Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1."   
An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

* Medicare Part D prescription drugs, ***and***
* drugs and items covered under Michigan Medicaid, ***and***
* drugs and items covered by the plan as additional benefits.

Because you are eligible for Michigan Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

* **The plan’s *List of Covered Drugs.***We call this the “Drug List.” It tells you:
* Which drugs the plan pays for
* Which of the <number of tiers> tiers each drug is in
* Whether there are any limits on the drugs

If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at <web address>. The Drug List on the website is always the most current.

* **Chapter 5 of this Member Handbook.** Chapter 5 [plans may insert reference, as applicable] tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
* **The plan’s *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5 [plans may insert reference, as applicable].

# The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of your total drug costs*.* This includes the amount of money the plan pays (or others pay for you) for your prescriptions.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

* **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs and what the plan paid, and what others paying for you paid.
* **“Year-to-date” information.** This is your total drug costs and the total payments made for you since January 1.
* We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your Part D total out-of-pocket costs. To find out which drugs our plan covers, see the Drug List.

# Keeping track of your drug costs

To keep track of drug costs, we use records we get from you and from your pharmacy. Here is how you can help us:

## 1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill.

## 2. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your total costs. For example, payments made by [plans without an SPAP in their state, delete the next item:] a state pharmaceutical assistance program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

## 3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. [Plans that allow members to manage this information online may describe that option here.] Be sure to keep these reports. They are an important record of your drug expenses.

# A summary of your drug coverage

## The plan’s tiers

[Plans should provide an explanation of tiers; see the example below.

Tiers are groups of drugs. Every drug on the plan’s Drug List is in one of <number of tiers> tiers. There is no cost to you for drugs on any of the tiers.

* Tier 1 drugs are generic drugs.
* Tier 2 drugs are brand name drugs.
* Tier 3 drugs are over-the-counter drugs.]

## Getting a long-term supply of a drug

[Plans that do not offer extended supplies, delete the following two paragraphs:]

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is [insert if applicable: up to] a <number of days>-day supply. There is no cost to you for a long-term supply.

* For details on where and how to get a long-term supply of a drug, see Chapter 5 [plans may insert reference, as applicable] or the *Provider and Pharmacy Directory.*

**Your coverage for a *one-month* [insert if applicable: or long-term] supply of a covered prescription drug from:**

[Keep entire chart on one page.]

[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include the high/low ranges in the chart, as well as a statement that the co-pays for prescription drugs may vary based on the level of Extra Help the Participant receives (if the plan charges co-pays for any of its Part D drugs). Modify the chart as necessary to include co-pays for non-Medicare covered drugs.]

[Plans should add or remove tiers as necessary. If mail-order is not available for certain tiers, plans should insert the following text in the cost sharing cell: Mail-order is not available for drugs in [insert tier].]

[Plans may merge the “network long-term care pharmacy” and “out-of-network pharmacy” columns with the “network pharmacy” column if days supply is the same as for network pharmacies.]

[Plans may merge tier rows if all information – including days supply across all pharmacy settings and availability via mail order – is identical. However, the merged row must include a tier number and description for each tier.]

|  | **A network pharmacy**  A one-month or up to a <number of days>-day supply | **The plan’s mail-order service**  A one-month or up to a <number of days>-day supply | **A network long-term care pharmacy**  Up to a <number of days>-day supply | **An out-of-network pharmacy**  Up to a <number of days>-day supply. Coverage is limited to certain cases. See Chapter 5 [plans may insert reference, as applicable] for details. |
| --- | --- | --- | --- | --- |
| **Tier 1**  ([Insert description; e.g., “generic drugs.”]) | $0 | $0 | $0 | $0 |
| **Tier 2**  ([Insert description.]) | $0 | $0 | $0 | $0 |
| **Tier 3**  ([Insert description.]) | $0 | $0 | $0 | $0 |
| **Tier 4**  ([Insert description.]) | $0 | $0 | $0 | $0 |

* For information about which pharmacies can give you long-term supplies, see the plan’s *Provider and Pharmacy Directory.*

# Vaccinations

[Plans may revise this section as needed.]

Our plan covers Medicare Part D vaccines. You will not have to pay for vaccines if you receive the vaccine through an in-network provider.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the shot**.

## Before you get a vaccination

[Plans may revise this section as needed.]

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

* We can tell you about how your vaccination is covered by our plan
* [Insert if applicable: We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with <plan name> to ensure that you do not have any upfront costs for a Part D vaccine.]

[Insert any additional information about your coverage of vaccinations.]