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

**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.

|  |
| --- |
| **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.” |

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 <MMP 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].

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

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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# 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 on your behalf pay) for your prescriptions.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

* **Information for the month**. The summary 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.
* **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
* **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

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, refer to the Drug List.

# How to keep 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 Member ID Card.

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

* + - 1. 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.

* + - 1. Check the EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing 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 EOBs. They are an important record of your drug expenses

# A summary of your drug coverage

As a <plan name> member, you pay nothing for covered prescription and over-the-counter (OTC) drugs as long as you follow <plan name>’s rules.

## C1. The plan’s tiers

[Plans must provide an explanation of tiers; refer to the example below. Plans have the flexibility to describe their tier model but must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.

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 OTC drugs.]

## C2. 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, refer to Chapter 5 [plans may insert reference, as applicable] or the *Provider and Pharmacy Directory*.

## C3. Drug coverage summary

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

[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Modify the chart as necessary to include non-Medicare covered drugs on the approved Additional Demonstration Drug (ADD) file. Plans must ensure the tier label or description of the types of drugs on each tier is consistent with the guidance regarding generic tier labels in the 2016 Final Call Letter.]

[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. Refer to 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, refer to 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 get 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 vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

## D1. What you need to know 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.]