| POLICY AND PROCEDURE | |
|---|---|
| **Title:**<br>Part D Explanation of Benefits (EOB) | |
| **Primary policy owner:**<br>Pharmacy | **Policy #:**<br>PH39 |
| **Impacted/Secondary policy owner:** Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined | |
| 1) ☐All Departments<br>2) ☐Behavioral Health & Social Services (BH/SS)<br>3) ☒ Benefits Administration (BA)<br>4) ☐ Case Management (CM)<br>5) ☒ Claims (CLMS)<br>6) ☒ Community Marketplace & Member Engagement (MAR)<br>7) ☐ Compliance (CMP/HPA)<br>8) ☐ Configuration (CFG)<br>9) ☐ Provider Contracting (CONT)<br>10) ☒ Cultural & Linguistics (CL)<br>11) ☒ Customer Service (CS) | 12) ☐ Facilities (FAC)<br>13) ☒ Finance (FIN)<br>14) ☐ Human Resources (HR)<br>15) ☐ Information Technology / Core Systems (IT)<br>16) ☒ Pharmacy (PH)<br>17) ☐ Provider Networks (PRO)<br>18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM)<br>19) ☒ Utilization Management (UM)<br>20) ☐ Procurement (PRM)<br>21) ☐ Administration (SAF/BC/EM)<br>22) ☒ Medical Management (MM) |
| **Product Type:**<br>☐Medi-Cal<br>☒D-SNP | **Supersedes Policy Number:**<br>NA |

## I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health Plan provides Medicare Part D enrollees with a written Part D Explanation of Benefits (EOB) consistent with Centers for Medicare and Medicaid Services (CMS) requirements and in compliance with federal and state regulations and other program requirements.

## II. POLICY

A. Health Plan must furnish, directly to enrollees, in a form easily understandable, a written explanation of their Medicare Part D prescription drug claim activity, referred to as EOB.

B. The Part D EOB must be provided to the member no later than the end of the month following any month when prescription benefits are provided.

C. The Part D EOB must include:

1. A summary of the claims processed during the monthly reporting period, including the name(s) and quantity of medication(s).
2. A summary of payments made by the member (out-of-pocket), Health Plan, and, as applicable, other programs or organizations.
3. Information about the member's current drug payment stage (deductible, initial coverage, or catastrophic coverage).
4. A record of the member's total out-of-pocket costs and total drug costs transferred from their previous plan(s), if a member changed plans during the calendar year.
5. Any adjustments for that plan year (e.g. a reversed claim) or corrections (e.g. a clerical error) to a person's total out-of-pocket costs and total drug costs that are not shown in a previous EOB, if applicable.
6. As Applicable:
    a. Totals for the month.
    b. Year-to-date totals.
    c. Member out-of-pocket spending totals (TrOOP)
7. Any updates to the drug plan's formulary that will affect medications an enrollee is currently utilizing, if applicable.
8. Contact information for Member Services.
9. Language instructing members about reporting fraud.

10. Language informing members about what to do if they disagree with the plan's coverage decision or if they think the EOB is not accurate and contains errors.

## III. PROCEDURE

Generating the EOB:

A. The Pharmacy Benefit Manager (PBM):
   1. Uses its claims system to produce, monthly, the member's EOB document according to its claim system. The EOB document meets CMS requirements listed in the Policy section of this document.
   2. Generates data file reports corresponding to the dates that the EOB covers.
   3. Performs internal quality checks to ensure that the claims data and financial data listed in the letters are correct.
   4. Provides EOB samples to Health Plan by the 15th of the month following the month covered on the EOB. The samples have several scenarios to allow Health Plan to review different letters.
   5. Once Health Plan approves the letters, the PBM sends the EOB reports to the Print Vendor in a timely manner.
   6. Ensures the letters are received by the last day of every month following the month when the member utilized the drug benefit.
   7. Provide Health Plan access to the Print Vendor web application to allow viewing of the EOBs.

Oversight and Monitoring:

A. Health Plan:
   1. Verifies that member information supplied to the PBM is accurate and complete by running the PBM generated "Part D Setup Error Report" and "Skip Logs," monthly, to resolve potential data integrity issues.
   2. Monthly, selects 5-10 different samples of EOBs for review from the EOB report provided by the PBM.
   3. Verifies the accuracy of the samples selected by checking the following information:

a. The letter uses the latest template approved by Health Plan.
b. The Member Services Toll Free and TTY Phone numbers are listed correctly on the letter.
c. The claims and the financial data match the member's claim history for the month.
d. Any formulary related communication is accurate.

4. Completes the review of the EOB samples, timely, and informs the PBM to proceed with sending the print files to the Print Vendor for processing.
5. Reviews the PBM's quality verification process, annually.

## IV. ATTACHMENT(S)

A. Glossary of Terms Link

## V. REFERENCES

A. EOB Requirement: 42CFR 423.128(e)
B. Centers for Medicare & Medicaid Services (CMS) model letters - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials
C. State Medicaid Agency Contract (SMAC)
D. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

## VI. REVISION HISTORY

| Version* | Revision Summary | Date |
|---|---|---|
| 001 | | |
| 002 | | |
| 003 | | |
| 004 | | |
| **Initial Effective Date: 09/24/2025** | | |
| **Published Date:09/30/2025** | | |

## VII. Committee Review and Approval To Be Completed by Compliance

| Committee Name | Version | Date |
|---|---|---|
| Compliance Committee | 001 | 09/24/2025 |
| • Privacy & Security Oversight Committee | | |
| • Program Integrity Committee | | |
| • Audits & Oversight Committee | | |
| • Policy Review Committee | | |
| Quality Improvement Health Equity Committee (QIHEC) | | |
| • Quality Operations Committee | | |
| • Grievance Committee | | |

## VIII. REGULATORY AGENCY APPROVALS

| Department | Reviewer | Version | Date |
|---|---|---|---|
| Department of Healthcare Services (DHCS) | | | |
| Department of Managed Care (DMHC) | | | |

## IX. *Approval signature**

| Signature | Name<br>Title | Date |
|---|---|---|
| | PRC Chairperson | |
| | Policy Owner | |
| | Department Executive | |
| | Chief Executive Officer | |

*Signatures are on file, will not be on the published copy