Model Monthly Drug Claim EOB

## Instructions to Health Plans

**NOTE: Do not include these instruction pages when you send EOBs to beneficiaries.**

This is a model Explanation of Benefits (EOB) for monthly reporting of drug claims only.

Plans are not required to send an EOB if the beneficiary has no drug claims in the reporting period.

**Claims that must be included within the EOB**

* Insert Part D drug claims and non-Part D (Medicaid) drug and non-Part D (Medicaid) over-the-counter product claims from all pharmacy settings (mail order, retail, LTC) in the Drug Claims section (Section A). Note that Part A and Part B drug claims should not be included.
* Drug claim information must include the name of the drug, followed by quantity, strength and form (for example: 25 mg tabs) and the name of the pharmacy.
* Prior-year fills that do not apply to the current EOB do not need to be included in this EOB and do not require a separate EOB.
* Plans must include all drug claims processed during the reporting period. Any benefit information that cannot be included timely must be accounted for in a following reporting period.

**Instructions within the template**

* Italicized blue text in square brackets is information for the plans. Do not include it in the EOB.
* Non-italicized blue text in square brackets is text that can be inserted or used as replacement text in the EOB. Use it as applicable.
* The first time the plan name is mentioned, the plan type designation “(Medicare-Medicaid Plan)” must be included after the plan name, as detailed in the State’s marketing guidance for Medicare-Medicaid Plans.
* When instructions say to insert the month and year, spell out the full name of the month (for example: January 2015).

**Permissible document alterations**

* Plans should add Medicaid-specific language where appropriate.
* Minor grammar or punctuation changes are permissible.
* References to “year” or “calendar year” may be changed to “plan year.”
* Plans should make every effort to use a reporting period that aligns with a complete calendar month. However, if your plan uses a reporting period that does not correspond exactly to a calendar month, you may substitute the date range for your reporting period (for example: 1/1/15 to 2/3/15 **or** January 1 – February 3, 2015) whenever instructions say to insert the month and year.

**Formatting**

* Changes to the font type and/or font color are only permissible if such changes comply with Section 508 requirements.
* With the exception of charts, which should generally be in landscape formation, either landscape or portrait page format may be used.
* With the exception of Section A, the remaining sections of the document are to be formatted as two-column or three-column text to keep line lengths easy to read. (The main title of a section may extend beyond the first column.) Plans may adjust the width of the columns in the template.
* To help conserve paper, the document can be printed double-sided.
* The document must have a header or footer that includes the page number. If desired, plans may also include any of the following information in the header or footer: Participant identifiers, month and year, title of the document. The marketing material ID must appear in the header or footer on the first page only.
* Charts that continue from one page to the next should be marked with “continue” at the bottom on the page. An individual row of a chart should not break across pages. (In the model language in this document, rows sometimes break across pages because of instructions and substitution text.)
* Unless specific formatting instructions for dates have been given, plans may use their preferred method of formatting the date (for example, “mm/dd/yy”).

**Participant disenrollment**

* When a beneficiary disenrolls from the plan during the plan year, the plan must send an EOB to the beneficiary after disenrollment if any drug claims are processed prior to the beneficiary disenrolling. For example, if a beneficiary disenrolls at the end of August and the plan processes claims in months prior to disenrollment, the disenrolling plan must send the beneficiary a final EOB.

**HPMS submission**

* Prior to use, all plans must upload an EOB in HPMS under the material code and review process outlined for that specific State.

<Plan name>

Explanation of Benefits

A summary of your drug claims for [insert month and year or date range]

[Insert mailing date]

**For <Participant name>**

[Plans may also insert a Participant’s mailing address, Participant ID number, and/or other information typically used in Participant communications. Do not use complete HICN.]

**This is not a bill.**

[Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

This Explanation of Benefits (EOB) is a summary of claims (bills) sent to <plan name> for drugs you received during [insert month and year **or** date range]. The EOB tells you what we paid pharmacies.

#### Disclaimers

Limitations and restrictions may apply. For more information, call <plan name> Participant Services or read the <plan name> Participant Handbook.

Benefits, List of Covered Drugs*,* and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year. [Plans that do not renew on January 1, revise date as needed.]

###### Languages other than English

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. [The preceding sentence must be in English and in all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]

###### Other formats

You can ask for this Explanation of Benefits in other formats, such as Braille or large print. Call Participant Services at <toll-free number>, <days and hours of operation>.

###### Need help?

If you have questions, call us at <toll-free number>. We are here <days and hours of operation>. TTY/TDD only: <TTY/TDD number>.

You can also find information in your Participant Handbook or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

The State of New York has created a Participant Ombudsman Program to provide Participants free, confidential assistance on any services offered by <plan name>. The Participant Ombudsman may be reached toll-free at <toll-free number> or online at <website URL>.

#### How to use this Explanation of Benefits

Please check it over carefully.

* **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
* **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call <plan name> Participant Services or read the <plan name> Participant Handbook.

#### What if you see mistakes on this summary?

If something is confusing or doesn’t look right on this Explanation of Benefits, please call us at <plan name> Participant Services. [If applicable: You can also find answers to many questions on our website: <web address>.]

#### What about possible fraud?

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

* Call us at <plan name> Participant Services.
* 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.
* [Plans may also insert additional State-based resources for reporting fraud.]

# Your drug claims for [insert month and year or date range]

[Drug claims in this section should not include Part A or Part B drug claims.]

**NOTE:** The amount in the “plan’s share” column includes payments made for you by Extra Help for Medicare Part D drugs. Extra Help is a Medicare program that helps you pay prescription drug costs. [Insert if applicable: The “plan’s share” column also includes payments made for you by <names(s) of other programs or organizations>.]

| [Plans should include the name of the pharmacy. Plans may add the location of the pharmacy and other additional pharmacy information (for example: Non-network pharmacy), if desired.] | Date(s) of service  The date(s) you received the drugs | Plan’s share  The amount <plan name> pays for the drugs | Your share  The amount you may need to pay for the drugs |
| --- | --- | --- | --- |
| [**Insert name of drug (other than compound) followed by quantity, strength, and form (for example: 25 mg tabs). Identify compound drugs as such and provide quantity.**]  [Insert prescription number], [insert amount dispensed as quantity filled and/or days’ supply (for example: 15 tablets **or** 30 days’ supply).] [Plans may add additional information about the prescription; if preferred, plans may insert drug information here exactly as shown on the pharmacy claim.]  [If Section C contains a change that applies to a drug listed in the drug claims chart, plans must insert a note here to alert the Participant that this change has taken place. For example: **Note:** Beginning on June 1, 2015, step therapy will be required for this drug. See Section C for details.]  [The plan may also suggest lower-cost alternatives that a Participant and his or her doctor might want to consider in this section.] | [Insert date(s) filled, using mm/dd/yy format.] | $[Insert plan share amount for this drug. Include any payments (e.g., Extra Help) made by other programs or organizations. Use $0.00 if applicable.] | $[Insert Participant liability amount for this drug. Use $0.00 if applicable.] |
| [Insert next drug for the pharmacy, using language described above.] |  |  |  |
| [Insert next drug for the pharmacy, using language described above.] |  |  |  |

**THIS IS NOT A BILL**

# You have the right to make an appeal about your drug claims

[Include plan-specific information about Medicaid appeals.]

When <plan name> or your Interdisciplinary Team (IDT) decides whether a drug is covered, it’s called a “coverage decision.” Making an appeal is a formal way of asking for a change to that coverage decision. You can make an appeal if a claim is denied in whole or in part.

There are rules for how appeals are handled. These are legal procedures, and the deadlines are important. You can get a fast appeal if your doctor tells us that your health requires a quick decision.

If you have questions, or if you need help making an appeal, you can call:

* <Plan name> Participant Services at <toll-free number>.
* 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.
* Medicaid at 1-800-541-2831. TTY users should call 1-877-898-5849.
* The FIDA Participant Ombudsman at <phone number>. TTY users should call <TTY number>.
* The Health Insurance Information, Counseling, and Assistance Program (HIICAP) at 1-800-701-0501.

For more information about making an appeal, please see Chapter 9 of your Participant Handbook.

# Updates to our Drug List that will affect drugs you take

* [Use this section to provide negative formulary updates that affect drugs the Participant is taking—that is, any plan-covered drugs the Participant received during the current calendar year while a Participant of the plan. Include updates only if they affect drugs the Participant is taking and involve negative changes. (Changes to the formulary from one year to the next do not need to be included in the EOB.)
* **If there are no updates, delete this section.**
* If an update is for a negative formulary change that is not a formulary maintenance change, insert: If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.]

#### About the Drug List

<Plan name> sent you a “List of Covered Drugs,” or “Drug List” for short. The Drug List tells which drugs are covered by our plan. It also tells which tier each drug is in and whether there are any restrictions on coverage for a drug.

Our website (<web address>) always has the most current version of the Drug List. You can also call Participant Services and ask for a copy.

During the year, 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 tier to another.
* Unless noted otherwise, you will have at least 60 days’ notice before any changes take effect unless a serious safety issue is involved (for example, a drug is taken off the market).

#### Updates that affect drugs you take

The list that follows tells *only* about updates to the Drug List that will change the coverage of **drugs you take**.

“Drugs you take” means any plan-covered drugs that you received in [insert year] as a Participant of our plan.

[Below we show model language for reporting several common types of changes to the Drug List. Do not include sections that are not applicable. Plans may adapt this language as needed for grammatical consistency, accuracy, and relevant detail (for example, describing a drug as “brand name” or “generic”). Plans may also provide additional explanation of changes, if desired, and suggest specific drugs that might be suitable alternatives. To report changes for which model language is not supplied, use the model language shown below as a guide.]

**<Drug name>** [Insert name of step therapy drug. Plans may also insert information about the strength or form in which the drug is dispensed (for example: tablets **or** injectable).]

* **Date and type of change:** Beginning [insert effective date of the change], step therapy will be required for this drug. This means you will be required to try [insert either: a different drug first **or** one or more other drugs first] before we will cover [insert name of step therapy drug]. This requirement encourages you to try another drug that is just as safe and effective but less costly than [insert name of step therapy drug]. If [insert either: this other drug does not **or** the other drugs do not] work for you, the plan will then cover [insert name of step therapy drug].
* **Note:** See the information later in this section that tells “What you and your doctor can do.” [If applicable, plans may insert information that identifies possible alternate drugs, for example: You and your doctor may want to consider trying <alternate-drug-1> or <alternate drug-2>. Both are on our Drug List and have no restrictions on coverage. They are used in similar ways as [insert name of step therapy drug].]

**<Drug name>** [Insert name of drug for which the quantity is limited. Plans may also insert information about the strength or form in which the drug is dispensed (for example: tablets **or** injectable).]

* **Date and type of change:** Beginning [insert effective date of the change], there will be a new limit on the amount of the drug you can have. [Insert description of how the quantity will be limited.]
* **Note:** See the information later in this section that tells “What you and your doctor can do.”

**<Drug name>** [Insert name of drug for which prior authorization is required. Plans may also insert information about the strength or form in which the drug is dispensed (for example: tablets **or** injectable).]

* **Date and type of change:** Beginning [insert effective date of the change], prior authorization will be required for this drug. This means you or your doctor need to get approval from the plan before we will agree to cover the drug for you.
* **Note:** See the information later in this section that tells “What you and your doctor can do.” [Plans may insert more explanation if desired, for example: Your choices include asking for prior authorization in order to continue having this drug covered or changing to a different drug.]

**<Drug name>** [Insert name of brand-name drug to be replaced with generic. Plans may also insert information about the strength or form in which the drug is dispensed (for example: tablets **or** injectable).]

* **Date and type of change:** Effective [insert effective date of the change], the brand-name drug [insert name of brand-name drug to be replaced with generic] will be removed from our Drug List. We will add a new generic version of [insert name of brand-name drug to be replaced with generic] to the Drug List (it is called [insert name of replacement generic drug]).
* **Note:** [Plans may insert further information if applicable, for example: Beginning [insert effective date of the change], any prescription written for [insert name of brand-name drug to be replaced with generic] will automatically be filled with [insert name of replacement generic drug]. If you want to keep using [insert name of brand-name drug to be replaced with generic], see the information later in this section that tells “What you and your doctor can do.”]

#### What you and your doctor can do

We are telling you about these changes now so that you and your doctor will have time (at least 60 days) to decide what to do.

Depending on the type of change, there may be different options to consider. For example:

* **You can call Participant Services** at <toll-free number> to ask for a list of covered drugs that treat the same medical condition.
* **Your doctor might be able to find a different drug** covered by the plan. The drug might work just as well for you and have fewer restrictions.
* **You and your doctor can ask the plan or your Interdisciplinary Team (IDT) to make an exception for you.** Your doctor will need to explain why making an exception is medically necessary for you. For more information about requesting an exception, call Participant Services at <toll-free number>.