[***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.*

*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 get this copy of the LIS Rider.*]

Effective Date: [*Insert Date as Month Day, Calendar Year or Date Range.*]

[Date]

[Member Name]

[Address]

[City, State Zip]

***Member Handbook* Rider**

**for People Who Get Extra Help Paying for Prescription Drugs**

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

[*OPTIONAL: Sponsors may insert member’s Rx BIN/PCN*]

Dear <Member Name>:

Please keep this notice. It is part of your <Plan Name (Plan Type)> *Member Handbook*.

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 get 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 *Member Handbook*.

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/$1.30/$3.70/15%> (each prescription) | <$0/$4.00/$9.20/15%> (each prescription) |

[*Sponsors: Please fill out the chart to reflect the deductible and cost sharing amounts applicable to the member who will get this form. If you were notified that one of your members qualifies for the subsidy and has a $92 deductible but the plan is a zero deductible plan, please insert a $0 in the chart above. In addition, if you were notified that one of your members qualifies for a copay amount that is more than the copay amounts listed in the Member Handbook, insert the copay amount listed in the Member Handbook in the chart above*. *For example, if the member qualifies for a $3.70 copay 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 members who get Extra Help as displayed on HPMS at Plan Bids/Bid Submission/Contract Year 2021 Manage Plans/Review Plan Data. The only exception is that sponsors have the option to modify the premium and copay 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. You must continue to pay your Medicare Part B premium.

Please refer to your *Member Handbook* for more information on paying your plan premium.

[*Plan Benefit structure with $0 generic copay 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 <$1.30/$3.70/15%> for generic and preferred multi-source drugs.]

[*Sponsors: Add the following if this Member Handbook 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. These drugs are covered through Medical Assistance (Medicaid). Your <copayment/copay/co-insurance> amounts for these drugs are as follows: [*Sponsors should insert their cost-sharing structure for supplemental drugs covered under their enhanced alternative prescription benefit:* $0per prescription]*.*]

However, the amount you pay when you fill a prescription for these non-Part D drugs does not count towards your [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* “us” *or* *applicable title for* “Member/Customer Services”] 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 $6,550 in a year, your <copayment/copay> amount(s) will go down to $0 per prescription.

[*Sponsors: 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 owe us money, we will let you know how much. [*Insert detailed explanation on how it will be collected*].]

[*Sponsors: 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 back member*].]

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 Medical Assistance (Medicaid).

If you have any questions about this notice, please contact [*optional to insert:* usat] <Plan Name> [*optional to insert:* Member Services] at <Toll-free Number>,(<Toll-free TTY Number>), <Days/Hours of Operation>. You can also visit us at <Internet address>.

[*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]

To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at <Toll-free Number>, (<Toll-free TTY Number>), <Days/Hours of Operation>.

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

[Plan includes American Indian Language insert if plan does not include in its language block/non-discrimination notice.]