

(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 Customer Service can be changed to the appropriate name your plan uses.*
- *Use information in brackets as needed for specific audiences.*
- *An italicized word in parentheses is information for the plans. Do not include in EOB.*
- *Plans should only include sections 1 and/or 5 when applicable. Section 2 is optional. When not including sections 1, 2, or 5, plans should renumber the remaining sections appropriately.)*

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> <Date>
 <Street Address> Member ID Number: <Member ID>
 <City, State Zip Code><Rx PCN or Rx Group Number>:

This notice includes:

1. *[(If applicable during the period covered by the EOB, TrOOP and Gross Drug Spend balances from previous plan(s)) Your out-of-pocket costs and total drug costs from your previous plan[(s)] as of <insert either: (1) the most recent date on the Financial Information Reporting transaction field “DateTime” received from previous plan(s), if the EOB is sent after final implementation of the automated TrOOP balance transfer process; or (2) the most recent date on the manual transfer EOB, if the EOB is sent prior to final implementation of the automated TrOOP balance transfer process>]*
2. *[(Optional: If applicable, plans may include any adjustments to TROOP and Gross Drug Spend balances that are due to reversed claims, supplemental payer wraparound payments, or any other adjustments that are not reflected in the member’s prescription drug activity in an enrollee’s prior or current EOB) Any adjustments to your out-of-pocket costs or total drug costs not reflected in the Summary of Your Year-to-Date Medicare Prescription Drug Costs on this EOB or a prior EOB.]*
3. How much you’ve paid so far this year for your prescriptions
4. Your recent claims for prescriptions
5. [Updates to our drug list (formulary)]

1. [Adjustment amount due to updated information on your previous Part D coverage as of

<Insert either: (1) the most recent date on the Financial Information Reporting transaction field “DateTime” received from previous plan(s), if the EOB is sent after final implementation of the automated TrOOP balance transfer process; or (2) the most recent date on the manual transfer EOB, if the EOB is sent prior to final implementation of the automated TrOOP balance transfer process.>: (Adjust fields as appropriate on the summary chart in the EOB to reflect transferred TrOOP and gross drug spend amounts.)

Out-of-Pocket Costs: <\$xxx>

Total Drug Costs: <\$xxx>]

2. [(Optional): Adjustment amount due to <insert change, for example a reversed claim or supplemental payer wraparound payment>:

Out-of-Pocket Costs: <-\$xxx>

Total Drug Costs: <-\$xxx>]

3. How much you've paid so far this year for your prescriptions. (Modify the chart below as appropriate based on your plan's benefit structure or on the beneficiary's LIS status (for example, only include yearly deductible and coverage gap rows if appropriate. Highlight the current coverage period row in a way that stands out to the member. An example of how to do this is captured in the chart below (e.g., move arrow to the appropriate row based on beneficiary's current coverage period. Column 5 includes what beneficiary pays, extra help (if applicable), and TrOOP amounts.). Ensure that information for previous coverage rows continues to be populated even after a member moves into a subsequent coverage period.

1. Yearly Deductible <enter plan deductible amount>[*]	Total <Plan> paid: <\$xxx>	Total you/others on your behalf paid: <\$xxx>	Total that you/others on your behalf paid that counted 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.	Total <Plan> paid:	Total you/others on your behalf paid:	Total that you/others on your behalf paid that counted toward your out-of-pocket costs:	Total that you/others on your behalf paid that didn't count toward your out-of-pocket costs:	Total Drug Costs left before the coverage gap:
2. Initial Coverage Period	<\$xxx>	<\$xxx>	<\$xxx>	<\$xxx>	<\$xxx>
3. Coverage Gap	Total <Plan> paid:	Total you/others on your behalf paid:	Total that you/others on your behalf paid that counted toward your out-of-pocket costs:	Total that you/others on your behalf paid that didn't count toward your out-of-pocket costs:	Out-of-Pocket Costs left before catastrophic coverage:
	<\$xxx>	<\$xxx>	<\$xxx>	<\$xxx>	<\$xxx>
4. Catastrophic Coverage	Total <Plan> paid: <\$xxx>	Total you/others on your behalf paid: <\$xxx>			

Enter for partial LIS enrollees only: “* The plan’s full deductible amount is <enter plan deductible>. Medicare’s extra help pays the difference between the plan’s full deductible amount and your deductible amount of <enter LICs4 deductible amount>.”

(insert TrOOP amount to date) **Out-of-Pocket Costs to Date:** <\$xxx>

(insert Gross Drug Spend to date) **Total Drug Costs to Date:** <\$xxx>

(Insert bracketed language as appropriate to reflect your benefit or the beneficiary's LIS status. Do not display "Yearly Deductible" or "Coverage Gap" definitions for individuals with full-subsidy LIS. Do not display "Coverage Gap" definition for individuals with partial subsidy LIS. Do not display "Coverage Gap" definition if your benefit fills in the coverage gap entirely for all enrollees and at the same cost-sharing levels as pre-ICL.)

[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.] [In this plan, only the amount you and/or others making payments on your behalf pay for brand-name drugs counts toward the <\$xx> deductible.]] [There is no deductible for this plan.]

(applicable to LIS or benefit designs with no coverage gap only) **[Initial Coverage Period** – [*(applicable to partial LIS)* 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 out-of-pocket drug costs reach <\$xx> during the coverage year.]

(applicable to non-LIS only) **[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 to non-LIS and benefit designs with a coverage gap only) **[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 [some] 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 [some] [generic drugs] [and] [some] [brand drugs] [on <insert appropriate tier>] 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,] [and/or] 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, [*(applicable to LIS only)* 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 [the greater of either 5% coinsurance or up to a <\$xx copayment] [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. [*(applicable to LIS only)* This amount also includes any extra help you got from Medicare this year.]

[(applicable only if you offer coverage of supplemental drugs as part of an enhanced alternative benefit) **Note:** We offer extra coverage for some drugs not generally covered by Medicare. These drugs are noted on your summary of claims in section [4]. The amounts paid for these drugs don't count toward your out-of-pocket costs or total drug costs.]

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

Date Prescription Filled	Prescription [Claim] Number	Name of Drug	Quantity Filled	Amount <Plan Name> Paid	Amount You Paid	[Amount Paid by Secondary Coverage/Other Sources]	[Extra Help from Medicare]
	*					**	

* Prescription filled at an out-of-network pharmacy
 ** Amount counted toward your out-of-pocket costs.

Totals

- (Insert 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, i.e., Gross Drug Spend) **Total Drug Costs from <date> to <date>:**
- (Insert total of all drug costs paid by the enrollee, the LIS subsidy, and all others whose payments count toward the enrollee’s TrOOP costs, i.e., TrOOP amount) **Out-of-Pocket costs:**
- (Insert total of all drug costs paid by the enrollee, i.e., Patient Pay amount) **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 initial coverage period/before the coverage gap/before catastrophic coverage]:**

Notes:

[<Name of Drug(s)> [isn’t or aren’t] generally covered by Medicare drug coverage and [doesn’t or don’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 Secondary Coverage/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.]

5. [Updates to <Plan Name>'s Drug List (formulary)]

*(Note: This is the 60 day notice chart; it must be included in this document only for those enrollees affected by any negative formulary changes, including formulary maintenance changes, described in section 30.3.3 of Chapter 6 of the Prescription Drug Benefit Manual. You are not required to provide this notice for any negative formulary changes that are not formulary maintenance change; however, if you do, you must add an asterisk to the "Change" column in the chart below and the following language below the chart: "*This change will not affect your coverage for this drug for the remainder of the plan year if you are currently taking this drug.")* <Plan Name> may remove drugs from our formulary or add rules about whether and when certain drugs are covered during the year. This chart lists upcoming changes. Unless otherwise noted in the chart below, these changes will be effective in 60 days.

Effective Date	Drug	Change	Reason	Other Possible Drugs (if applicable)**

* This change will not affect your coverage for this drug for the remainder of the plan year if you are currently taking this drug

**[These or This] drug[s] [is or are] on our drug list (formulary) that [is or are] used to treat the medical condition[s] for which you were prescribed. Please talk with your doctor to find out if [this or these] drug[s] [is or are] right for you. Note: The amount you will pay for [this drug or these drugs] depends on which coverage period you are in. Call our customer service number to find out how much you will pay for [this drug or these drugs].]

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

[If the change is to add a particular rule to one or more of the drugs listed in the chart above, include the appropriate description of the rule for each applicable drug: **Prior authorization** – This means your doctor must contact the plan before the plan will cover <name of drug>. Your doctor must show that <name of drug> is medically necessary for it to be covered. **Quantity limits** – This means there is a limit to how many <name of drug> <insert "pills" or other dosage form> 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, <name of drug>, is covered.]

What to do if you have any questions.

If you have questions, please call toll-free <number> <days and hours of operation> or, visit <Web site> on the web. TTY users should call <toll-free TTY 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>.

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 here we encourage you to contact us at the number shown. If still dissatisfied you have the right to file a grievance with us. Grievances 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.]