect unless a serious safety issue is involved (for example, a drug is taken off the market).

Updates that affect drugs you take

The list that follows tells *only* about updates to the Drug List that will change the coverage or cost of drugs you take.

(For purposes of this update list, “drugs you take” means any plan-covered drugs for which you filled prescriptions in *[insert year]* as a member of our plan.)

[Below we show model language for reporting several common types of changes to the Drug List. Use it as applicable. Plans may adapt this language as needed for grammatical consistency, accuracy, and relevant detail (e.g., describing a drug as “brand name” or “generic”). Plans may also provide additional explanation of changes if desired, and suggest specific drugs that might be suitable alternatives. To report changes for which model language is not supplied, use the model language shown below as a guide. Also, see the examples in Exhibit E in the Appendix.]

[Insert name of step therapy drug; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectible, etc.)]

- ***Date and type of change:*** Beginning *[insert effective date of the change]*, “step therapy” will be required for this drug. This means you will be required to try a different drug first before we will agree to cover *[name of step therapy drug]*. This requirement encourages you to try another drug that is less costly, yet just as safe and effective as *[insert name of step therapy drug]*. If this other drug does not work for you, the plan will then cover *[insert name of step therapy drug]*.

- **Note:** See the information later in this section that tells “What you and your doctor can do.” *[If applicable, plans may insert information that identifies possible alternate drug(s). For example, “(You and your doctor may want to consider trying {alternate-drug-1} or {alternate drug-2}. Both are on our Drug List and have no restrictions on coverage. They are used in similar ways as [name of step therapy drug] and they are on a lower cost-sharing tier.)”]*

[Insert name of quantity limits drug; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectible, etc.)]

- **Date and type of change:** Beginning *[insert effective date of the change]*, there will be a new limit on the amount of the drug you can have: *[insert description of how the quantity will be limited]*.
- **Note:** See the information below that tells “What you and your doctor can do.”

[Insert name of prior authorization drug; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectible, etc.)]

- **Date and type of change:** Beginning *[insert effective date of the change]*, “prior authorization” will be required for this drug. This means you or your doctor need to get approval from the plan before we will agree to cover the drug for you.
- **Note:** See the information later in this section that tells “What you and your doctor can do.” *[Plans may insert more explanation if desired, for example, “Your choices include asking for prior authorization in order to keep using this drug and have it be covered, or changing to a different drug.]*

[Insert name of brand-name drug to be replaced with generic; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectible, etc.)]

- **Date and type of change:** Effective *[insert effective date of the change]*, the brand-name drug *[insert name of brand-name drug to be replaced with generic]* will be removed from our Drug List. We will add a new generic version of *[insert name of brand-name drug to be replaced with generic]* to the Drug List (it is called *[insert name of replacement generic drug]*).
- **Note:** *[Plans may insert further information if applicable. For example, “Beginning [insert effective date of the change], any prescription written for [insert name of brand-name drug to be replaced with generic] will automatically be filled with [insert name of replacement generic drug]. This change can save you money because [insert name of replacement generic drug] (tier [insert cost-sharing tier number or name for the replacement generic drug]) is in a lower cost-sharing tier than [insert name of brand-name drug to be replaced with generic] (tier [insert cost-sharing tier number or name for the replacement generic drug]). If you want to keep using [insert name of brand-name drug to be replaced with generic], see the information later in this section that tells “What you and your doctor can do.”*

[Insert name of drug for which cost-sharing will increase; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectible, etc.)]

- **Date and type of change:** Effective *[insert effective date of the change]*, *[insert description of the change, for example, “the brand-name drug [insert name of drug for which cost-sharing will increase] will move from tier 2 to a higher cost-sharing tier (tier3).”]* The amount you will pay for this drug

depends on which drug payment stage you are in when you fill the prescription. To find out how much you will pay, please call us at *[insert plan name]* Member Services (our phone numbers and calling hours are on the cover).

- **Note:** See the information later in this section that tells “What you and your doctor can do.” *[Plans may add more information if desired, for example, “(You and your doctor may want to consider trying a lower cost generic drug, [insert name of lower-cost generic drug], which is in cost-sharing tier [insert number or name of cost-sharing tier].)”*

What you and your doctor can do

We are telling you about these changes now, so that you and doctor will have time (at least 60 days) to decide what to do.

Depending on the type of change, there may be different options to consider. For example:

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you.
 - You can call us at *[insert plan name]* Member Services to ask for a list of covered drugs that treat the same medical condition.
 - This list can help your doctor to find a covered drug that might work for you and have fewer restrictions or a lower cost.
- **You and your doctor can ask the plan to make an exception for you.** This means asking us to agree that the upcoming change in coverage or cost-sharing tier of a drug does not apply to you.
 - Your doctor will need to tell us why making an exception is medically necessary for you.
 - To learn what you must do to ask for an exception, see the *Evidence of Coverage* that we sent to you. *[MA-PD plans insert: Look for Chapter 9, What to do if you have a problem or complaint.] [PDP plans*

insert: Look for Chapter 7, What to do if you have a problem or complaint.]

- (Section 6 of this monthly summary tells how to get a copy of the *Evidence of Coverage* if you need one.)

VII. Model language for Sections 5 and 6

[For an example of these sections, see Exhibit F in the Appendix]

SECTION 5. If you see mistakes on this summary or have questions, what should you do?

Do you think there's something wrong in your monthly summary?

- Maybe we made a mistake, or someone at the pharmacy made a mistake.
- Maybe you didn't understand something about how the drug plan works.

We want to get it right. If you think something looks wrong, or you have questions, call us at *[insert plan name]* Member Services:

- Call us at *[insert plan name]* Member Services: Call *[insert phone number; plan may add local phone number if desired]* TTY users call: *[insert TTY number]*. We are available *[insert days of week and calling hours]*. Calls to these numbers are *[insert if applicable: not]* free.
- *[If applicable:]* You can also find answers to many questions at our website: *[insert plan website URL]*

What if you think someone is trying to cheat Medicare?

For example, what if this monthly summary shows drugs you're not taking? Or maybe there's something else that makes you wonder if someone might be trying to cheat Medicare.

It might be an honest mistake, or it might not. Although fraud is not common, it does happen.

If you think someone might be trying to cheat Medicare, please tell us:

- Call us at *[insert plan name]* Member Services: Call *[insert phone number; plan may add local phone number if desired]* TTY users call: *[insert TTY number]*. We are available *[insert days of week and calling hours]*. Calls to these numbers are *[insert if applicable: not]* free.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

SECTION 6. Important things to know about your drug coverage and your rights

Your "Evidence of Coverage" *[has OR if EOB is for a member with LIS, insert and "LIS Rider" have]* the details about your drug coverage and costs

The *Evidence of Coverage* is your benefits booklet for *[insert plan name]*. It explains your drug coverage and the rules you need to follow when you are using your drug coverage. *[If EOB is for a member with LIS, insert: Your LIS Rider ("Evidence of Coverage Rider for People Who Get Extra Help Paying for their Prescriptions") is a very short separate document that tells what you pay for your prescriptions.]*

We have sent you a copy of the *Evidence of Coverage* *[if EOB is for a member with LIS, insert: and LIS Rider]*. If you need another copy *[if EOB is for a member with LIS, insert: of either of these]*, please call us (phone numbers for *[insert plan name]* Member Services are on the cover of this monthly summary).

What if you have problems related to coverage or payments for your drugs?

Your *Evidence of Coverage* has step-by-step instructions that explain what to do if you have problems related to your drug coverage and costs. Here are the chapters to look for:

- [\[MA-PD insert: Chapter 7.\]](#) [\[PDP insert: Chapter 5.\]](#) Asking the plan to pay its share of a bill you have received for covered services or drugs.
- [\[MA-PD insert: Chapter 9.\]](#) [\[PDP insert: Chapter 7.\]](#) Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

Here are things to keep in mind:

- When we decide whether a drug is covered for you and how much you must pay, it's called a "coverage decision." If you disagree with a coverage decision we have made, you can appeal our decision (see [\[MA-PD insert: Chapter 9\]](#) [\[PDP insert: Chapter 7\]](#) of the *Evidence of Coverage*).
- Medicare has set the rules for how coverage decisions and appeals are handled. These are legal procedures and the deadlines are important. The process can be done if your doctor tells us that your health requires a quick decision.

Please ask for help if you need it. Here's how:

- You can call us at [\[insert plan name\]](#) Member Services (phone numbers are on the cover of this monthly summary).
- You can call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- You can call your State Health Insurance Assistance Program (SHIP). The name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*.

Did you know there are programs to help people pay for their drugs?

- **“Extra Help” from Medicare.** This program is also called the “low-income subsidy” or LIS. People whose yearly income and resources are below certain limits can qualify for this help. See Section [\[insert appropriate section number\]](#) of your *Medicare & You* [\[insert year\]](#) Handbook or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- **Help from your state’s pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules. Check with your State Health Insurance Assistance Program (SHIP). The name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*.

APPENDIX (Exhibits with examples)

This appendix contains examples of the Part D EOB. Since this Appendix provides examples rather than model language, it does not follow the conventions for showing model language (e.g., no text in blue).

The Exhibits in the appendix are listed below:

EXHIBIT A. Example of a cover page

EXHIBIT B. Examples that show different versions of Section 1 (the list of prescriptions)

EXHIBIT C. Examples that show different versions of Section 2 (drug payment stages)

EXHIBIT D. Example of Section 3 (amounts and definitions for TrOOP and total drug costs)

EXHIBIT E. Example of Section 4 (changes to the formulary)

EXHIBIT F. Example of Sections 5 and 6 (information for reference)

EXHIBIT G. Example of a Part D EOB (all sections included)

NOTE: Each exhibit is provided as a separate document.