Community HealthFirst™
Medicare Advantage Plans
Offered by COMMUNITY HEALTH PLAN of Washington™

<LetterGenerationDate>

<MemberName>
<MemberAddressLine1>
<MemberAddressLine2>
<MemberCity>, <MemberState> <MemberZipCode>

Member ID: <MemberID>

Effective Date: <EffectiveDateofLISElgiblity> - <EndDateOfLISElgiblity>

Evidence of Coverage Rider
for People Who Get Extra Help Paying for Prescription Drugs
(also called a Low Income Subsidy Rider or LIS Rider)

Please keep this notice - it is part of Community HealthFirst™ MA <PlanName>'s Evidence of Coverage.

Our records show that you qualify for extra help paying for your prescription drug coverage. This means that you will get help paying your monthly premium and prescription drug cost sharing.

As a member of our Plan, you will receive the same coverage as someone who is not getting extra help. Your membership in our Plan will not be affected by the extra help. This also means that you must follow all the rules and procedures in the Evidence of Coverage.

Please see the chart below for a description of your prescription drug coverage:

Your monthly plan premium is	Your yearly deductible is	Your cost sharing amount for generic/preferred multi-source drugs is no more than	Your cost sharing amount for all other drugs is no more than
$<Insert LISMonthlyPremium>*	$0	<$0/$1.25/$3.40/15%> (each prescription)	<$0/$3.80/ $8.50/15%> (each prescription)

* The monthly plan premium does not include any Medicare Part B premium that you may still need to pay. The plan premium you pay has been calculated based on the Plan's premium and the amount of extra help you get.

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Please refer to your Evidence of Coverage for more information on paying your plan premium.

[Plans, insert this statement for LIS members who qualify for the 15% co-insurance amount and if you have tiered co-payment structure:>
If your co-insurance is 15% or less, the amount you pay per prescription may vary each time you fill a prescription. In addition, if the co-payment amount listed in the Evidence of Coverage is less than the amount listed above, you will pay the co-payment amount listed in the Evidence of Coverage. For example, if the 15% co-insurance for a generic drug is $7.50 and the Evidence of Coverage states the co-payment for a generic drug is $5, you will pay $5 for your generic drugs.]

Once the amount both you **and** Medicare pay (as the extra help) reaches $5,100 in a year, your co-payment amount(s) will go down to <$0 per prescription/$3.40 for generic and preferred brand drugs that are multisource, or $8.50 for all others>.

[Sponsors: insert this statement for LIS members who have an increase in their cost-sharing, premium, and/or deductible level:
The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you have filled prescriptions since this date, you may have been charged less than you should have paid as a member of our plan. In addition, if your premium has increased, you may not have paid enough. If you do owe us money, we will let you know how much. We will send you a bill for the amount due.]

[Sponsors: insert this statement for LIS members who have been LIS eligible and now have a decrease in their cost-sharing, premium, and/or deductible level, or for those newly LIS eligible with a retroactive effective date:
The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you have filled prescriptions or paid premiums since this date, you may have been charged more than you should have paid as a member of our plan. If we owe you money, we will send you a separate letter to let you know how much. We will mail you a check for the amount we owe you.]

Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for extra help with your Medicare prescription drug plan costs. Your eligibility for extra help might change if there is a change in your income or resources, if you get married or become single, or you lose Medicaid.

If you have any questions about this notice, please contact the Community HealthFirst™ Customer Service Department at 1-800-942-0247 (TTY Relay: Dial 7-1-1), 8 a.m. to 8 p.m., 7 days a week, or at healthfirst.chpw.org.
<Insert Language Disclaimer for PBP 009>
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-942-0247 (TTY: 7-1-1).

Thank you.

Community Health Plan of Washington is an HMO Plan with a Medicare contract and a contract with the Washington State Medicaid Program. Enrollment in Community Health Plan of Washington depends on contract renewal.