[DATE]

Member ID: [F54]

[F101]

[F109]

[F8] [F9] [F10]

[F102]

[F103]

[F104] [F105] [F106]-[F107]

[(If F36=835 or 836 populate)**FINAL NOTICE]**

Dear [F8] [F9] [F10]:

[(If F36=831 or 836 populate)You recently enrolled in [PlanName] prescription drug plan, and Medicare’s records show that you may owe a Part D late enrollment penalty.

Prior to enrolling in [PlanName], it appears that you had a break in prescription drug coverage from [F90] to [F91]. If you did not have prescription drug coverage during this time period that met Medicare’s minimum standards, you will owe a penalty on your monthly premiums. If you did have prescription drug coverage during this time period, you may be able to avoid the penalty by returning the enclosed form.]

[(If F36=830 or 835 populate)Prior to enrolling in [PlanName], it appears that you did not have prescription drug coverage that met Medicare’s minimum standards. If your records show that you did have prescription drug coverage from [F90] to [F91], you may be able to avoid paying the monthly penalty by returning the enclosed form.]

Please complete the enclosed form and return it immediately to SilverScript Insurance Company, [ReturnEnrollAddress2], [ReturnEnrollCity], [ReturnEnrollState] [ReturnEnrollZip], or call us at 1-855-559-6434 (TTY: [CustomerCareTTY]), [CustomerCareHours], to provide us with the information by [ReturnMailDate].

If you don’t contact SilverScript® Insurance Company by [ReturnMailDate], we will assume the above information is correct and you will owe a Part D late enrollment penalty.

Thank you,

SilverScript Insurance Company