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

Because you are eligible for Texas 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> [*Plans that do not have cost sharing in any tier may omit*: cost sharing] 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 <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 [*insert if applicable:* your care coordinator] or Member Services for more information.

[Plans with no cost sharing for all outpatient drugs, delete Sections D, E, and F and change section G to section D.]

[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 *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).
* 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 [*insert, as applicable:* such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options]. The EOB includes:

* **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
* **“Year-to-date” information.** This is your total drug costs and the total payments made 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 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 Texas Medicaid 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 and the payments you make, 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.

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

Give us copies of receipts for covered drugs that you have paid for. You can ask us to help you get paid back for [insert if plan has cost sharing: our share of the cost of] the drug. Contact your Service Coordinator for information on how to get paid back.

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 [*insert if plan has cost sharing:* our share of the cost of] the drug, refer to Chapter 7 [*plans may insert reference, as applicable*].

**3. Send us information about the payments others have made for you.**

Payments made by certain other people and organizations also count toward your out-of-pocket 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. [Plans should delete the rest of this paragraph if they cover all Part D drugs at $0 cost-sharing:] This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, <plan name> pays all of the costs of your Medicare Part D drugs for the rest of the year.

**4. 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.

[*Plans with two payment stages, insert:* Drug Payment Stages for Medicare Part D drugs] [*Plans with one payment stage, insert:* You pay nothing for a one-month [*insert if applicable:* or long-term] supply of drugs]

[Plans with one payment stage (i.e., those with no cost-sharing for all Part D drugs), include the following sentence: With <plan name>, you pay nothing for covered drugs as long as you follow the plan’s rules.]

[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), include the following paragraph and table.]

There are two payment stages for your Medicare Part D prescription drug coverage under <plan name>. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| **Stage 1: Initial Coverage Stage** | **Stage 2: Catastrophic Coverage Stage** |
| --- | --- |
| During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.  You begin in this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through <end date>.  You begin this stage when you have paid a certain amount of out-of-pocket costs. |

[Plans with one payment stage (i.e., those with no cost-sharing for all Part D drugs), include the following information up to Section D.]

## C1. The plan’s [*Plans that do not have cost sharing in any tier may omit:* cost-sharing] tiers

[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.*]

[*Plans that have cost sharing in any tier include*: Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan’s Drug List is in one of <number of tiers> cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

*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>.]

[*Plans that do not have cost sharing in any tier include:* 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.

Include examples such as the following:

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

## C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

* a network pharmacy, **or**
* an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5 [plans may insert reference, as applicable] to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 [plans may insert reference, as applicable] in this handbook and the plan’s *Provider and Pharmacy Directory.*

## C3. 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. [Plans with cost sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost sharing, insert: 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*.

## C4. What you pay

[Plans that have copays on at least one tier must include the following language:] You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month**[insert if applicable: **or long-term**] **supply of a covered prescription drug from:**

[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. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. 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].]

|  | **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. |
| --- | --- | --- | --- | --- |
| **Cost Sharing**  **Tier 1**  ([Insert description; e.g., “generic drugs.”]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 2**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 3**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 4**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |

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

Stage 1: The Initial Coverage Stage [*Plans with one coverage stage should delete this section*]

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost sharing tier the drug is in and where you get it.

[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.*]

[*Plans that have cost sharing in any tier include*: Cost sharing tiers are groups of drugs with the same copay. Every drug in the plan’s Drug List is in one of <number of tiers> cost sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost sharing tiers for your drugs, you can look in the Drug List.

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>.]

[*Plans that do not have cost sharing in any tier include:* 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.

Include examples such as the following:

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

## D1. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

* a network pharmacy, **or**
* an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5 [plans may insert reference, as applicable] to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 [plans may insert reference, as applicable] in this handbook and the plan’s *Provider and Pharmacy Directory.*

## D2. 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. [Plans with cost sharing, insert: It costs you the same as a one-month supply.] [Plans with no cost sharing, insert: 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*.

## D3. What you pay

During the Initial Coverage Stage, you will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Member Services to find out how much your copay is for any covered drug.

**Your share of the cost when you get a one-month**[insert if applicable: **or long-term**] **supply of a covered prescription drug from:**

[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. 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. Plans should remove references to “cost sharing” to describe tiers if they do not have cost sharing in any tier. 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].]

|  | **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. |
| --- | --- | --- | --- | --- |
| **Cost Sharing**  **Tier 1**  ([Insert description; e.g., “generic drugs.”]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 2**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 3**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |
| **Cost Sharing**  **Tier 4**  ([Insert description.]) | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] | [Insert copay(s).] |

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

## D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach [insert as applicable: $<initial coverage limit> **or** $<TrOOP amount>]. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Your EOBs will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the [insert as applicable: $<initial coverage limit> **or** $<TrOOP amount>] limit. Many people do not reach it in a year.

Stage 2: The Catastrophic Coverage Stage [*Plans with one coverage stage should delete this section*]

When you reach the out-of-pocket limit of $<TrOOP amount> for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs. [Plans that cover Medicaid drugs or excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following as applicable and adjust as needed: For Medicaid drugs and excluded drugs under our enhanced benefit you pay <insert copay amount>.]

[*Plans that do not reduce the copays for Texas Medicaid-covered drugs in the catastrophic coverage stage should insert the following language:*] **When you are in the Catastrophic Coverage Stage, you will continue to make copays for your Texas Medicaid-covered drugs**.

Your drug costs if your doctor prescribes less than a full month’s supply [*Plans with no Part D drug cost-sharing should delete this section*]

[*Insert as appropriate*: Typically ***or*** In some cases], you pay a copay to cover a full month’s supply of a covered drug. However, your doctor can prescribe less than a month’s supply of drugs.

* There may be times when you want to ask your doctor about prescribing less than a month’s supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
* If your doctor agrees, you will not have to pay for the full month’s supply for certain drugs.

When you get less than a month’s supply of a drug, the amount you pay will be based on the number of days of the drug that you get. We will calculate the amount you pay per day for your drug (the “daily cost sharing rate”) and multiply it by the number of days of the drug you get.

* [Plans may revise the information in this paragraph to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example*.*]Here’s an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days’ supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment of less than $0.35.
* Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month’s supply.
* You can also ask your provider to prescribe less than a full month’s supply of a drug, if this will help you:
  + better plan when to refill your drugs,
  + coordinate refills with other drugs you take, **and**
  + take fewer trips to the pharmacy.

# 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.

## G1. 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 the plan has cost sharing: and explain your share of the cost].
* [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 Medicare Part D vaccine.]

[Plans that do not charge any Part D vaccine copays may delete the following section.]

## G2. 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 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*. [*Insert if applicable:* You may have to pay a copay for Medicare Part D vaccines.] If the vaccine is recommended for adults by an organization called the **Advisory Committee on 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.

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

* You will pay [*insert as applicable*: nothing ***or*** a copay] 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 [*insert as applicable*: nothing ***or*** a copay] 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 [*insert as applicable:* nothing***or***a copay] for the vaccine.
* Our plan will pay for the cost of giving you the vaccine.

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