(Instructions for plans:

- *This is a model EOB. You may use your own format but the EOB must include all model language exactly as provided.*
- *Use information in brackets as needed for specific audiences.*
- *An italicized word in parentheses is information for the plans. Do not include in EOB.)*

(*Part D Model*) Explanation of Benefits (EOB) for Your Medicare Prescription Drug Coverage (Part D)

THIS IS NOT A BILL. Keep this notice for your records.

<Member Name>
<Street Address>
<City, State Zip Code>

<Date>
Member ID Number: <Member ID>
<Rx PCN or Rx Group Number>:

Para obtener una copia de esta información en español, llame GRATIS al <1-XXX-XXX-XXXX>. Los usuarios de TTY deben llamar al <1-XXX-XXX-XXXX>.

Customer Service Information

If you have any questions, call

<toll-free number>
<days and hours of operation>.

TTY users should call
<toll-free TTY number>.

Or, visit <Web site> on the web.

This notice includes

1. [(*TrOOP and Gross Drug Spend balances from previous plan if applicable*) your out-of-pocket costs and total drug costs from <Previous Plan's Name> as of <date>]
2. How much you've paid so far this year for your prescriptions
3. Your recent claims for prescriptions
4. Updates to our drug list (formulary)

1. Costs from <Previous Plan's Name> as of <date>

Out-of-Pocket Costs: <$xxx>
Total Drug Costs: <$xxx>

<Material ID number>
<mm/yyyy>

(Modify the chart below as appropriate based on your plan structure.)(Move arrow (with "Your Current Coverage Period" label and highlight appropriate row based on beneficiary's current period.)(Column 5 includes what beneficiary pays, extra help, TrOOP and non-TrOOP costs)

2. Summary of Your Year-to-Date Medicare Prescription Drug Costs

Definitions of the terms used are provided on the next page of this document.

1. Yearly Deductible	Plan Deductible: <$xxx>	Total <Plan> paid: <$xxx>	Total you/others on your behalf paid: <$xxx>	Total that you/others on your behalf paid that **counts** toward your out-of-pocket costs: <$xxx>	Total that you/others on your behalf paid that **didn't count** toward your out-of-pocket costs: <$xxx>	Total Drug Costs left to move to the initial coverage period: **<$xxx>**
YOUR CURRENT COVERAGE PERIOD. **2. Initial Coverage Period**	Maximum you/plan/others pay in this period (*ICL*): <$xxx>	Total <Plan> paid: <$xxx>	Total you/others on your behalf paid: <$xxx>	Total that you/others on your behalf paid that **counts** toward your out-of-pocket costs: <$xxx>	Total that you/others on your behalf paid that **didn't count** toward your out-of-pocket costs: <$xxx>	Total Drug Costs left before the coverage gap: **<$xxx>**
3. Coverage Gap	Maximum you/ certain others pay in this period (*TrOOP threshold*): <$xxx>	Total <Plan> paid: <$xxx>	Total you/others on your behalf paid: <$xxx>	Total that you/others on your behalf paid that **counts** toward your out-of-pocket costs: <$xxx>	Total that you/others on your behalf paid that **didn't count** toward your out-of-pocket costs: <$xxx>	Amount left before catastrophic coverage: **<$xxx>**
4. Catastrophic Coverage	No maximum	Total <Plan> paid: <$xxx>	Total you/others on your behalf paid: <$xxx>			

Out-of-Pocket Costs to Date: <$xxx>
Total Drug Costs to Date: <$xxx>

Yearly Deductible – [The amount of total drug costs, <$xx,> you and/or all others making payments on your behalf must pay, before <plan name> begins to pay for covered drugs.] [[The amount of total drug costs, <$xx,> you and/or all others making payments on your behalf must pay before <plan name> begins to pay for covered drugs.] [In this plan, only the amount you and/or others making payments on your behalf pay for generic drugs counts toward the <$xx> deductible.]] [There is no deductible for this plan.] [You don't pay a deductible for this plan. (*applicable LIS*)]

(*LIS*) [**Initial Coverage Period –** [(*applicable partial LIS*) The initial coverage period begins after you meet the yearly deductible.] You generally pay a copayment for each prescription during this period. The initial coverage period ends when your total drug costs reach the initial coverage limit of <$xx> during the coverage year. During the initial coverage period, total costs for your drugs include amounts paid for your prescriptions so far this year by <plan name>, you, Medicare, and/or others making payments on your behalf.

(*non-LIS*) [**Initial Coverage Period –** [The initial coverage period begins after you meet the yearly deductible.] You generally pay a copayment/coinsurance for each prescription during this period. The initial coverage period ends when your total drug costs reach the initial coverage limit of <$xx> during the coverage year.] The total costs for your drugs in this period include the amount <plan name>, you, and/or all others making payments on your behalf have paid for your prescriptions so far this coverage year [after meeting the deductible].

(*applicable non-LIS*) [**Coverage Gap -** This is the period after the initial coverage limit and before catastrophic coverage during which you and/or all others making payments on your behalf are responsible for [all of] your drug costs. [<Plan name> doesn't cover any drug costs during this coverage period.] [<Plan name> covers generic drugs only during the coverage gap. You pay a copayment/coinsurance for the drugs covered during this period. The amount you pay may differ from what you paid in the initial coverage period.] [<Plan name] covers generic drugs and preferred brand drugs only during this period.] You pay a copayment/coinsurance for the drugs covered during this period. The amount you pay may differ from what you paid in the initial coverage period.] This period ends when you or certain others making payments on your behalf spend <$xx> in out-of-pocket costs.]

Out-of-Pocket Costs - Includes payments that you and/or certain others on your behalf paid for covered drugs during the coverage year. This includes payments made in the deductible, initial coverage period, and/or coverage gap this coverage year. Payments made by certain others that **count** toward your out-of-pocket costs include those made by family members, [Medicare's extra help,] State Pharmaceutical Assistance Programs (SPAPs), and most charities. This amount does not include amounts paid by <plan name> or certain others making payments on your behalf. Payments made by certain others that **don't count** toward your out-of-pocket costs include those made by group health plans (like from a current or former employer or union), other insurance, or Government-funded health programs. Once your out-of-pocket costs reach <$xx>, you move into the catastrophic coverage period.

Catastrophic Coverage – This period begins once your out-of-pocket drug costs reach <$xx>. This is the period where you pay [5% coinsurance] [up to a <$xx> copayment] for your covered drugs for the remainder of the coverage year.

Total Drug Costs - This is the total amount spent on your covered drugs this coverage year by <Plan Name>, you, and/or all others making payments on your behalf during all coverage periods. [This amount also includes any extra help you got from Medicare this year.]

Premium - The premium is the monthly fee you pay to <plan name> for your Medicare prescription drug coverage. The premium amount doesn't count toward your out-of-pocket costs or your total drug cost. [You don't pay a premium for this plan. *(applicable LIS)*]

[**Note**: We offer extra coverage for some drugs not generally covered by Medicare. These drugs were noted on your summary of claims in section [3]. The amounts paid for these drugs don't count toward your out-of-pocket costs or total drug costs.]

3. Summary of Prescription Claims Processed from <mm/dd/yyyy> through <mm/dd/yyyy>

Date prescription filled:	**Amount You Paid:**
Claim Number:	[**Amount Paid by Other Sources**:]
Name of Drug:	[**Extra Help from Medicare:**]
Quantity Filled:	**Price of Generic Equivalent:**
Amount <Plan Name> Paid:	

(*Repeat above for each claim*)

Totals

- **Drug Costs from <date> to <date>:**
- **Out-of-Pocket costs:**
- **Amount you paid:**
- (*Repeat amount beneficiary has left to pay in his current coverage period from previous section*) **[Total Drug Costs/Amount] left to pay [to move to the next coverage period/before the coverage gap/before catastrophic coverage]:**

Notes:
[<Name of Drug> isn't generally covered by Medicare drug coverage and doesn't count toward your out-of-pocket or total drug costs or help you reach catastrophic coverage. See section [2] for more information.]
[The amount listed in "Amount Paid by Other Sources" includes payments made by all sources other than yourself or extra help from Medicare. Amounts paid on your behalf that do not count toward your out-of-pocket costs described in section 2 include those made by group health plans (like from a current or former employers or union), other insurance, or Government-funded health programs. Amounts paid on your behalf that do count toward your out-of-pocket costs include those made by family members, Medicare's extra help, State Pharmaceutical Assistance Programs (SPAPs), and most charities.]

4. Updates to <Plan Name>'s Drug List (formulary)

(Plans: this is the 60 day notice chart) <Plan Name> may add or remove drugs from our formulary or add rules about whether and when certain drugs are covered during the year. This chart lists upcoming changes.

Effective Date:
Drug:
Change:
Reason:
<**Other Possible Drug**:>

[<Other Possible Drug> is a generic or therapeutic alternative (other brand-name drug) on our drug list (formulary) that is used to treat your medical condition. Please talk with your doctor to find out if this

drug is right for you. The amount you will pay for this drug depends on which coverage period you are in. Call our customer service number to find out how much you will pay for this drug.]

[*(If the change is to preferred or tiered cost-sharing status)* The amount you will pay for this drug depends on which coverage period you are in. Call our customer service number to find out how much you will pay for this drug.]

[(*If the change is to add a particular rule, add the definition of the rule*) **Prior authorization** – This means your doctor must contact the plan before the plan will cover the prescription drug. Your doctor must show that the drug is medically necessary for it to be covered. **Quantity limits** – This means there is a limit to how many pills you can get at a time. **Step therapy** – This means one or more similar lower cost drugs must be tried before the step-therapy drug is covered.]

What to do if you disagree with the accuracy of this Explanation of Benefits.

If you have a question or complaint about any information contained in this you have the right to file a grievance with us>. Grievance should be sent to us at <address, telephone number>.

What to do if you disagree with a Medicare Drug Plan's coverage decision.

If we deny your request for a drug you haven't received, or deny your request to pay you back for a drug you have received, we will send you a letter explaining our decision . If you disagree with our decision, you can request an appeal within 60 calendar days from the date of our first decision. You can request a standard or fast (expedited) appeal. We will automatically give you a fast appeal if your physician tells us that your life or health may be seriously jeopardized by waiting for a standard decision. You can request an appeal by:

- [Writing a letter to <address>]
- [Calling <telephone number>] [If the plan does not accept standard appeal requests by phone, insert the following: We do not accept standard requests by phone.]
- [Sending a fax to <fax number>]

Your doctor needs to give us a statement explaining that the drug you need is medically necessary to treat your condition if you or your doctor believe:

- You need a drug that isn't on our list of covered drugs (formulary),
- The plan should waive a coverage rule or limit on a drug you need, or
- You can't take any of the drugs on our preferred tier for your condition, and you would like us to cover a non-preferred drug at the preferred cost-sharing amount.

Your doctor needs to give us a statement by sending it to <Provide necessary address, fax number> or calling us at <phone number>.

Suspect fraud?
If you suspect fraud, please contact <plan name, address, telephone number>. Or, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

[**Do you have limited income and resources?**
You may qualify for extra help paying your Medicare prescription drug costs. For more information about applying for extra help, visit www.socialsecurity.gov on the web or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.]