Chapter 6: What you pay for your outpatient 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 MassHealth, **and**
* drugs and items covered by the plan as additional benefits.

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

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| --- |
| **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 that <plan name> covers, 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 at <toll-free number>. You can also find the *Drug List* on our website at <URL>. 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].
* When you use the plan’s “Real Time Benefit Tool” to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in “real time” meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call [i*nsert if applicable:* your care coordinator] or Member Services for more information.

[Plans should refer members to other parts of the handbook using the appropriate chapter number and section. For example, “refer to Chapter 9, Section A.” 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 Part D *Explanation of Benefits* (EOB)

[Plans with a single payment stage (i.e., no cost sharing differences between the Initial Coverage Stage and the Catastrophic Coverage Stage), modify this section as necessary.]

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

* Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by “Extra Help” from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs). With <plan name>, you do not have to pay anything for your prescriptions, as long as you follow the rules in Chapter 5. Your out-of-pocket costs will be zero.
* Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, and what other programs or organizations paid for your covered Part D drugs.

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 Part D prescription drugs you got for the previous month. It shows the total Part D drug costs, what the plan paid, and what you and others paid for your drugs.
* **“Year-to-date” information.** This is your total drug costs and the total payments made this year.
* **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 total out-of-pocket costs.
* [Insert only if the plan pays for OTC drugs as part of its administrative costs under Part D, rather than as a MassHealth benefit: We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.]
* 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 your 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 and what you pay for them.

**2. Make sure we have the information we need.**

Give us copies of receipts for covered drugs that you have paid for. You should always follow the rules in Chapter 5 for getting drugs. If you follow the rules, you will pay nothing for drugs covered by <plan name>.If you ever pay the full cost of your drug, you should keep the receipt and you can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

* when you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
* when you pay a copay for drugs that you get under a drug-maker’s patient-assistance program.
* when you buy covered drugs at an out-of-network pharmacy.
* when you pay the full price for a covered drug.

To learn how to ask us to pay you back for the drug, refer to Chapter 7 [plans may insert reference, as applicable].

**3. 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.

# You pay nothing for a one-month [insert if applicable: or long-term] supply of drugs

With <plan name>, you pay nothing for covered drugs as long as you follow the plan’s rules.

## C1. The plan’stiers

[Plans must provide an explanation of tiers; refer to the examples below. *Plans have 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.*]

[*If a plan has no cost sharing for one or more tiers of drugs, the plan should modify the cost sharing information accordingly.* Include examples such as the following:

* Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from <amount> to <amount>, depending on your income.
* Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from <amount> to <amount>, depending on your income.
* Tier 3 drugs have the highest copay. They have a copay of <amount>.]

Tiers are groups of drugs on our Drug List.Every drug in the plan’s Drug List is in one of <number of tiers> tiers. You have no copays for prescription and OTC drugs on <plan name>’s Drug List.To find the tiers for your drugs, you can look in the Drug List.

[Plans should include examples such as the following:

* Tier 1 drugs are generic drugs.
* Tier 2 drugs are brand name 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*.

[Plans may delete columns and modify the table as necessary to reflect the plan’s prescription drug coverage. Include all possible copay amounts (not just the high/low ranges) – i.e., all three possible copay amounts for a tier in which LIS cost sharing applies – in the chart, as well as a statement that the copays for prescription drugs may vary based on the level of Extra Help the member gets (if the plan charges copays for any of its Part D drugs). Modify the chart as necessary to include copays for 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].]

# Vaccinations

[Plans may revise this section as needed.]

**Important Message About What You Pay for Vaccines:** Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary).* Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan’s *List of Covered Drugs* (*Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

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.

## D2. What you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

* Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to Immunizations on the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].
* Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan’s *Drug List*. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.

* For most adult Part D vaccines, you will pay nothing.
* For other Part D vaccines, you will pay nothing.Some states do not allow pharmacies to give shots.

1. You get the Medicare Part D vaccine at your doctor’s office and the doctor gives you the shot.

* You will pay nothing to the doctor for the vaccine.
* Our plan will pay for the cost of giving you the shot.
* The doctor’s office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

1. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor’s office to get the shot.

* For most adult Part D vaccines, you will pay nothing for the vaccine itself.
* For other Part D vaccines, you will pay nothing for the vaccine.
* Our plan will pay for the cost of giving you the shot.

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