

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. (This is coverage for non-Part D drugs).*
 - *References to “cost-sharing tiers” may be expanded to include additional description, including the standardized names of the tiers used by your plan.*
 - *References to “brand-name/tier-level” deductible can be changed to the appropriate name your plan uses.*
 - *Unless specific formatting instructions for dates have been given, plans may use their preferred method of formatting the date (such as “mm/dd/yy”).*
 - *References to “calendar year” may be changed to “plan year.”*
- *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.*
 - *Prior year fills that do not apply to the current EOB or current year gross drug spend or TrOOP do not need to be included in this EOB and would not require a separate EOB.*
 - *References to “Extra Help” mean LIS.*
 - *The first time the plan name is mentioned, the plan type designation (i.e., HMO, PPO, etc.) must be identified (see model language for the cover).*
 - *If the total drug costs and out-of-pocket costs change due to an automatic TrOOP balance transfer for the current year the plan must send the EOB depicting the changes to the totals in the year- to-date totals in sections 1 and totals in 3. If a plan transfer has occurred in a given month, the EOB should be sent even if there were no prescriptions filled in the prior month. The note regarding the transferred amounts should remain in Section 3 for the rest of the year.*
 - *To accommodate use of standard window envelopes for ease of mailing, the model language includes a version of the cover page that uses portrait orientation. There is also a version of the cover that uses landscape orientation. Plans may use either version.*
 - *Except for the cover page, all other pages are to be formatted in landscape orientation.*
 - *To keep line lengths easy to read, the landscape-oriented cover page and sections 3 through 7 are to be formatted as two-column text.*
 - *To help conserve space, the document has been designed so that Sections 3 through 7 can be printed as a continuous flow of two-column headings and text.*
 - *To help conserve space, the document can be printed double-sided.*

- *The document must include page numbers. If desired, plans may add a header or footer that includes some or all of the following information: member identifiers; month and year; page number.*
- *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

NOTE TO PLANS ABOUT THE COVER PAGE:

- This page can be formatted in either portrait or landscape orientation. For examples of both formats, see Exhibit A in the Appendix.
- Instructions to plans are shown below on the landscape version of the cover. These same instructions apply if the portrait version is used.

[Insert plan name and/or logo.]

[Insert mailing date.]

[Insert beneficiary name.]

[Insert beneficiary mailing address.]

[Insert plan name followed by model type shown in parentheses, e.g., “(HMO)” is operated by [insert plan sponsor name and mailing address].

[If desired, plans may insert member ID number and/or other member numbers typically used in member communications, for easy reference by the plan member. 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.]

Need large print or another format?

To get this material in other formats, or ask for language translation services, call *[insert plan name]* Member Services (the number is on this page).

For languages other than English:

Your Monthly Prescription Drug Summary

For *[insert month, year using a format that spells out the name of the month and gives the full 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

[Consistent with the Medicare Marketing Guidelines, insert text in this space that provides phone numbers and/or other contact information for members who need information in a language other than English. As long as the text conforms to the Medicare Marketing Guidelines, it can be adapted to reflect state requirements. For an example, see Exhibit A in the Appendix.]

[Insert Material ID number]

*[Insert **CMS Approved OR File & Use** (whichever is applicable) followed by mm/dd/yyyy]*

If you have questions or need help, call us *[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]*

On the Web at: *[insert URL]*

[Insert Federal Contracting Statement.]

III. Model language for Section 1

[NOTE TO PLANS ABOUT SECTION 1:

The amounts for “you paid” are the final amounts after other payments (those made by programs, organizations, or other plans).]

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 non-Part D 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>[If the EOB is being sent to a member who has not filled any prescriptions for covered Part D drugs during the month, plans should (1) insert the following note in this column: “No prescriptions for covered Part D drugs this month,” (2) insert amounts of “\$0.00” for the columns labeled “Plan paid,” “You paid” and “Other payments....” and (3) omit the row with “Totals for the month...” at the end of this chart.]</i></p> <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 should include the name of the pharmacy if known. Plans may add the location of the pharmacy, and other additional pharmacy information if desired, such as “non-network</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 when paid by the Medicare Coverage Gap Discount Program or Extra Help. e.g.: “\$5.00 (paid by Medicare Coverage Gap Discount Program), “\$5.00 (paid by “Extra Help”). Plan may insert other payers if known.</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)

pharmacy.”]

[Insert prescription number], [Insert amount dispensed as quantity filled and/or days supply, e.g., “15 tablets”, “30 days supply.”] [Plans may add additional information about the prescription if desired.]

[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.”]

[If desired, plans may add optional notes that give members additional 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.]

(e.g., \$10.00 (paid by Veteran’s Administration)”. If payer is not known, plan should identify as “other payer.”

For an illustration, see Example 2 in Exhibit B in the Appendix.]

TOTALS for the month of *[insert month and year]*:

Your “out-of-pocket costs” amount is \$*[insert TrOOP for the month. Use “\$0.00” if applicable]*.
(This is the amount you paid this month (*[insert total paid by member for the month. Use “\$0.00” if applicable]*) plus the amount of “other payments” made this month that count toward your “out-of-pocket costs”

[Insert total amount paid by the plan this month; use \$0.00 if applicable.]
(total for the month)

[Insert total amount paid by member this month; use \$0.00 if applicable.]
(total for the month)
[If amount is not \$0.00, and any of this total does not count toward

[Insert total amount of “other payments” for the month; use \$0.00 if applicable.]
(total for the month)
[If amount is not \$0.00, and there are any payments that do not

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)

([insert total of “other payments” made that count toward the member’s out-of-pocket costs. Use “\$0.00” if applicable]). See definitions in Section 3.)

Your “total drug costs” amount is \$*[insert Total Drug Costs for the month; use “\$0.00” if applicable]*. (This is the total for this month of all payments made for your drugs by the plan (*[insert total paid by plan for the month. Use “\$0.00” if applicable]*) and you (*[insert total paid by member for the month; use “\$0.00” if applicable]*) plus “other payments” (*[insert total of “other payments for the month; use “\$0.00” if applicable]*).)

out-of-pocket costs, add the following text: (Of this amount, \$[insert amount paid that does count toward out-of-pocket costs]* counts toward your out-of-pocket costs.)]*

count toward out-of-pocket costs, add the following text: (Of this amount, \$[insert amount that does count toward out-of-pocket costs]* counts toward your “out-of-pocket costs. See definitions in Section 3.)]*

Year-to-date totals

[insert beginning date for the period covered by year-to-date, e.g., “1/1/11”] through [insert ending date for the month]

Plan paid

You paid

Other payments
(made by programs or organizations; see Section 3)

Your year-to-date amount for “out-of-pocket costs” is \$*[insert year-to-date TrOOP; use “\$0.00” if applicable]*.

[Insert year-to-date amount of payments made by the plan; use \$0.00 if applicable.]

[Insert year-to-date amount paid by the member; use \$0.00 if applicable.]

[Insert year-to-date total for “other payments”; use \$0.00 if applicable]

(year-to-date total)

<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>.</p> <p>For more about “out-of-pocket costs” and “total drug costs,” see Section 3.</p> <p><i>[If the member was enrolled in a different plan for Part D coverage earlier in the year, plans should insert the following: “NOTE: Your year-to-date totals shown here include payments of \$<i>[insert the TrOOP balance transferred from prior plan]</i> in out-of-pocket costs and \$<i>[insert amount for Total Drug Costs]</i> in total drug costs made for your Part D covered drugs when you were in a different plan earlier this year.”]</i></p> <p><i>[Optional: If corrections have been made that affect amounts shown in previous monthly summaries during the calendar year, plans may use this space for a explanatory note: “NOTE: The following <i>[insert whichever applies: correction has OR corrections have OR adjustment has OR adjustments have]</i> been made to amounts that were shown in a monthly summary sent to you earlier this calendar year: <i>[Plans should insert a brief explanation of the correction or adjustment that identifies the change that has been made and provides relevant dates and a reason for the change, e.g., clerical error, updated information about the prescription, decision on an appeal, etc.]</i> Plans have the flexibility to report such adjustments or corrections to members using other means instead of, or in addition to, inserting this explanatory note into the EOB.]</i></p>	(year-to-date total)	(year-to-date total)	<p><i>[If total is not \$0.00 and there are any payments that do <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.” See definitions in Section 3.)]</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 non-Part D drug that is covered by the plan's Supplemental Drug 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 should include the name of the pharmacy if known. Plans may add the 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, as quantity filled and/or days supply, e.g., "15 tablets", "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 if known. If payer is not known, identify as "other payer."]</i>
Totals for the month of <i>[insert month, year]</i>	<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 <u>not</u> generally covered by Medicare. (See definitions in Section 3.)</p>		

IV. Model language for Section 2

[NOTE TO PLANS ABOUT SECTION 2:

Consistent with the goal of standardizing the EOB document, this section on drug payment stages always shows all four stages, even though some of these stages will not be applicable to certain plans and/or plan members. When a drug payment stage is not applicable to members, the model language includes explanatory notes to insert that tell the members that the stage does not apply to them.

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. brand-name/tier level only 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 applicable to ALL tier levels, 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 begin in this payment stage when you fill your first prescription of the calendar year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally 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**

STAGE 2

Initial Coverage

- During 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 generally stay in this stage until the amount of your year-to-date “total drug costs” (see Section 3) reaches \$[insert initial coverage limit]. When this happens, you move to payment stage 3, Coverage Gap.

STAGE 3

Coverage Gap

- During this payment stage, *[Insert either: you (or others on your behalf) receive a discount on brand name drugs and you pay only 93% of the costs of generic drugs OR you receive limited coverage by the plan and a discount on brand name drugs. You (or others on your behalf) pay up to 93% of the costs of generic drugs.]*
- You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” (see Section 3) reaches \$[insert TrOOP limit]. When this happens, you move to payment stage 4, Catastrophic Coverage.

STAGE 4

Catastrophic Coverage

- During this payment stage, the plan pays most of the cost for your covered drugs.
- You generally stay in this stage for the rest of the calendar year (through December 31, [insert year]).

additional amount needed to satisfy the deductible] for your drugs, you move to the next payment stage (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.)]

[If the plan has a brand-name/tier level deductible, insert the following two bullets.]

- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-*

You are in this stage:

STAGE 2

Initial Coverage

- *[Insert either: You begin in this payment stage when you fill your first prescription of the year. During this OR During this payment]* stage, the plan pays its share of the cost of your *[insert if applicable: generic/ tier levels]* drugs and you (or others on your behalf) pay your share of the cost.
- *[Insert if applicable: After you (or others on your behalf) have met your [brand-name/tier level] deductible, the plan pays its share of the cost of your [brand-name/tier level] drugs and you (or others on your behalf) pay your share of the cost.]*
- You generally stay in this stage

STAGE 3

Coverage Gap

- During this payment stage, *[Insert either: you (or others on your behalf) receive a discount on brand name drugs and you pay only 93% of the costs of generic drugs OR you receive limited coverage by the plan and a discount on brand name drugs. You (or others on your behalf) pay up to 93% of the costs of generic drugs.]*
- You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” (see Section 3) reaches \$*[insert TrOOP limit]*. When this happens,

STAGE 4

Catastrophic Coverage

- During this payment stage, the plan pays most of the cost for your covered drugs.
- You generally stay in this stage for the rest of the calendar year (through December 31, *[insert year]*).

name/tier level] drugs until you (or others on your behalf) have paid \$*[insert deductible amount]* for your *[brand-name/tier level]* drugs (\$*[insert deductible amount]* is the amount of your *[brand name/tier level]* deductible.)

[If the plan has a deductible for all tiers, insert the following two bullets.]

- You begin in this payment stage when you fill your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally stay in this stage until you have paid \$*[insert deductible amount]* for your drugs (\$*[insert deductible amount]* is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.

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.)

you move to payment stage 4, Catastrophic Coverage.

What happens next?

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

[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.)]

[If the plan has a brand-name/tier level deductible, insert the following two bullets.]

- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-name/tier level]* drugs until you (or others on your behalf) have paid \$*[insert*

STAGE 2

Initial Coverage

- *[Insert either: You begin in this payment stage when you fill your first prescription of the year. During this OR During this payment/* stage, the plan pays its share of the cost of your *[insert if applicable: generic/ tier levels]* drugs and you (or others on your behalf) pay your share of the cost.
- *[Insert if applicable: After you (or others on your behalf) have met your [brand-name/tier level] deductible, the plan pays its share of the cost of your [brand-name/tier level] drugs and you (or others on your behalf) pay your share of the cost.]*
- You generally stay in this

You are in this stage:

STAGE 3

Coverage Gap

- During this payment stage, *[Insert either: you (or others on your behalf) receive a discount on brand name drugs (and you pay only 93% of the costs of generic drugs. OR you receive limited coverage by the plan and a discount on brand name drugs. You (or others on your behalf) pay up to 93% of the costs of generic drugs.]*
- You generally 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 Section 3).

STAGE 4

Catastrophic Coverage

- During this payment stage, the plan pays most of the cost for your covered drugs.
- You generally stay in this stage for the rest of the calendar year (through December 31, *[insert year]*).

deductible amount] for your *[brand-name/tier level]* drugs (\$*[insert deductible amount]* is the amount of your *[brand name/tier level]* deductible.)

[If the plan has a deductible for all tiers, insert the following two bullets.]

- You begin in this payment stage when you fill your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally stay in this stage until you have paid \$*[insert deductible amount]* for your drugs (\$*[insert deductible amount]* is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.

stage until the amount of your year-to-date “total drug costs” reaches \$*[insert initial coverage limit]*. Then you move to payment stage 3, Coverage Gap.

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 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.)]

[If the plan has a brand-name/tier level deductible, insert the following two bullets.]

- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-name/tier level]* drugs until you (or others on your behalf) have paid \$*[insert deductible amount]* for your *[brand-name/tier level]* drugs (\$*[insert*

STAGE 2

Initial Coverage

- *[Insert either: You begin in this payment stage when you fill your first prescription of the year. During this OR During this payment]* stage, the plan pays its share of the cost of your *[insert if applicable: generic/ tier levels]* drugs and you (or others on your behalf) pay your share of the cost.
- *[Insert if applicable: After you (or others on your behalf) have met your* *[brand-name/tier level]* deductible, the plan pays its share of the cost of your *[brand-name/tier level]* drugs and you (or others on your behalf) pay your share of the cost.]
- You generally stay in this stage until the amount of your year-to-date “total

STAGE 3

Coverage Gap

- During this payment stage, *[Insert either: you (or others on your behalf) receive a discount on brand name drugs and you pay only 93% of the costs of generic drugs. OR you receive limited coverage by the plan and a discount on brand name drugs. You (or others on your behalf) pay up to 93% of the costs of generic drugs].*
- You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches \$*[insert TrOOP limit]*. Then you move to payment stage 4, Catastrophic Coverage.

You are in this stage:

STAGE 4

Catastrophic Coverage

- During this payment stage, the plan pays 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 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)”].*

deductible amount] is the amount of your *[brand name/tier level]* deductible.)

[If the plan has a deductible for all tiers, insert the following two bullets.]

- You begin in this payment stage when you fill your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally stay in this stage until you have paid \$*[insert deductible amount]* for your drugs (\$*[insert deductible amount]* is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.

drug costs” reaches \$*[insert initial coverage limit]*. Then you move to payment stage 3, Coverage Gap.

What happens next?

You generally 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 applicable to ALL tier levels, 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 begin in this payment stage when you fill your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally 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?

STAGE 2

Initial Coverage

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

- During this payment stage, the plan pays most of the cost for your covered drugs.
- You generally stay in this stage for the rest of the calendar year (through December 31, *[insert year]*).

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

[If the plan has a brand-name/tier level deductible, insert the following two bullets.]

You are in this stage:

STAGE 2

Initial Coverage

- *[Insert either: You begin in this payment stage when you fill your first prescription of the year. During this OR During this payment]* stage, the plan pays its share of the cost of your *[insert if applicable: generic/tier levels]* drugs and you (or others on your behalf, including “Extra Help” from Medicare) pay your share of the cost.
- *[Insert if applicable: After you (or others on your behalf) have met your [brand-name/tier level] deductible, the plan pays its share of the cost of your [brand-name/tier level] drugs and you (or others on your behalf) pay your share of the cost.]*
- You generally 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”

STAGE 3

Coverage Gap

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

STAGE 4

Catastrophic Coverage

- During this payment stage, the plan pays *[insert either: most of the cost for OR for all]* your covered drugs.
- You generally stay in this stage for the rest of the calendar year (through December 31, *[insert year]*).

- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-name/tier level]* drugs until you (or others on your behalf) have paid \$*[insert deductible amount]* for your *[brand-name/tier level]* drugs (\$*[insert deductible amount]* is the amount of your *[brand name/tier level]* deductible.) *[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.)]*

[If the plan has a deductible for all tiers, insert the following two bullets.]

- You begin in this payment stage when you fill your first prescription of the year. During this stage,

was \$*[insert year-to-date TrOOP]* (see definitions in Section 3).

you (or others on your behalf) pay the full cost of your drugs.

- You generally 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 (\$*[insert appropriate deductible amount for member with partial LIS]* is the amount of your deductible). Then you move 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 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.)]

[If the plan has a brand-name/tier level deductible, insert the following two bullets.]

STAGE 2

Initial Coverage

- *[Insert either: You begin in this payment stage when you fill your first prescription of the year. During this OR During this payment/ stage, the plan pays its share of the cost of your [insert if applicable: generic/tier levels] drugs and you (or others on your behalf, including “Extra Help” from Medicare) pay your share of the cost.*
- *[Insert if applicable: After you (or others on your behalf) have met your [brand-name/tier level] deductible, the plan pays its share of the cost of your [brand-name/tier level] drugs and you (or others on your behalf) pay your share of the cost.]*
- You generally stay in this

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

- During this payment stage, the plan pays *[insert either: most of the cost for OR for all]* your covered drugs.
- *[When applicable, plans should insert a brief explanation of what the member pays during this stage. For example: “For each prescription, you pay up to \$2.40 for a generic drug or a drug that is treated like a generic, and \$6.00 for all other drugs. OR you pay nothing.”].*

- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-name/tier level]* drugs until you (or others on your behalf) have paid \$*[insert deductible amount]* for your *[brand-name/tier level]* drugs (\$*[insert deductible amount]* is the amount of your *[brand name/tier level]* deductible.)

[If the plan has a deductible for all tiers, insert the following two bullets.]

- You begin in this payment stage when you fill your first prescription of the year. During this stage, you (or others on your behalf) pay the full cost of your drugs.
- You generally 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 (\$*[insert*

stage until the amount of your “out-of-pocket costs” reaches \$*[insert TrOOP limit]*. Then you move to payment stage 4, Catastrophic Coverage.

appropriate deductible amount for member with partial LIS] is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.

What happens next?

When you are in this payment stage, Catastrophic Coverage, you generally stay in it 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. 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)*)

[If applicable, insert the following text in every EOB after the inclusion of the prior plan’s balance transfer: “(This total includes \$(insert the TrOOP balance transferred from prior plan) in out-of-pocket costs from when you were in a different plan earlier this year.)”]

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)*)

[If applicable, insert the following text in every EOB after the inclusion of the prior plan’s balance transfer: “(This total includes \$(insert the Total Drug Costs balance transferred from prior plan) in total drug costs from when you were in a different plan earlier this year.)”]

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; Medicare’s Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs).

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.

\$(Insert only if the plan offers coverage of supplemental drugs)

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.]*
- Payments made for your drugs by any of the following programs or organizations: employer or union health plans; some government-funded programs, including TRICARE and the Veteran's Administration; Worker's Compensation; and some other programs.

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 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. (Changes to the formulary from one year to the next are announced in the ANOC and do not need to be included in the EOB.)*
- *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.)*
- *If an update is for a negative formulary change that is not a formulary maintenance change, insert: “If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.”]*

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.
- Unless noted otherwise, 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, injectable, 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 *[insert either: a different drug first OR one or more other drugs first]* before we will 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 *[insert either: this other drug does not OR the other drugs do 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 continue having this drug 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, injectable, 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 it.)

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?

If you have questions, call us

If something is confusing or doesn't look right on this monthly prescription drug summary, please call us at *[insert plan name]* Member Services (phone numbers are on the cover of this summary). *[If applicable:]* You can also find answers to many questions at our website: *[insert plan website URL]*

What about possible fraud?

Most health care professionals and organizations that provide Medicare services are honest. Unfortunately, there may be some who are dishonest.

If this monthly summary shows drugs you're not taking, or anything else that looks suspicious to you, please contact us.

- Call us at *[insert plan name]* Member Services (phone numbers are on the cover of this summary).
- 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 our plan's benefits booklet. 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 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 are on the cover of this summary).

Remember, to get your drug coverage under our plan you must use pharmacies in our network, except in certain circumstances. Also, quantity limitations and restrictions may apply.

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.]* 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 and how much you pay, it's called a “coverage decision.” If you disagree

with our coverage decision, 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.** You may be able to get Extra Help to pay for your prescription drug premiums and costs. 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. To see if you qualify for getting Extra 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. You can also call the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778. You can also call your State Medicaid Office.

- **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.