

| Value | Choice |

# Summary of Benefits

January 1 – December 31, 2014

S5660 & S5983

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## Introduction to Summary of Benefits

Thank you for your interest in **Express Scripts Medicare™** (PDP). Our plan is offered by Medco Containment Life Insurance Company, which is also called Express Scripts Medicare, and Medco Containment Insurance Company of New York/Express Scripts Medicare, a Medicare prescription drug plan that contracts with the Federal government. This *Summary of Benefits* tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call Express Scripts Medicare and ask for the *Evidence of Coverage*.

### You have choices in your Medicare prescription drug coverage

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare prescription drug plan, like Express Scripts Medicare. Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

### How can I compare my options?

The charts in this booklet list some important drug benefits. You can use this *Summary of Benefits* to compare the benefits offered by Express Scripts Medicare to the benefits offered by other Medicare prescription drug plans or Medicare Advantage Plans with prescription drug coverage.

### Where is Express Scripts Medicare available?

The service area for the Value and Choice plans includes: All 50 states, the District of Columbia, and Puerto Rico. There is more than one plan listed in this *Summary of Benefits*.

### Who is eligible to join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area. If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO, or MA PFFS plan.

Enrollees in a Private Fee-for-Service Plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) Plan may enroll in a PDP. Enrollees in an 1876 Cost Plan may enroll in a PDP.

### Where can I get my prescriptions?

Express Scripts Medicare has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

Express Scripts Medicare – Choice (PDP) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

You can ask for a *Pharmacy Directory* or visit us at <http://www.Express-ScriptsMedicare.com>. Our Customer Service numbers are listed at the end of this introduction.

## **What if my doctor prescribes less than a month's supply?**

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand [and generic] drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

## **Does my plan cover Medicare Part B or Part D drugs?**

Express Scripts Medicare does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products, and medical supplies associated with the delivery of insulin that are covered under the Medicare prescription drug benefit (Part D) and that are on our formulary.

## **What is a prescription drug formulary?**

Express Scripts Medicare uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change

that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you, and you can see our complete formulary on our website at <http://www.Express-ScriptsMedicare.com>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **What should I do if I have other insurance in addition to Medicare?**

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap issuer to let them know that you have joined a Medicare prescription drug plan. If you decide to keep your current Medigap supplement policy, your Medigap issuer will remove the prescription drug coverage portion of your policy. Call your Medigap issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join Express Scripts Medicare. Get this information before you decide to enroll in this plan.

## **How can I get Extra Help with my prescription drug plan costs or get Extra Help with other Medicare costs?**

You may be able to get Extra Help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting Extra Help, call:

- 1.800.MEDICARE (1.800.633.4227). TTY/TDD users should call 1.877.486.2048, 24 hours a day/7 days a week; and see <http://www.medicare.gov> “Programs for People with Limited Income and Resources” in the publication *Medicare & You*;
- The Social Security Administration at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1.800.325.0778; or
- Your state Medicaid office.

### **What are my protections in this plan?**

All Medicare prescription drug plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare prescription drug program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare prescription plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Express Scripts Medicare, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred

drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the *Evidence of Coverage (EOC)* for the QIO contact information.

### **What is a Medication Therapy Management (MTM) Program?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Express Scripts Medicare for more details.

### **Where can I find information on plan ratings?**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients, and Customer Service). If you have access to the Web, you may use the web tools on <http://www.medicare.gov> and select “Health and Drug Plans” then “Compare Drug and Health Plans” to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our Customer Service numbers are listed below.

Please call Express Scripts Medicare for more information about  
Express Scripts Medicare.

**On the Web:**

Visit us at

**<http://www.Express-ScriptsMedicare.com>**

**By Phone:**

**1.866.477.5704**

**(TTY/TDD: 1.800.716.3231)**

24 hours a day, 7 days a week (except Thanksgiving and Christmas)

**Contact Medicare:**

For more information about Medicare, please call Medicare at

1.800.MEDICARE (1.800.633.4227).

TTY users should call 1.877.486.2048.

You can call 24 hours a day, 7 days a week.

Or visit <http://www.medicare.gov> on the Web.

This document may be available in other formats, such as braille, large print, or other alternate formats.

This document may be available in a non-English language.

For additional information, call Customer Service at the phone numbers listed above.

Este documento puede estar disponible en idiomas distintos del inglés. Para obtener información adicional, llame a Servicio al cliente a los números telefónicos que figuran arriba.

## Summary of Benefits

If you have any questions about this plan's benefits or costs,  
please contact Express Scripts Medicare for details.

**Original Medicare:** Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

<b>Prescription Drug Benefits</b>	
<b>OUTPATIENT PRESCRIPTION DRUGS</b>	<p><b>Drugs Covered Under Medicare Part D</b></p> <p><b>General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.Express-ScriptsMedicare.com">http://www.Express-ScriptsMedicare.com</a> on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>• have limited incomes,</li> <li>• live in long-term care facilities, or</li> <li>• have access to Indian/Tribal/Urban (Indian Health Service) providers.</li> </ul> <p>For the Value plan, you pay from \$28.60–\$68.70 each month for your Medicare Part D prescription benefits. For the Choice plan, you pay from \$49.50–\$90.90 each month for your Medicare Part D prescription benefits. Refer to the Premium Table after this section to find out the premiums in your area.</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You may also call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Express Scripts Medicare for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p>

<b>Prescription Drug Benefits</b>	<b>Value</b>	<b>Choice</b>
<b>OUTPATIENT PRESCRIPTION DRUGS</b> contd.	<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Express Scripts Medicare approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost-sharing for that drug.</p>	<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Express Scripts Medicare approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost-sharing for that drug.</p>
<b>IN-NETWORK DEDUCTIBLE</b>	\$310 annual deductible	\$0 deductible
<b>INITIAL COVERAGE</b>	After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,850:	You pay the following until total yearly drug costs reach \$2,850:
<b>RETAIL PHARMACY</b>  Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.	<p>You can get drugs the following way(s):</p> <p><b>Tier 1: Preferred Generic</b>  \$2 copay for a one-month (31-day) supply of drugs in this tier  \$6 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>	<p>You can get drugs from a preferred and non-preferred pharmacy the following way(s):</p> <p><b>Tier 1: Preferred Generic</b>  \$2 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy  \$5 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy  \$8 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy  \$20 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>

Prescription Drug Benefits	Value	Choice
<b>RETAIL PHARMACY</b> contd.	<p><b>Tier 2: Non-Preferred Generic</b></p> <p><b>State of residence:</b> AL, AR, GA, LA, MS, NY, TN</p> <p>\$6 copay for a one-month (31-day) supply of drugs in this tier</p> <p>\$18 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>State of residence:</b> AK, AZ, CA, DC, DE, FL, IA, IL, IN, KS, KY, MD, MI, MN, MO, MT, NC, ND, NE, NJ, NV, OH, OK, PA, SC, SD, WV, WY</p> <p>\$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>\$21 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>State of residence:</b> CO, CT, HI, ID, MA, ME, NH, NM, OR, PR, RI, TX, UT, VA, VT, WA, WI</p> <p>\$8 copay for a one-month (31-day) supply of drugs in this tier</p> <p>\$24 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>	<p><b>Tier 2: Non-Preferred Generic</b></p> <p>\$10* copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy</p> <p>\$25* copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p> <p>\$16 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>\$40 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>*State of Residence:</b> AL, AR, GA, LA, MS, NY, TN</p> <p>\$9 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy</p> <p>\$23 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>

Prescription Drug Benefits	Value	Choice
<p><b>RETAIL PHARMACY</b> contd.</p>	<p><b>Tier 3: Preferred Brand</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier 25% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 4: Non-Preferred Brand</b> 50%* coinsurance for a one-month (31-day) supply of drugs in this tier 50%* coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>*State of Residence:</b> Wisconsin . . . . . 45% coinsurance</p>	<p><b>Tier 3: Preferred Brand</b> \$40 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy \$120 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy \$45 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy \$135 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 4: Non-Preferred Brand</b> \$90 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy \$270 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy \$95 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy \$285 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>

<b>Prescription Drug Benefits</b>	<b>Value</b>	<b>Choice</b>
<p><b>RETAIL PHARMACY</b> contd.</p>	<p><b>Tier 5: Specialty Tier</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p>	<p><b>Tier 5: Specialty Tier</b> 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy  33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy</p>
<p><b>LONG-TERM CARE PHARMACY</b></p> <p>Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14 days' supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs the following way(s):</p>	<p><b>Tier 1: Preferred Generic</b> \$2 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic</b> <b>State of residence:</b> AL, AR, GA, LA, MS, NY, TN \$6 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>State of residence:</b> AK, AZ, CA, DC, DE, FL, IA, IL, IN, KS, KY, MD, MI, MN, MO, MT, NC, ND, NE, NJ, NV, OH, OK, PA, SC, SD, WV, WY \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>State of residence:</b> CO, CT, HI, ID, MA, ME, NH, NM, OR, PR, RI, TX, UT, VA, VT, WA, WI \$8 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand</b> 50%* coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>*State of Residence:</b> Wisconsin . . . . . 45% coinsurance</p>	<p><b>Tier 1: Preferred Generic</b> \$8 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic</b> \$16 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand</b> \$45 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand</b> \$95 copay for a one-month (31-day) supply of drugs in this tier</p>

Prescription Drug Benefits	Value	Choice
<p><b>LONG-TERM CARE PHARMACY</b> contd.</p>	<p><b>Tier 5: Specialty Tier</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p>	<p><b>Tier 5: Specialty Tier</b> 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>
<p><b>MAIL ORDER</b></p> <p>Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.</p> <p>You can get drugs from a preferred and non-preferred mail order pharmacy the following way(s):</p>	<p><b>Tier 1: Preferred Generic</b> \$4 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$6 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 2: Non-Preferred Generic</b> <b>State of residence:</b> AL, AR, GA, LA, MS, NY, TN</p> <p>\$12 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$18 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>State of residence:</b> AK, AZ, CA, DC, DE, FL, IA, IL, IN, KS, KY, MD, MI, MN, MO, MT, NC, ND, NE, NJ, NV, OH, OK, PA, SC, SD, WV, WY</p> <p>\$14 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$21 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>	<p><b>Tier 1: Preferred Generic</b> \$0 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$16 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 2: Non-Preferred Generic</b> \$20* copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$32 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>*State of Residence:</b> AL, AR, GA, LA, MS, NY, TN</p> <p>\$18 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p>

Prescription Drug Benefits	Value	Choice
<p><b>MAIL ORDER</b> contd.</p>	<p><b>State of Residence:</b> CO, CT, HI, ID, MA, ME, NH, NM, OR, PR, RI, TX, UT, VA, VT, WA, WI</p> <p>\$16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 3: Preferred Brand</b> 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 4: Non-Preferred Brand</b> 50%* coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>50%* coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p><b>*State of Residence:</b> Wisconsin . . . . . 45% coinsurance</p>	<p><b>Tier 3: Preferred Brand</b> \$100 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$113 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p> <p>Not all drugs on this tier are available at this extended-day supply. Please contact the plan for more information.</p> <p><b>Tier 4: Non-Preferred Brand</b> \$225 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>\$238 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p>

<b>Prescription Drug Benefits</b>	<b>Value</b>	<b>Choice</b>
<b>MAIL ORDER</b> contd.	<p><b>Tier 5: Specialty Tier</b></p> <p>25% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>25% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p>	<p><b>Tier 5: Specialty Tier</b></p> <p>33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred mail-order pharmacy</p> <p>33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred mail-order pharmacy</p>
<b>COVERAGE GAP</b>	<p>After your total yearly drug costs reach \$2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand-name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p>	<p>After your total yearly drug costs reach \$2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand-name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p>
<b>CATASTROPHIC COVERAGE</b>	<p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- 5% coinsurance, or</li> <li>- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs.</li> </ul>	<p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- 5% coinsurance, or</li> <li>- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs.</li> </ul>
<b>OUT OF NETWORK</b>  You can get out-of-network drugs the following way:	<p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Express Scripts Medicare.</p>	<p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Express Scripts Medicare.</p>

Prescription Drug Benefits	Value	Choice
<p><b>OUT-OF-NETWORK INITIAL COVERAGE</b></p>	<p>After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug, minus the following for drugs purchased out of network until your total yearly costs reach \$2,850:</p> <p><b>Tier 1: Preferred Generic</b> \$2 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic</b> <b>State of residence:</b> AL, AR, GA, LA, MS, NY, TN \$6 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>State of residence:</b> AK, AZ, CA, DC, DE, FL, IA, IL, IN, KS, KY, MD, MI, MN, MO, MT, NC, ND, NE, NJ, NV, OH, OK, PA, SC, SD, WV, WY \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>State of residence:</b> CO, CT, HI, ID, MA, ME, NH, NM, OR, PR, RI, TX, UT, VT, VA, WA, WI \$8 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand</b> 50%* coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>*State of Residence:</b> Wisconsin . . . . . 45% coinsurance</p> <p><b>Tier 5: Specialty Tier</b> 25% coinsurance for a one-month (31-day) supply of drugs in this tier</p>	<p>You will be reimbursed up to the plan's cost of the drug, minus the following for drugs purchased out of network until your total yearly costs reach \$2,850:</p> <p><b>Tier 1: Preferred Generic</b> \$8 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic</b> \$16 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand</b> \$45 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand</b> \$95 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 5: Specialty Tier</b> 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>

<b>Prescription Drug Benefits</b>	<b>Value</b>	<b>Choice</b>
<b>OUT-OF-NETWORK COVERAGE GAP</b>	<p>You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out of network until total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p> <p>You will be reimbursed up to 52.5% of the plan allowable cost for brand-name drugs purchased out of network until your total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p>	<p>You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out of network until total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p> <p>You will be reimbursed up to 52.5% of the plan allowable cost for brand-name drugs purchased out of network until your total yearly out-of-pocket drug costs reach \$4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).</p>
<b>OUT-OF-NETWORK CATASTROPHIC COVERAGE</b>	<p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out of network up to the plan's cost of the drug minus your cost-share, which is the greater of:</p> <ul style="list-style-type: none"> <li>- 5% coinsurance, or</li> <li>- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs.</li> </ul>	<p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out of network up to the plan's cost of the drug minus your cost-share, which is the greater of:</p> <ul style="list-style-type: none"> <li>- 5% coinsurance, or</li> <li>- \$2.55 copay for generic (including brand drugs treated as generic) and a \$6.35 copay for all other drugs.</li> </ul>

**2014 Premium Table  
Express Scripts Medicare**

<b>Region</b>	<b>Service Area</b>	<b>Value</b>	<b>Choice</b>
1	ME, NH	\$48.70	\$70.50
2	CT, MA, RI, VT	\$44.20	\$49.50
3	NY	\$36.40	\$49.50
4	NJ	\$32.90	\$49.50
5	DE, DC, MD	\$29.10	\$49.60
6	PA, WV	\$32.20	\$80.50
7	VA	\$45.80	\$49.50
8	NC	\$30.40	\$49.50
9	SC	\$34.90	\$49.50
10	GA	\$30.20	\$75.80
11	FL	\$68.70	\$78.80
12	AL, TN	\$28.60	\$70.50
13	MI	\$36.80	\$65.90
14	OH	\$46.30	\$66.70
15	IN, KY	\$30.90	\$70.50
16	WI	\$47.20	\$84.70
17	IL	\$43.60	\$77.80
18	MO	\$47.10	\$49.60
19	AR	\$29.20	\$49.60
20	MS	\$41.20	\$79.50
21	LA	\$30.10	\$49.50
22	TX	\$52.00	\$90.90
23	OK	\$39.10	\$49.50
24	KS	\$33.90	\$80.00
25	IA, MN, MT, ND, NE, SD, WY	\$41.70	\$70.60
26	NM	\$47.20	\$70.50
27	CO	\$60.60	\$89.60
28	AZ	\$54.70	\$70.50
29	NV	\$55.80	\$70.50
30	OR, WA	\$55.40	\$49.50
31	ID, UT	\$36.50	\$49.60
32	CA	\$62.10	\$70.50
33	HI	\$38.30	\$56.00
34	AK	\$46.90	\$70.60
38	PR	\$51.90	\$57.00



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# **Important Information**

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## Important Information Regarding Your Prescription Benefits for Express Scripts Medicare (PDP) January 1, 2014 – December 31, 2014

Please read the important information below prior to enrolling in this plan.

With **Express Scripts Medicare™** (PDP), you will have access to over 69,000 network pharmacies nationally. You may fill your prescriptions at a retail, home infusion, long-term care, or Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacy, or through our convenient mail-order service.\* In order to maximize your benefits, covered drugs must be filled at a network pharmacy. However, there are emergency circumstances under which you may be reimbursed for a formulary prescription that is not filled at a network pharmacy. Limitations, copayments, and restrictions may apply. For additional information, please contact us at the numbers listed in the preceding *Summary of Benefits*, or visit us on the Web at <http://www.Express-ScriptsMedicare.com>.

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year.

### **Premium Information**

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.

If you have or are assessed a late enrollment penalty (LEP), the LEP amount is considered part of your premium. If you fail to pay your premium or the portion of your premium represented by the LEP amount, you may be disenrolled from this plan.

\*Other pharmacies are available in our network.

You may pay your premium in several ways. If you choose to make a change to your method of payment, it may take up to 3 months for the change to take effect. In the meantime, you will still be responsible for paying your premium via the original method of payment.

### **Extra Help**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy-five (75) percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the Coverage Gap or a late enrollment penalty. Many people are eligible for these savings and don't know it. For more information about this Extra Help, contact your local Social Security office or call 1.800.MEDICARE (1.800.633.4227), 24 hours per day, 7 days per week. TTY users should call 1.877.486.2048.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day/7 days a week;
- The Social Security Office at 1.800.772.1213, between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778; or
- Your State Medicaid Office.

## Enrollment Information

Members may enroll in the plan only during specific times of the year. Contact Express Scripts Medicare at the numbers listed in the preceding *Summary of Benefits* for more information.

Beneficiaries may enroll in this plan by doing one of the following:

Mail in the signed enrollment form to:

Express Scripts Medicare  
P.O. Box 14717  
Lexington, KY 40512

Enroll over the phone by calling the numbers listed in the preceding *Summary of Benefits*.

Enroll through our website,  
**<http://www.Express-ScriptsMedicare.com>**.

Enroll through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at <http://www.medicare.gov>.

## Service Complaint/Filing a Grievance

If you are not satisfied with the service received from Express Scripts Medicare, you may file a complaint. Use any of the following ways to respond to problems with service from your retail network pharmacy, from Express Scripts pharmacy services, which includes the Express Scripts pharmacy and the **Medco Pharmacy**<sup>®,\*</sup> or from Express Scripts Medicare's Customer Service department:

- Call us toll-free at the numbers listed in the preceding *Summary of Benefits*; or
- Fill out the Service Complaint Form located at **<http://www.Express-ScriptsMedicare.com>** on the Web.

Please mail your completed Service Complaint Form to:

Express Scripts Medicare  
Express Scripts  
Attn: Grievance Resolution Team  
P.O. Box 630035  
Irving, TX 75063-0035

If you need assistance or more information on filing a complaint, please call us toll-free at the numbers listed in the preceding *Summary of Benefits*.

## Coverage Limits and Restrictions

Some of the drugs covered by Express Scripts Medicare have coverage limits or restrictions (such as a quantity limit, prior authorization, or step therapy). Information on drugs that have coverage limits or restrictions is listed in our formulary (Drug List). You may obtain additional information on these drugs by calling us or by viewing the formulary on our website, **<http://www.Express-ScriptsMedicare.com>**.

For example, prescription drugs used for cosmetic reasons may not be covered without your doctor's approval. In addition, some medications might be limited to a certain number of pills or a total dosage within a specific period of time.

If you have a prescription for a drug with a coverage limit, your pharmacist may tell you that an approval is needed before the prescription can be filled. The pharmacist will also give you a toll-free number to call in order to have the appropriate approvals processed. If you are told there is a coverage limit, more information may be needed to see if your prescription meets the plan's coverage conditions.

We will notify you and your doctor of our decision in writing. If coverage is approved, the letter will indicate the period of time you will be allowed coverage under your benefit. If coverage is denied, the letter will provide an explanation and information on how to file an appeal.

## **Coverage Decisions and Appeals**

A coverage decision is a decision the plan makes about your benefits and coverage or about the amount the plan will pay for your prescription drugs. If the plan makes a coverage decision and you are not satisfied with the decision, you may file an “appeal.” An appeal is a formal way of asking us to review and change a coverage decision the plan has made. For more information on coverage decisions and appeals, you may call us at the numbers listed in the preceding *Summary of Benefits* or visit our website,

**<http://www.Express-ScriptsMedicare.com>**.

Complete information on the coverage decision and appeals process is included in the plan’s *Evidence of Coverage*.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. Coverage in this plan is for one year at a time. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question, and the Centers for Medicare & Medicaid Services renews its approval of our plan. We may reduce our service area and no longer offer services in the area in which the beneficiary resides.



Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.

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