[**Legend for Model LIS Rider:**

* *Variable Placeholders are located within < >.*
* Language that a sponsor may include or remove in its entirety, based on benefit design, is located within [ ].
* Language in italics is instructions to sponsors.
* SNPs that provide prescription drug benefits exclusively to Medicare/Medicaid duals and do not charge any cost sharing in excess of the LIS cost-sharing levels must reflect their plan amounts in the LIS Rider.
* D-SNPs that have $0 cost sharing for all Part D drugs are exempt from sending the LIS Rider.

In all instances throughout this document in which dollar or percentage values appear (for instance, deductibles or copays), sponsors must provide the one (not multiple) value that applies to the enrollee who will receive this copy of the LIS Rider.]

[*Insert* <Effective date as Month Day, Calendar Year or Date Range>]

Evidence of Coverage Rider

for People Who Get Extra Help Paying for Prescription Drugs

(also called a Low Income Subsidy Rider or LIS Rider)

[*Optional insert* < member’s Rx BIN/PCN>]

Please keep this notice - it is part of [*Insert* <Plan Name>’s] Evidence of Coverage.

Our records show that you qualify for extra help paying for your prescription drug coverage. This means that you will get help paying your monthly premium, yearly deductible, and prescription drug cost sharing.

As a member of our Plan, you will receive the same coverage as someone who is not getting extra help. Your membership in our Plan will not be affected by the extra help. This also means that you must follow all the rules and procedures in the Evidence of Coverage.

*[Instructions to plans offering VBID reduced or eliminated cost sharing for Part D drugs targeted to LIS Enrollees:*

*• Plans who choose to reduce cost sharing for Part D drugs covered by MA-PD plans through member participation in a plan-sponsored disease management or similar programs may include a summary of the additional supplemental benefits they would receive as well as the activities and/or programs the member must complete in order to receive the benefit.*

*• If applicable, plans must update the Prescription Drug Chart below to reflect the VBID Part D drug benefit.]*

Please see the chart below for a description of your prescription drug coverage:

|  |  |  |  |
| --- | --- | --- | --- |
| **Your monthly plan premium is** | Your yearly deductible is | **Your cost-sharing amount for generic/preferred multi-source drugs is no more than** | **Your cost-sharing amount for all other drugs is no more than** |
| <Insert applicable amount>\* | **<**$0> | <$0/$1.55/$4.50> (each prescription) | **<**$0/$4.60/$11.20> (each prescription) |

[*Insert the chart to reflect the deductible and cost-sharing amounts applicable to the beneficiary who will receive this form. In addition, if you were notified that one of your members qualifies for a copayment amount that is more than the copayment amounts listed in the Evidence of Coverage, insert the copayment amount listed in the Evidence of Coverage in the chart above*. *For example, if the member qualifies for a $4.50 copayment for generics, but your plan is a $0 generic plan, insert a $0 in the chart above. Sponsors must ensure that the premiums displayed in the table above are accurate and therefore reflect the premiums for beneficiaries who receive extra help as displayed on HPMS at Plan Bids/Bid Submission/CY 2025/Manage Plans/Review Plan Data. The only exception is that sponsors have the option to modify the premium and copayment amounts to reflect any wraparound coverage provided by a State Pharmacy Assistance Program in which a member is enrolled. Premiums in this chart must reflect the total plan premium for Part C and Part D, including both the basic and supplemental premium for each if applicable.*]

\* The monthly plan premium does not include any Medicare Part B premium that you may still need to pay. The plan premium you pay has been calculated based on the Plan’s premium and the amount of extra help you get.

Please refer to your Evidence of Coverage for more information on paying your plan premium.

*[Instructions to plans offering VBID reduction or elimination of their cost sharing for Part D drug benefits for LIS Targeted Enrollees: Modify/remove the following paragraphs to reflect the VBID Part D drug benefit, as applicable:]*

*[Insert this statement for a benefit structure with $0 generic copayment that does not extend past the ICL:* Once the amounts paid by you and/or others on your behalf reach $<ICL> you will start paying [<$1.55 / $4.50> (for generic and preferred multi-source drugs.]

Once the amount both you and Medicare pay (as the extra help) reaches $8,000 in a year, your copayment amount(s) will go down to <$0 per prescription/ $4.50 for generic and preferred brand drugs that are multi-source, or $11.20 for all others >.

[*Insert this statement for a benefit structure with $0 generic copayment that does not extend past the ICL should include the following statement:* Once the amounts paid by you and/or others on your behalf reach $<ICL> you will start paying [<$1.55 / $4.50 > (for generic and preferred multi-source drugs.]

[*Insert the following if this EOC is for your enhanced prescription benefit and you cover non-Part D drugs as part of your benefit:* We offer coverage of some supplemental prescription drugs not normally covered in a Medicare Prescription Drug Plan. You will not get any extra help to pay for these drugs. Your copayment/coinsurance amounts for these drugs are as follows: [*Insert cost-sharing structure for supplemental drugs covered under their enhanced alternative prescription benefit.*]

In addition, the amount you pay when you fill a prescription for these non-Part D drugs (supplemental drugs) does not count towards your [*Insert when applicable* <deductible,>] total drug costs or total out-of-pocket expenditures (that is, the amount you pay does not help move you through the benefit or reach catastrophic coverage). Please contact [*Insert* one <us> <applicable title for “Member/Customer Service>] to find out to which drugs this applies. Our contact information appears at the end of this notice.

Once the amount both you **and** Medicare pay (as the extra help) reaches $8,000 in a year, your copayment amount(s) will go down to <$0 per prescription/ $4.50 for generic and preferred brand drugs that are multi-source, or $11.20 for all others>.

[*Insert* this statement for LIS members who have an increase in their cost sharing, premium, and/or deductible level: The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you have filled prescriptions since this date, you may have been charged less than you should have paid as a member of our plan. In addition, if your premium has increased, you may not have paid enough. If you do owe us money, we will let you know how much. [*Insert detailed explanation on how it will be collected*.]]

[*Insert* this statement for LIS members who have been LIS eligible and now have a decrease in their cost sharing, premium, and/or deductible level, or for those newly LIS eligible with a retroactive effective date: The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you have filled prescriptions or paid premiums since this date, you may have been charged more than you should have paid as a member of our plan. If we owe you money, we will send you a separate letter to let you know how much. [*Insert detailed explanation of how plan will pay beneficiary back*.]]

Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for extra help with your Medicare prescription drug plan costs. Your eligibility for extra help might change if there is a change in your income or resources, if you get married or become single, or you lose Medicaid.

If you have any questions about this notice, please contact [*Insert* <Customer/Member> Service at <phone number> (TTY users should call <TTY number>) <days/hours of operation> or at <web address.>]

[*Pursuant to 42 CFR §423.2267, applicable disclaimers must be included in this document.*]