[Plan Name with Plan Type] is operated by
[Client Name]
[Address Line 1]
[Address Line 2]
[City], [State] [Zip code]

[Plan / Client / and/or Company Logo]

[Member First Name] [Middle Initial] [Member Last Name]
[Member Address Line 1]
[Member Address line 2]
[City], [State] [Zip code]

[mm/dd/yyyy]
Your member numbers are:
Member ID: [Member ID number]
Rx PCN: [MEDDADV/MEDDAET/ MEDDMCDMN]

Your Monthly Prescription Drug Summary

For *[Month, Year]*

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 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

Need large print or another format?
To get this material in other formats, or ask for language translation services, call [Plan Name] [Member/Customer/Participant Services] (the number is on this page).

For languages other than English:

[Español: [Customer Service/Other Phone number]]
[Other language: [Customer Service/Other Phone number]]

[Plan Name] [Member/Customer/ Participant Services]

If you have questions or need help, call us [Days and Hours of Operation]. Calls to these numbers are free.

[Customer Service Phone Number]

TTY users call: [TTY Number]
On the web at: [Website URL]

[Appropriate language as described in the Medicare Communications and Marketing Guidelines, including disclaimers, is expected to appear in this document.]

[MATERIAL ID]

SECTION 1. Your prescriptions during the past month

- Chart 1 shows your prescriptions for covered Part D drugs for the past month. [*If the plan has supplemental drug coverage, include Chart 2 in the EOB and print*: (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 and check to see that it's correct.** If you have any questions or think there is a mistake, Section 5 shows you what to do.
- **Drug Pricing Information (Drug Price & Price Change)**
  - The **Drug Price** shows the cost of each drug (including what you, your plan and other programs paid). The **Price Change** shows the percentage of the drug price since it was first filled during this benefit year.
  - There may be **Lower Cost Therapeutic Alternative drugs** (when applicable) listed below some of your current drugs. These are drugs that may be an alternative to the ones you are taking but with lower cost-sharing or a lower drug price. You may want to speak with your prescriber to see if the lower cost therapeutic alternative is right for you.

CHART 1.
Your prescriptions for covered Part D drugs
[Month, Year]

	Plan paid	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
[*If no Medicare Part D prescriptions were filled, print and Suppress totals for the month row*: No prescriptions for covered Part D drugs this month] **[Drug name strength form]** [Date of fill] [Pharmacy Name] [*If the pharmacy is out of network, print:* an out-of-network pharmacy] Rx# [#], [#] days' supply [This is a reversed claim] [This claim is a multi-ingredient compound drug. This drug may only be partially covered because it is a compound drug that may also include non-Part D drugs.] [Lower Cost Therapeutic Alternative: [Drug Name]]	$[x.xx]	$[x.xx]	$[x.xx] [$[x.xx] (paid by "Extra Help")] [$[x.xx] (paid by Medicare Coverage Gap Discount Program)] [$[x.xx] (paid by [other payer name])] [$[x.xx] (paid by other payer)]	$[x.xx] [+/-x.x]%

[*If Chart continues from one page to the next, print:* continue]

CHART 1. Your prescriptions for covered Part D drugs [Month, Year]	**Plan paid**	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
[*If Chart 1 contains affected drugs in Section 4, insert note for the applicable reason code(s)*: [*01 step therapy (Non-Maintenance Change, With Grandfathering Statement, 30 Day Advance Notice):* **NOTE:** Beginning on [date], step therapy will be required for this drug. See Section 4 for details.] [*02 quantity limits (Non-Maintenance Change, With Grandfathering Statement, 30 Day Advance Notice):* **NOTE:** Beginning on [date], there will be a new limit on the amount of the drug you can have. See Section 4 for details.] [*3A prior authorization (Non-Maintenance Change, With Grandfathering Statement, 30 Day Advance Notice):* **NOTE:** Beginning on [date], "prior authorization" will be required for this drug. See Section 4 for details.] [*3B prior authorization (Maintenance Change, No Grandfathering Statement, 30 Day Advance Notice):* **NOTE:** Beginning on [date], "prior authorization" will be required for this drug. See Section 4 for details.] [*4A name of brand-name drug that has been replaced with the addition of a new generic drug (New Generic Substitution, Immediate Effective Date, Retrospective Notice):* **NOTE:** Effective [date], this brand-name drug was				

[*If Chart continues from one page to the next, print:* continue]

CHART 1. Your prescriptions for covered Part D drugs [Month, Year]	**Plan paid**	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
replaced with a new generic drug. See Section 4 for details.] [*4B name of brand-name drug that will be replaced with a new generic drug (New Generic Substitution, Future Effective Date, Advance Notice):* **NOTE:** Effective [date], this brand-name drug will be replaced with a new generic drug. See Section 4 for details.] [*4C name of brand-name drug that will add a new restriction with the addition of a new generic drug (New Generic Substitution, Future Effective Date, Advance Notice):* **NOTE:** Effective [date], a "prior authorization" will be required for this brand-name drug with a newly added generic drug. See Section 4 for details.] [*4D name of brand-name drug that will be replaced with an existing generic drug (Maintenance Change, 30 Day Advance Notice):* **NOTE:** Effective [date], this brand-name drug will be replaced with a generic drug. See Section 4 for details.] [*5A name of drug for which cost-sharing increased, with the addition of a new generic (New Generic Substitution, Immediate Effective Date, Retrospective Notice):*				

[*If Chart continues from one page to the next, print:* continue]

CHART 1. Your prescriptions for covered Part D drugs [Month, Year]	**Plan paid**	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
NOTE: Effective [date], this brand-name drug moved to a higher cost-sharing tier, because a new generic drug was added. See Section 4 for details.] [*5B name of drug for which cost-sharing will increase, with the addition of a new generic (New Generic Substitution, Future Effective Date, Advance Notice):* **NOTE:** Effective [date], this brand-name drug will move to a higher cost-sharing tier, because a new generic drug will be added. See Section 4 for details.] [*5C name of drug for which cost-sharing will increase, with no replacement (Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice):* **NOTE:** Effective [date], this brand-name drug will move to a higher cost-sharing tier. See Section 4 for details.] [*06 Manufacturer discontinuation (Maintenance Change, Immediate Effective Date, Retrospective Notice):* **NOTE:** Effective [date], this drug is being removed from our Drug List as the manufacturer has discontinued the product. See Section 4 for details.] [*07 FDA unsafe (Maintenance Change, Immediate Effective Date, Retrospective Notice):* **NOTE:** Effective [date], this drug is being removed from our Drug List as the product has been deemed unsafe by the Food and Drug Administration and is being removed from the market. See Section 4 for details.]				

[*If Chart continues from one page to the next, print:* continue]

CHART 1. Your prescriptions for covered Part D drugs [Month, Year]	**Plan paid**	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
[*08 Part D Non eligible (Maintenance Change, Immediate Effective Date, Retrospective Notice):* **NOTE:** Effective [date], this drug is being removed from our Drug List as the product has been determined to be not eligible for Medicare Part D coverage. See Section 4 for details.] [*09 name of affected drug being replaced with alternative drug (Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice):* **NOTE:** Effective [date], this drug will be replaced by an alternative drug. See Section 4 for details.] [*10 name of affected drug due to formulary change (Maintenance Change, No Grandfathering Statement, 30-Day Advance Notice):* **NOTE:** Beginning on [date], there will be a formulary change to this drug. See Section 4 for details.] [*11 name of affected drug due to formulary change (Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice):* **NOTE:** Beginning on [date], there will be a formulary change to this drug. See Section 4 for details.]				

[*If Chart continues from one page to the next, print:* continue]

CHART 1. Your prescriptions for covered Part D drugs [Month, Year]	**Plan paid**	**You paid**	**Other payments** (made by programs or organizations; see Section 3)	**Drug Price & Price Change**
[TOTALS for the month of: [Month, Year]] **Your "out-of-pocket costs" amount is $[x.xx].** (This is the amount you paid this month ($[x.xx]) plus the amount of "other payments" made this month that count toward your "out-of-pocket costs" ($[x.xx]). See definitions in Section 3.) **Your "total drug costs" amount is $[x.xx].** (This is the total for this month of all payments made for your drugs by the plan ($[x.xx]) and you ($[x.xx]) plus "other payments" ($[x.xx]).)	$[x.xx] (total for the month)	$[x.xx] (total for the month) [(Of this amount, $[x.xx] counts toward your "out-of-pocket costs.")]	$[x.xx] (total for the month) [(Of this amount, $[x.xx] counts toward your "out-of-pocket costs." See definitions in Section 3.)]	Not Applicable

[*If Chart continues from one page to the next, print:* continue]

Year-to-date totals **[Plan Start date] through [End of data 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 $[x.xx]. **Your year-to-date amount for "total drug costs" is $[x.xx].** For more about "out-of-pocket costs" and "total drug costs," see Section 3. [**NOTE:** Your year-to-date totals shown here include payments of $[x.xx] in "out-of-pocket costs" and $[x.xx] in "total drug costs" made for your Part D covered drugs when you were in a different plan earlier this year.] [**NOTE:** The following adjustment has been made to amounts that were shown in a monthly summary sent to you earlier this [calendar/plan] year: Your year-to-date amount for "out-of-pocket costs" has been [increased/decreased] by $[x.xx] for the period [beginning date of plan year] through [EOB month] due to adjustments.] [**NOTE:** The following adjustment has been made to amounts that were shown in a monthly summary sent to you earlier this [calendar/plan] year: Your year-to-date amount for "total drug costs" has been [increased/decreased] by $[x.xx] for the period [beginning date of plan year] through [EOB month] due to adjustments.]	$[x.xx] (year-to-date total)	$[x.xx] (year-to-date total) [(Of this amount, $[x.xx] counts toward your "out-of-pocket costs.")]	$[x.xx] (year-to-date total) [(Of this amount, $[x.xx] counts toward your "out-of-pocket costs." See definitions in Section 3.)]

[*If Chart continues from one page to the next, print:* continue]

[**NOTE:** The following adjustments have been made to amounts that were shown in a monthly summary sent to you earlier this [calendar/plan] year: Your year-to-date amount for "out-of-pocket costs" has been [increased/decreased] by $[x.xx] for the period [beginning date of plan year] through [EOB month] due to adjustments. Your year-to-date amount for "total drug costs" has been [increased/decreased] by $[x.xx] for the period [beginning date of plan year] through [EOB month] due to adjustments.]			

[*If Chart continues from one page to the next, print:* continue]

CHART 2.

Your prescriptions for drugs covered by our plan's **Supplemental Drug Coverage**

[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)
[Drug name strength form] [Date of fill] [Pharmacy Name] [*If the pharmacy is out of network, print:* an out-of-network pharmacy] Rx# [#], [#] days' supply [This is a reversed claim] [This claim is a multi-ingredient compound drug]	$[x.xx]	$[x.xx]	$[x.xx] [$[x.xx] (paid by [other payer name])] [$[x.xx] (paid by other payer)]
Totals for the month of: [Month, Year]	$[x.xx]	$[x.xx]	$[x.xx]

These payments do not count toward your "out-of-pocket costs" or your "total drug costs" because they are for drugs that are not generally covered by Medicare. (See definitions in Section 3.)

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] 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 2	STAGE 3	STAGE 4
STAGE 1 **Yearly Deductible** [*If the plan has a deductible for all tiers, print*: • You begin in this payment stage when you fill your first prescription of the [calendar/plan] 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 $[Annual Front End Deductible]** for your drugs. ($[Annual Front End Deductible] is the amount of your deductible.) • As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs.]	**Initial Coverage** [*If the plan has a deductible for all tiers, and NOT only the amount paid for brand drugs counts towards the deductible (0), print*: • 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 $[Initial Coverage Limit Amount]. When this happens, you move to payment stage 3, Coverage Gap.]	**Coverage Gap** [*If the plan has no coverage through the Gap, or has coverage through the Gap for Generic Drugs (1) OR Brand Drugs (2), OR both Generic and Brand Drugs (3) print*: • During this payment stage, you (or others on your behalf) receive a 70% manufacturer's discount on covered brand-name drugs and the plan will cover [*insert if additional brand gap coverage:* "at least"] another 5%, so you will pay [*insert if additional brand gap coverage:* "less than"] 25% of the negotiated price on brand-name drugs. In addition you pay [*insert if*	**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/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

[*If the plan has a brand-name deductible and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs **until you (or others on your behalf) have paid $[Annual Front End Deductible]** for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)
- As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs in the deductible.]

[*If the plan has a deductible for all tiers, and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs.
- You generally pay the full cost of your tier [tier number(s)] level drugs **until you (or others on your behalf) have paid $[Annual Front End Deductible]** for your tier [tier number(s)] level drugs. ($[Annual

[*If the plan has a deductible for all tiers, and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name 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 $[Initial Coverage Limit Amount]. When this happens, you move to payment stage 3, Coverage Gap.
- As of [end date for the month], your year-to-date "total drug costs" were $[Year-to-date Total Drug Costs]. (See definitions in Section 3.)]

additional generic gap coverage: "less than"] 25% 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 $[Catastrophic Coverage Threshold]. When this happens, you move to payment stage 4, Catastrophic Coverage.]

[*If Chart continues from one page to the next, print:* continue]

Front End Deductible] is the amount of your tier [tier number(s)] level deductible.) • As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs in the deductible.]	[*If the plan has a deductible for all tiers, and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print*: • During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf) pay your share of the cost. • After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] 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 drug costs" (see Section 3) reaches $[Initial Coverage Limit Amount]. When this happens, you move to payment stage 3, Coverage Gap. • As of [end date for the month], your year-to-date "total drug costs" were		

[*If Chart continues from one page to the next, print:* continue]

What happens next? Once you (or others on your behalf) have paid **an additional $[additional amount needed to satisfy the deductible]** for your drugs, you move to the next payment stage (stage 2, Initial Coverage).	$[Year-to-date Total Drug Costs]. (See definitions in Section 3.)]		

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] 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** [*If the plan has no deductible, print:* (Because there is no deductible for the plan, this payment stage does not apply to you.)] [*If the plan has a deductible for all tiers and NOT only the amount paid for brand drugs counts towards the deductible (0), print:* • 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 $[Annual Front End	STAGE 2 **Initial Coverage** [*If the plan has no deductible, print:* • You begin in this payment stage when you fill your first prescription of the year. During this 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" reaches $[Initial Coverage Limit Amount].** As of [end date of month], your year-to-date "total drug costs" were **$[Year-to-date Total Drug Costs].** (See definitions in Section 3.)] [*If the plan has a deductible for all tiers and NOT only the amount paid*	STAGE 3 **Coverage Gap** [*If the plan has no coverage through the Gap, or has coverage through the Gap for Generic Drugs (1) OR Brand Drugs (2), OR both Generic and Brand Drugs (3) print:* • During this payment stage, you (or others on your behalf) receive a 70% manufacturer's discount on covered brand-name drugs and the plan will cover [*insert if additional brand gap coverage:* "at least"] another 5%, so you will pay [*insert if additional brand gap coverage:* "less than"] 25% of the negotiated price on brand-name drugs. In addition you pay [*insert if additional generic gap coverage:* "less than"] 25%	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/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

Deductible] for your drugs. ($[Annual Front End Deductible] is the amount of your deductible.) Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a brand-name deductible and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of

for brand drugs counts towards the deductible (0), print:

- 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" reaches $[Initial Coverage Limit Amount].** As of [end date of month], your year-to-date "total drug costs" were **$[Year-to-date Total Drug Costs].** (See definitions in Section 3.)]

[*If the plan has a brand-name deductible and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name 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-**

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 $[Catastrophic Coverage Threshold]. When this happens, you move to payment stage 4, Catastrophic Coverage.]

[*If Chart continues from one page to the next, print:* continue]

your tier [tier number(s)] level drugs.

- You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your tier [tier number(s)] level drugs. ($[Annual Front End Deductible] is the amount of your tier [tier number(s)] level deductible.)]

date "total drug costs" reaches $[Initial Coverage Limit Amount]. As of [end date of month], your year-to-date "total drug costs" were **$[Year-to-date Total Drug Costs].** (See definitions in Section 3.)]

[*If the plan has a deductible for all tiers and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print:*

- During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] 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 drug costs" reaches $[Initial Coverage Limit Amount].** As of [end date of month], your year-to-date "total drug costs" were **$[Year-to-date Total Drug Costs].** (See definitions in Section 3.)]

What happens next?

[*If Chart continues from one page to the next, print:* continue]

Once you have **an additional $[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, Coverage Gap).

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1 **Yearly Deductible**	STAGE 2 **Initial Coverage**	**You are in this stage:** STAGE 3 **Coverage Gap**	STAGE 4 **Catastrophic Coverage**
[*If the plan has no deductible, print:* (Because there is no deductible for the plan, this payment stage does not apply to you.)] [*If the plan has a deductible for all tiers and NOT only the amount paid for brand drugs counts towards the deductible (0), print:* • 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 $[Annual Front End Deductible] for your drugs. ($[Annual Front End	[*If the plan has no deductible, print:* • You begin in this payment stage when you fill your first prescription of the year. During this 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" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.] [*If the plan has a deductible for all tiers, and NOT only the amount paid for brand drugs counts towards the deductible (0), print:*	[*If the plan has no coverage through the Gap, or has coverage through the Gap for Generic Drugs (1) OR Brand Drugs (2), OR both Generic and Brand Drugs (3) print:* • During this payment stage, you (or others on your behalf) receive a 70% manufacturer's discount on covered brand-name drugs and the plan will cover [*insert if additional brand gap coverage:* "at least"] another 5%, so you will pay [*insert if additional brand gap coverage:* "less than"] 25% of the negotiated price on brand-name drugs. In addition you pay [*insert if additional generic gap coverage:* "less than"] 25% of the costs of generic drugs.	• 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/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

Deductible] is the amount of your deductible.) Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a brand-name deductible and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs.

- 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" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.]

[*If the plan has a deductible for all tiers, and only the amount paid for brand drugs counts towards the deductible (1), print*:

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name drugs and you (or others on your behalf) pay your share of the cost.
- You generally stay in this stage until the amount of

- You generally stay in this stage **until the amount of your year-to-date "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold].** As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP]** (see Section 3).]

[*If Chart continues from one page to the next, print:* continue]

- You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your tier [tier number(s)] level drugs. ($[Annual Front End Deductible] is the amount of your tier [tier number(s)] level deductible.)]

your year-to-date "total drug costs" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.]

[*If the plan has a deductible for all tiers, and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print*:

- During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] 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 drug costs" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.]

What happens next?

[*If Chart continues from one page to the next, print:* continue]

Once you (or others on your behalf) have paid **an additional $[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).

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] 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** [*If the plan has no deductible, print:* (Because there is no deductible for the plan, this payment stage does not apply to you.)] [*If the plan has a deductible for all tiers and NOT only the amount paid for brand drugs counts towards the deductible (0), print:* • 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 $[Annual Front End Deductible] for your drugs.	STAGE 2 **Initial Coverage** [*If the plan has no deductible, print:* • You begin in this payment stage when you fill your first prescription of the year. During this 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" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.] [*If the plan has a deductible for all tiers, and NOT only the amount paid for brand*	STAGE 3 **Coverage Gap** [*If the plan has no coverage through the Gap, or has coverage through the Gap for Generic Drugs (1) OR Brand Drugs (2), OR both Generic and Brand Drugs (3) print:* • During this payment stage, you (or others on your behalf) receive a 70% manufacturer's discount on covered brand-name drugs and the plan will cover [*insert if additional brand gap coverage:* "at least"] another 5%, so you will pay [*insert if additional brand gap coverage:* "less than"] 25% of the negotiated price on brand-name drugs. In addition you pay [*insert if additional generic gap coverage:* "less than"] 25%	STAGE 4 **Catastrophic Coverage** [*If the plan uses standard CMS Catastrophic copay only limits, print:* • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay up to $[Maximum co-payment for generic drug during catastrophic phase] for a generic drug or a drug that is treated like a generic, and $[Catastrophic Copay Limit Amount] for all other drugs.] [*If the plan uses standard CMS Catastrophic 5% limits, print:* • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost

[*If Chart continues from one page to the next, print:* continue]

($[Annual Front End Deductible] is the amount of your deductible.) Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a brand-name deductible and only the amount paid for brand drugs counts towards the deductible (1), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print:*

- During this payment stage, you (or others on your behalf) pay the full cost of

drugs counts towards the deductible (0), print:

- 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" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.]

[*If the plan has a deductible for all tiers, and only the amount paid for brand drugs counts towards the deductible (1), print*:

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name drugs and you (or others on

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 $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]

of the drug (this is called "coinsurance"), or a copayment ($[Maximum co-payment for generic drug during catastrophic phase] for a generic drug or a drug that is treated like a generic, $[Catastrophic Copay Limit Amount] for all other drugs).]

[*If the plan uses alternative CMS Catastrophic limits, print:*

- During this payment stage, the plan pays most of the cost for your covered drugs.
- For additional copayment information, please refer to your Evidence of Coverage (EOC).]

[*If Chart continues from one page to the next, print:* continue]

your tier [tier number(s)] level drugs. • You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your tier [tier number(s)] level drugs. ($[Annual Front End Deductible] is the amount of your tier [tier number(s)] level deductible.)]	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" reaches $[Initial Coverage Limit Amount]. Then you move to payment stage 3, Coverage Gap.] [*If the plan has a deductible for all tiers, and Formulary Tiers determine whether amount paid by member counts towards deductible (2), print*: • During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf) pay your share of the cost. • After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] 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		

[*If Chart continues from one page to the next, print:* continue]

	drug costs" reaches $[Initial Coverage Limit Amount]. 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/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] 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 2	STAGE 3	STAGE 4
STAGE 1 **Yearly Deductible** [*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*: • 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 $[Annual Front End Deductible]** for your drugs. • As of [end date of month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs.] [*If the plan has a deductible for all tiers, that is higher than the partial subsidy*	**Initial Coverage** [*If the plan has a deductible for all tiers, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*: • 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 $[Catastrophic Coverage Threshold]. When this happens, you move to	**Coverage Gap** (Because you are receiving "Extra Help" from Medicare, this payment stage does not apply to you.)	**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/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

deductible limit, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print:

- 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 $[deductible amount for member with partial LIS]** for your drugs. (The plan deductible is usually $[Annual Front End Deductible], but you pay $[deductible amount for member with partial LIS] because you are receiving "Extra Help" from Medicare.)
- As of [end date of month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs.]

[*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs **until you (or others** payment stage 4, Catastrophic Coverage.]

[*If the plan has a deductible for all tiers, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name 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 $[Catastrophic Coverage Threshold]. When this happens, you move to

[*If Chart continues from one page to the next, print:* continue]

on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. $[Annual Front End Deductible] is the amount of your brand-name deductible. • As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs in the deductible.] [*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*: • During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs. • You generally pay the full cost of your brand-name drugs **until you (or others on your behalf) have paid $[deductible amount for member with partial LIS]** for your brand-name drugs. $[deductible amount for member with partial LIS] is the amount of your brand-name deductible. (The plan deductible is usually $[Annual Front End Deductible], but you pay $[deductible amount for member with partial LIS] because you are receiving "Extra Help" from Medicare.) • As of [end date for the month], you have paid **$[Year-to-date Deductible**	payment stage 4, Catastrophic Coverage. • As of [end date for the month], your year-to-date "out-of-pocket costs" were $[Year-to-date TrOOP]. (See definitions in Section 3.)] [*If the plan has a deductible for all tiers, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*: • During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost. • After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier		

[*If Chart continues from one page to the next, print:* continue]

Total Drug Costs] for your drugs in the deductible.] [*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*: • During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs. • You generally pay the full cost of your tier [tier number(s)] level drugs **until you (or others on your behalf) have paid $[deductible amount for member with partial LIS]** for your tier [tier number(s)] level drugs. $[deductible amount for member with partial LIS] is the amount of your tier [tier number(s)] level deductible. (The plan deductible is usually $[Annual Front End Deductible], but you pay $[deductible amount for member with partial LIS] because you are receiving "Extra Help" from Medicare.)] • As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs in the deductible.] [*If the plan has a deductible for all tiers, that is lower or equal the partial subsidy*	number(s)] 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 $[Catastrophic Coverage Threshold]. When this happens, you move to payment stage 4, Catastrophic Coverage. • As of [end date for the month], your year-to-date "out-of-pocket costs" were $[Year-to-date TrOOP]. (See definitions in Section 3.)]		

[*If Chart continues from one page to the next, print:* continue]

deductible limit, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print:

- During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs.
- You generally pay the full cost of your tier [tier number(s)] level drugs **until you (or others on your behalf) have paid $[Annual Front End Deductible]** for your tier [tier number(s)] level drugs. $[Annual Front End Deductible] is the amount of your tier [tier number(s)] level deductible.
- As of [end date for the month], you have paid **$[Year-to-date Deductible Total Drug Costs]** for your drugs in the deductible.]

What happens next?

Once you (or others on your behalf) have paid **an additional $[additional amount needed to satisfy the deductible]** for your drugs, you move to the next payment stage (stage 2, Initial Coverage).

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*Use the following version of Section 2 for members with LIS who are in the initial coverage stage*]

SECTION 2. Which "drug payment stage" are you in?

As shown below, your Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] 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

[*If the LIS level is 1, 2 or 4 and the plan has no deductible, print*:
(Because there is no deductible for the plan, this payment stage does not apply to you.)]

[*If the LIS level is 1 or 2 and the plan has a deductible print*: (Because you are receiving "Extra Help" from Medicare, this payment stage does not apply to you.)]

[*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*:

STAGE 2
Initial Coverage

[*If the LIS level is 1, 2 or 4 and the plan has no deductible, print*:

- You begin in this payment stage when you fill your first prescription of the year. During this 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 $[Catastrophic Coverage Threshold].** As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP].** (See definitions in Section 3.)]

[*If the LIS level is 1 or 2 and the plan has a deductible print*:

STAGE 3
Coverage Gap

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

STAGE 4
Catastrophic Coverage

[*If the LIS level is 1 or 2, print*:

- During this payment stage, the plan pays for all your covered drugs.
- You generally stay in this stage for the rest of the [calendar/plan] year (through [December 31, 2022]).]

[*If the LIS level is 4, print*:

- 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/plan] year (through [December 31, 2022]).]

[*If Chart continues from one page to the next, print:* continue]

- 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 $[Annual Front End Deductible] for your drugs ($[Annual Front End Deductible] is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*:

- 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 begin in this payment stage when you fill your first prescription of the year. During this 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 $[Catastrophic Coverage Threshold].** As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP].** (See definitions in Section 3.)]

[*If the plan has a deductible for all tiers, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*:

- 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-**

[*If Chart continues from one page to the next, print:* continue]

- You generally stay in this stage until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your drugs ($[deductible amount for member with partial LIS] is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your brand-name drugs. ($[deductible amount for member with partial LIS] is the amount of your

date "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP].** (See definitions in Section 3.)]

[*If the plan has a deductible for all tiers, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name 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 $[Catastrophic Coverage Threshold].** As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP].** (See definitions in Section 3.)]

[*If Chart continues from one page to the next, print:* continue]

brand-name deductible.) (The plan deductible is usually $[Annual Front End Deductible], but you pay $[deductible amount for member with partial LIS] because you are receiving "Extra Help" from Medicare.)]

[*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers, that is higher*

[*If the plan has a deductible for all tiers, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] 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 $[Catastrophic Coverage Threshold].** As of [end date of month], your year-to-date "out-of-pocket costs" were **$[Year-to-date TrOOP].** (See definitions in Section 3.)]

[*If Chart continues from one page to the next, print:* continue]

than the partial subsidy deductible limit, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print:

- During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs.
- You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your tier [tier number(s)] level drugs. ($[deductible amount for member with partial LIS] is the amount of your tier [tier number(s)] level deductible.) (The plan deductible is usually $[Annual Front End Deductible], but you pay $[deductible amount for member with partial LIS] because you are receiving "Extra Help" from Medicare.)]

[*If Chart continues from one page to the next, print:* continue]

[*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs.
- You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your tier [tier number(s)] level drugs. ($[Annual Front End Deductible] is the amount of your tier [tier number(s)] level deductible.)]

What happens next?

Once you (or others on your behalf) have paid **an additional $[amount needed in additional TrOOP to meet the TrOOP limit] in "out-of-pocket costs"** for your drugs, you move to the

[*If Chart continues from one page to the next, print:* continue]

next payment stage (stage 4, Catastrophic Coverage).

[*If Chart continues from one page to the next, print:* continue]

[*If the member is in LICS 3, Section 2 is suppressed and any other section reference will be renumbered*]
[*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 Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the [calendar/plan] year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1 **Yearly Deductible**	STAGE 2 **Initial Coverage**	STAGE 3 **Coverage Gap**	**You are in this stage:** STAGE 4 **Catastrophic Coverage**
[*If the LIS level is 1, 2 or 4 and the plan has no deductible, print*: (Because there is no deductible for the plan, this payment stage does not apply to you.)] [*If the LIS level is 1 or 2 and the plan has a deductible print*: (Because you are receiving "Extra Help" from Medicare, this payment stage does not apply to you.)] [*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, NOT only the amount paid for brand drugs counts towards the*	[*If the LIS level is 1, 2 or 4 and the plan has no deductible, print*: • You begin in this payment stage when you fill your first prescription of the year. During this 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 "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]	(Because you are receiving "Extra Help" from Medicare, this payment stage does not apply to you.)	[*If the LIS level is 1 or 2, print*: • During this payment stage, the plan pays for all your covered drugs. • For each prescription, you pay nothing.] [*If the LIS level is 4 and the plan uses standard CMS Catastrophic limits, print*: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay up to $[Maximum co-payment for generic drug during catastrophic phase] for a generic drug or a drug that is treated like a generic, and $[Catastrophic Copay Limit Amount] for all other drugs.]

[*If Chart continues from one page to the next, print:* continue]

deductible (0) and LIS level is 4, print:

- 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 $[Annual Front End Deductible] for your drugs ($[Annual Front End Deductible] is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*:

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

[*If the LIS level is 1 or 2 and the plan has a deductible print*:

- You begin in this payment stage when you fill your first prescription of the year. During this 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 "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]

[*If the plan has a deductible for all tiers, NOT only the amount paid for brand drugs counts towards the deductible (0) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your drugs and you (or others

[*If the LIS level is 4 and the plan uses alternative CMS Catastrophic limits, print*:

- During this payment stage, the plan pays most of the cost for your covered drugs.
- For additional copayment information, please refer to your Evidence of Coverage (EOC).]

[*If Chart continues from one page to the next, print:* continue]

behalf) pay the full cost of your drugs.

- You generally stay in this stage until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your drugs ($[deductible amount for member with partial LIS] is the amount of your deductible). Then you move to payment stage 2, Initial Coverage.]

[*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your brand-name drugs. ($[deductible

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 "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]

[*If the plan has a deductible for all tiers, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your generic drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- After you (or others on your behalf) have met your brand-name deductible, the plan pays its share of the cost of your brand-name drugs and you (or others on

[*If Chart continues from one page to the next, print:* continue]

amount for member with partial LIS] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, only the amount paid for brand drugs counts towards the deductible (1) and LIS level is 4, print*:

- During this payment stage, you (or others on your behalf) pay the full cost of your brand-name drugs.
- You generally pay the full cost of your brand-name drugs until you (or others on your behalf) have paid $[Annual Front End Deductible] for your brand-name drugs. ($[Annual Front End Deductible] is the amount of your brand-name deductible.)]

[*If the plan has a deductible for all tiers, that is higher than the partial subsidy deductible limit, Formulary Tiers determine whether amount paid by member counts towards* your behalf) pay your share of the cost.

- You generally stay in this stage until the amount of your "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]

[*If the plan has a deductible for all tiers, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*:

- During this payment stage, the plan pays its share of the cost of your tier [initial tier number(s)] level drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- After you (or others on your behalf) have met your tier [tier number(s)] level deductible, the plan pays its share of the cost of your tier [tier number(s)] level drugs and you (or others on

[*If Chart continues from one page to the next, print:* continue]

deductible (2) and LIS level is 4, print: • During this payment stage, you (or others on your behalf) pay the full cost of your tier [tier number(s)] level drugs. • You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[deductible amount for member with partial LIS] for your tier [tier number(s)] level drugs. ($[deductible amount for member with partial LIS] is the amount of your tier [tier number(s)] level deductible.)] [*If the plan has a deductible for all tiers, that is lower or equal to the partial subsidy deductible limit, Formulary Tiers determine whether amount paid by member counts towards deductible (2) and LIS level is 4, print*: • During this payment stage, you (or others on your behalf) pay the full cost of	your behalf) pay your share of the cost. • You generally stay in this stage until the amount of your "out-of-pocket costs" reaches $[Catastrophic Coverage Threshold]. Then you move to payment stage 4, Catastrophic Coverage.]		

[*If Chart continues from one page to the next, print:* continue]

your tier [tier number(s)] level drugs. • You generally pay the full cost of your tier [tier number(s)] level drugs until you (or others on your behalf) have paid $[Annual Front End Deductible amount] for your tier [tier number(s)] level drugs. ($[Annual Front End Deductible amount] is the amount of your tier [tier number(s)] level deductible.)]			**What happens next?** When you are in this payment stage, Catastrophic Coverage, you generally stay in it for the rest of the [calendar/plan] year (through [December 31, 2022]).

[*If Chart continues from one page to the next, print:* continue]

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"

$[TrOOP for month] month of [name of month], [year]

$[Year-to-date TrOOP] year-to-date (since [start of plan year])

[(This total includes $[TrOOP balance transferred from prior plan] in "out-of-pocket 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).

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), [*If the Non-Medicare Drug Coverage Plan Setting is enabled*: 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.]

Your "total drug costs"

$[Total Drug Costs for month] month of [name of month], [year]

$[Year-to-date Total Drug Costs] year-to-date (since [start of plan year])

[(This total includes $[Total Drug Costs balance transferred from prior plan] in "total drug costs" from when you were in a different plan earlier this year.)]

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.

[*If the Non-Medicare Drug Coverage Plan Setting is enabled, print:* **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."]

[*If Chart continues from one page to the next, print:* continue]

• 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 Veterans Administration; Workers' Compensation; and some other programs.	

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).

[*If Chart continues from one page to the next, print:* continue]

SECTION 4. Updates to the plan's Drug List that affect drugs you take

[If there are no updates, print the following as a replacement for all of the text that follows in this section:

- At this time, there are no new or 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 [Year] as a member of our plan.)]

About the Drug List and our updates

[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 ([Website URL]) is always the most current. Or call [Plan Name] [Member/Customer/Participant 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 [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, following Medicare rules, 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.

- Some changes to the Drug List may happen immediately:
  - We may immediately replace a brand name drug with a new generic that will appear on the same or lower cost-sharing tier and with the same or lower restrictions. Or we may immediately add the new generic and add new restrictions to the brand name drug or move it to a different cost-sharing tier.
  - We will immediately remove drugs from our Drug List for safety reasons or when manufacturers remove them from the market.
- For all other changes to drugs you take, you will have at least 30 days' notice before any changes take effect.

Updates that affect drugs you take

The list that follows tells *only* about updates to the Drug List that 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 [Year] as a member of our plan.)

[01 name of step therapy drug]
(Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)

- ***Date and type of change:*** Beginning [date of change], "step therapy" will be required for this drug. This means you will be required to try 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 [name of step therapy drug]. If the other drugs do not work for you, the plan will then cover [name of step therapy drug]. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug

applies: **Consult your Health Care Provider for alternative drugs.**]

- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.

[02 name of quantity limits drug] ***(Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)***

- ***Date and type of change:*** Beginning [date of change], there will be a new limit on the amount of the drug you can have. [Description of change.] [Reason for change.]
- ***Note:*** See the information below that tells "What you and your doctor can do."
- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.

[3A name of prior authorization drug] ***(Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)***

- ***Date and type of change:*** Beginning [date of 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. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." Your choices include asking for prior authorization in order to continue having this drug covered or changing to a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]
- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.

[3B name of prior authorization drug] ***(Maintenance Change, No Grandfathering Statement, 30-Day Advance Notice)***

- ***Date and type of change:*** Beginning [date of change], "prior authorization" is 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. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." Your choices include asking for prior authorization in order to continue having this drug covered or changing to a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]

[4A name of brand-name drug that has been replaced with the addition of a new generic drug] ***(New Generic Substitution, Immediate Effective Date, Retrospective Notice)***

- ***Date and type of change:*** Effective [date of the change], the brand-name drug [name of brand-name drug] [, tier #] was removed from our Drug List, because we added a new generic

version of [name of brand-name drug] [, tier #] to the Drug List (it is called [alternative generic drug name] [, tier #]).

- The amount you will pay for [name of alternative generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of alternative generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).
- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[4B name of brand-name drug that will be replaced with a new generic drug] ***(New Generic Substitution, Future Effective Date, Advance Notice)***

- ***Date and type of change:*** Effective [date of the change], the brand-name drug [name of brand-name drug] [, tier #] will be removed from our Drug List, because we will add a new generic version of [name of brand-name drug] [, tier #] to the Drug List (it is called [alternative generic drug name] [, tier #]).
- The amount you will pay for [name of alternative generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of alternative generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).
- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[4C name of brand-name drug that will add a new restriction with the addition of a new generic drug] ***(New Generic Substitution, Future Effective Date, Advance Notice)***

- ***Date and type of change:*** Effective [date of the change], the brand-name drug [name of brand-name drug] [, tier #] will require a "prior authorization" because a new generic version of [name brand-name drug] will be added to the Drug List (it is called [alternative generic drug name] [, tier #]).
- The amount you will pay for [name of alternative generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of alternative generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).
- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[4D name of brand-name drug that will be replaced with an existing generic drug] ***(Maintenance Change, 30-Day Notice)***

- ***Date and type of change:*** Effective [date of the change], the brand-name drug [name of brand-name drug] [, tier #] will be removed from our Drug List, because we will add a generic version of [name of brand-name drug] [, tier #] to the

Drug List (it is called [alternative generic drug name] [, tier #]).

- The amount you will pay for [name of alternative generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of alternative generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).
- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[5A name of drug for which cost-sharing increased, with the addition of a new generic drug] *(New Generic Substitution, Immediate Effective Date, Retrospective Notice)*

- ***Date and type of change:*** Effective [date of change], the brand-name drug [name of brand-name drug for which cost-sharing has increased] was moved from tier [X] to a higher cost-sharing tier (tier [Y]), because we have added a new generic version of [name of brand-name drug] to the Drug List (it is called [alternative generic drug name] [, tier #]).

- The amount you will pay for [name of new alternative generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of new alternative generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).

- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[5B name of drug for which cost-sharing will increase, with the addition of a new generic drug] *(New Generic Substitution, Future Effective Date, Advance Notice)*

- ***Date and type of change:*** Effective [date of change], the brand-name drug [name of drug for which cost-sharing will increase] will move from tier [X] to a higher cost-sharing tier (tier [Y]), because we will add a new generic version of [name of brand-name drug replaced with generic] to the Drug List (it is called [alternative generic drug name] [, tier #]).

- The amount you will pay for [name of generic drug] depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay for the [name of generic drug], please call us at [Plan Name] [Member/Customer/Participant Services] (our phone numbers and calling hours are on the cover).

- If your prescriber believes this generic drug is not right for you due to your medical condition, you or your prescriber can ask us to make an exception. See the information later in this section that tells "What you and your doctor can do."

[5C name of drug for which cost-sharing will increase, with no replacement] *(Non-*

Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)

- ***Date and type of change:*** Effective [date of change], [name of drug for which cost-sharing will increases] will move from tier [X] to a higher cost-sharing tier (tier [Y]). The amount you will pay for this drug depends on the drug tier and which drug payment stage you are in when you fill the prescription. To find out how much you will pay, please call us at [Plan Name] [Member/Customer/Participant 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." You and your doctor may want to consider trying a formulary alternative: [alternative drug name] [, tier #]. [Reason for change.]

- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.

[06 name of affected manufacturer discontinued drug] ***(Maintenance Change, Immediate Effective Date, Retrospective Notice)***

- ***Date and type of change:*** Effective [date of change], the drug [affected manufacturer discontinued drug] is being removed from our Drug List as the manufacturer has discontinued the product. We will continue to cover the drug until [date of change]. [Description of change.] [Reason for change.]

- ***Note:*** Because this drug has been removed from the market, we may immediately remove the drug from the Drug List and notify affected members as soon as possible. See the information later in this section that tells "What you and your doctor can do."

- ***Note:*** Please see your doctor as soon as possible for an alternative drug. You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]

[07 name of affected FDA unsafe drug] ***(Maintenance Change, Immediate Effective Date, Retrospective Notice)***

- ***Date and type of change:*** Effective [date of change], the drug [affected FDA unsafe drug] is being removed from our Drug List as the product has been deemed unsafe by the Food and Drug Administration and is being removed from the market. [Description of change.] [Reason for change.]

- ***Note:*** Because this drug has been deemed unsafe and removed from the market, we may immediately remove the drug from the Drug List and notify affected members as soon as possible. See the information later in this section that tells "What you and your doctor can do."

- ***Note:*** Please see your doctor as soon as possible for an alternative drug. You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]

- If you are taking this medication, you should ask your doctor if you still need treatment or to determine if discontinuing this medication is an option for you. Remember, **you should not stop taking your medication unless directed by your doctor**.

[08 name of affected not eligible Part D drug] *(Maintenance Change, Immediate Effective Date, Retrospective Notice)*

- ***Date and type of change:*** Effective [date of change], the drug [affected not eligible Part D drug] is being removed from our Drug List and/or will no longer be covered by the Medicare Part D drug benefit as the product has been determined to be not eligible for Medicare Part D coverage. [Description of change.] [Reason for change.]
- ***Note:*** Because this drug is not eligible for Medicare Part D coverage, you are being notified as an affected beneficiary that this drug will no longer be covered.
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." Please see your doctor for an alternative drug. You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]

[09 name of affected drug being replaced with alternative drug] (*Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)*

- ***Date and type of change:*** Effective [date of the change], the drug, [name of affected drug] will be removed from our Drug List and replaced by another drug [: alternative drug name]. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #].
- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.

[10 name of affected drug due to formulary change] (*Maintenance Change, No Grandfathering Statement, 30-Day Advance Notice)*

- ***Date and type of change:*** Effective [date of the change], a formulary change is being made to the drug [name of affected drug]. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]

[11 name of affected drug due to formulary change] (*Non-Maintenance Change, With Grandfathering Statement, 30-Day Advance Notice)*

- ***Date and type of change:*** Effective [date of the change], a formulary change is being made to the drug [name of Affected drug]. [Description of change.] [Reason for change.]
- ***Note:*** See the information later in this section that tells "What you and your doctor can do." You and your doctor may want to consider trying a formulary alternative [: alternative drug name] [, tier #]. [If no alternative drug applies: **Consult your Health Care Provider for alternative drugs.**]
- If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.
- **What you and your doctor can 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 [Plan Name] [Member/Customer/Participant 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 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* [*insert as applicable:*] that we sent to you *OR [insert if plan/Part D sponsor meets the conditions and is relying on notification of electronic availability pursuant to 42 CFR § 423.2267]* which is posted on our website at [Website URL]. Look for Chapter [7]/[9], *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. The Evidence of Coverage is also posted on our website at [Website URL].)

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 [Plan Name] [Member/Customer/Participant Services] (phone numbers are on the cover of this summary). You can also find answers to many questions on our website: [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 [Plan Name] [Member/Customer/Participant 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

[*If the LIS level is 0, print*:

Your "Evidence of Coverage" has 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.

We have sent you a copy of the *Evidence of Coverage*. This document is also available on our website: [Website URL]. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy, please call us [Plan Name] [Member/Customer/Participant Services] (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.]

[*If the LIS level is 1, 2, 3 or 4 print*:

Your "Evidence of Coverage" 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. 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* and *LIS Rider*. These documents are also available on our website: [Website URL]. You may also elect to receive the *Evidence of Coverage* electronically, please contact us if you would like to change your method of delivery. If you need another copy of either of these, please call us [Plan Name] [Member/Customer/Participant Services] (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:

- Chapter [5]/[7]. Asking the plan to pay its share of a bill you have received for covered services or drugs.
- Chapter [7]/[9]. 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 Chapter [7]/[9] 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 take place 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 [Plan Name] [Member/Customer/Participant 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?

[Nuxeo/Oracle ID]

- **"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 [#] of your *Medicare & You* [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*.