

There are currently 21 prescription drug plans in the State of Vermont. There are five plans that currently work with the State of Vermont Pharmacy Assistance Program, the benchmark (the premium the State of Vermont will pay for a premium this year is \$31.14 per month. Any amount over that will have to be paid by the consumer.

The Federal Assistance Program known as the Low Income Subsidy will also cover medication plans based upon the benchmark. To qualify for this program an individual cannot earn more than \$17,820 and not have resources in excess of \$13,640. A couple's combined income cannot exceed \$24,030.00 per month and their combined resources cannot exceed \$27,250.00.

Income includes: Social Security Income prior to deductions, earned income, dividend income, interest income, pension income.

Resources include: Rental property, money in the bank, stocks, bonds, mutual funds, property that is separate than the property one's home is on, other property (camps, cottages, etc.)

The co-pays for LIS are \$2.95 for each generic and \$7.40 for each brand name medication.

If a person is eligible for Medicare Savings Programs such as Qualified Medicare Beneficiary, they are automatically enrolled in LIS. If a person is on Community Medicaid, they are automatically LIS eligible.

QI-1 will pay for a Medicare Part B premium as long as financial perimeters are met.

#### Prescription drug plans and Advantage Plans

Plans have to cover a minimum of 3 drugs in each health care category. If a physician cannot obtain "prior authorization" or a "formulary exception", generally a consumer will have to try other medications first.

Supplemental Insurances will cover up to the other 20% of one's health care costs as long as Medicare is the first payer. Supplemental Insurances are a compliment to Original Medicare only. If Medicare does not pay nor will a supplemental insurance plan. These are all private insurances with very different costs for the same coverage.

Advantage Plans are the privatization of Medicare and when one enrolls in an Advantage Plan they are no longer on Original Medicare. This requires that they continue to pay their Part B premium. All Advantage Plans are cost share plans.

Some people are taking medications that they find they cannot afford, Patient Assistance Programs are available for some; each program has an income limit.

Foundations have been a go-to place for some very expensive medications: i.e. cancer medications, Parkinson's medications and medications for Multiple Sclerosis. Foundations have begun to limit what they can cover due to cost and availability of funds.

Patient Assistance Programs are on a case by case basis and can often require that one applies to more than one program for a specific medication.

The Health Center Pharmacy, affiliated with all the Federally Qualified Health Care Centers often do have a sliding scale fee or their costs are less.

The Northwest Canadian Pharmacy is a mail order pharmacy where some medications can be obtained for less.

Attached is evidence of various case scenarios and the costs associated with some commonly prescribed medications. Tier 1 medications are low cost medications, Tier 2 a bit higher. Tier 3 and above (to 5) are more costly.

Attachments include:

Some case scenarios of some actual client experiences. They are a depiction of actual fact.

The Advantage Plans are cost share plans and are also attached.

The plans that are available in Vermont are attached.

Supplemental Insurance information is attached.

Compounding medications are difficult to assess for cost, generally the client would cover this out of their pocket.

Some oral cancer medications and organ rejection medications are covered under Part B of Medicare. If a person has a medication administered either by injection or infusion in a physician's office or hospital that medication is covered by Medicare Part B.

Attachment 1: Plans available in Vermont

Attachment 2: Cost comparisons for actual medications consumers are requesting. This includes medications for some chronic health care conditions.

Attachment 3: A complete cost share analysis for one Advantage Plan. Advantage Plans are county specific, state specific, or Region specific. One county does not have any.

Attachment 4: The cost of supplemental insurances for the 65 and older population and the younger disabled population with a chart indicating what each plan will cover. When one is new to Medicare they cannot be denied coverage if they are within 6 months from the date their Part B begins.

The average cost for a Vermont resident for Medicare Part B has risen from \$104.90 per month, to \$121.80. If a person earns more income they may pay an IRMMA increasing the amount that one pays for their Part B premium and their Part D premium.

Respectfully Submitted:

Dagny E. Hoff, MA, SHIP Regional Coordinator, Central Vermont Council on Aging

PDP Premium History			
Under Benchmark and 100% LIS Elig. Plan			
Under Benchmark and NOT 100% LIS Elig. Plan (enhanced under the benchmark)			
New Contract and/or Plan			
Deleted Plan			
Plan within "de minimus"			
Name of Plan			
	2014	2015	2016
<b>Benchmark</b>	<b>\$28.00</b>	<b>\$29.65</b>	<b>\$31.14</b>
<b>Aetna (\$5810)</b>			
	036- \$26.30	036- \$22.10	036- \$25.60
BIN: 610502			
PCN: 00 670000	172- \$120.50	172- \$119.10	
<b>BCBSVT (\$2893)</b>			
PBM: Caremark			
BIN: 00 4336	001- \$33.30	001- \$40.30	001- \$49.60
PCN: ADV	003- \$99.70	003- \$110.20	003- \$127.60
<b>CIGNA (\$5617)</b>			
BIN: 0 12353	008- \$27.60	008- \$46.30	008- \$50.90
PCN: 0 34900000	247- \$58.20	247- \$35.80	247- \$50.10
	172- \$113.80	172- \$128.80	
<b>Envision (\$7694)</b>			
PCN: PART D	002- \$48.80	002- \$66.30	002- \$33.30
			118 \$33.50
<b>First Health (\$5768)</b>			
PBM: Medco			
BIN: 610014		186- \$97.90	186- \$67.70
PCN: MEDDPRIME	126- \$45.90	126- \$37.20	126- \$34.40
<b>Humana (\$5884)</b>			
	102- \$22.80	102- \$26.70	102- \$28.20
BIN: 6100649	002- \$46.90	002- \$50.60	002- \$64.20
PCN: 0 320000	Deleted Plan		
	149- \$12.60	149- \$15.60	149- \$18.40
<b>Express Scripts (\$5660)</b>			
aka Medco	105- \$44.20	105- \$47.40	105- \$49.00
BIN: 610014	206- \$49.50	206- \$51.00	206- \$72.20
PCN: MEDDPRIME			
<b>PacificCare (\$5921)</b>	See United Health Care	See United Health Care	See United Health Care
<b>Silverscript (\$5601)</b>			
PBM: Caremark	111- Deleted Plan		
BIN: 00 4336	004- \$23.30	004- \$23.30	004- \$24.90
PCN: ADV	005- \$74.30	005- \$74.30	005- \$77.60
<b>Stonebridge Life (\$9579)</b>			
PBM: PCS	002 - \$40.90	002 - \$34.70	002 - \$118.80
BIN/PCN:	035 - \$51.70	035 - \$41.00	Deleted Plan
<b>Symphonix Health (\$0522)</b>			
PBM			081- \$39.70
BIN:			079- \$27.80
PCN:			
		108- \$23.60	108- \$24.70
<b>United HealthCare (\$5820)</b>			
PBM: Caremark	002- \$40.60	002- \$48.20	002- \$55.40
BIN: 610097			
PCN: 9999			
<b>United HealthCare (\$5921)</b>			
PBM: Caremark	183- \$100.70	Deleted P	
BIN: 610097			
PCN: 9999	348- \$21.50	348- \$27.40	348- \$31.20
<b>Wellcare (\$5967)</b>			
PBM: Catalyst RX	139- \$22.30	139- \$30.70	139- \$30.90
BIN: 603286			
PCN: MEDD	174- \$50.90	174- \$52.70	174- \$59.50

# Financial parameters for State Pharmacy Assistance

P-2420 Eligibility Determination for Medicaid

B. Monthly Income Standards (Continued)

**2. Eligibility maximums for Medicare cost-sharing programs, effective 4/1/16**

Coverage Groups	Rule	% FPL	Household Size	
			1	2
Qualified Medicare Beneficiaries (QMB)	§ 8.07b1	100%	990	1,335
Specified Low-Income Medicare Beneficiaries (SLMB)	§ 8.07b2	120%	1,188	1,602
Qualified Individuals - 1 (QI-1)	§ 8.07b3	135%	1,337	1,803
Qualified Disabled and Working Individuals (QDWI)	§ 8.07b4	200%	1,980	2,670

**3. Ranges for premiums, effective 1/1/16 – Pregnant women no longer have a premium regardless of income.**

			Household Size							
			1	2	3	4	5	6	7	8
<b>VPharm 1 - VD, VG, VJ, VM</b> \$15/person/month	5550 5441	> 0 ≤ 150%	1,485	2,003	2,520	3,038	3,555	4,073	4,592	5,112
<b>VPharm 2 - VE, VH, VK, VN</b> \$20/person/month	5650 5441	> 150 ≤ 175%	1,733	2,337	2,940	3,544	4,148	4,752	5,357	5,964
<b>VPharm 3 - VF, VI, VL, VO</b> \$50/person/month	5650 5441	> 175 ≤ 225%	2,228	3,004	3,780	4,557	5,333	6,109	6,887	7,667
<b>Dr. Dynasaur children under 19 - C0, C4</b> No premium	§ 64.00	> 0 ≤ 195%	1,931	2,604	3,276	3,949	4,622	5,295	5,969	6,645
<b>Dr. Dynasaur children under 19 - C0, C4</b> \$15/family/month	§ 64.00	> 195 ≤ 237%	2,347	3,164	3,982	4,800	5,617	6,435	7,255	8,076
<b>Dr. Dynasaur children under 19 - C0, C4</b> \$20/family/month w. other insurance, \$60/family/month uninsured.	§ 64.00	> 237% ≤ 312%	3,089	4,166	5,242	6,318	7,395	8,471	9,550	10,632

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Medicare.gov

Type the name of your drug:



Or Browse A-Z:

**Medicare.gov** **K L M**  
**N O P Q R S T U V W X Y Z**

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[Help with common drug abbreviations](#)

[Hints on how to enter drug information](#)

[Why can't I find my drug?](#)

### Retrieve My Saved Drug List:

Your drug list has been saved. You can retrieve your selected drugs and pharmacies on future visits using this Drug List ID and Password Date.

Your personal information cannot be accessed using your drug ID list. Medicare doesn't share the drug information you enter.

Drug List ID: **4285842944**

Password Date: **4/5/2016** ([change date](#))

Zip Code: **05641**

[Use a different drug list ID](#)

## My Drug List (Maximum 25 Drugs)

Total Drugs in My Drug List: 5 [Print My Drug List](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
Citalopram Hydrobromide TAB 20MG	30	Every 1 Month Retail Pharmacy	Already Generic (You originally entered Celexa) <a href="#">Switch Back</a>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Humira INJ 40MG/0.8	4 X 1 Box of 1 solutions (sold in a package of 2 solutions)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Neyplog Flexpen INJ FLEXPEN	5 X 3ML Pen (sold in a package of 5 pens)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Proair HFA AER	1 X 8.5GM Inhaler	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Spiriva Handihaler CAP HANDIHLER	1 X 1 Box of 30 aerosols	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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*COST comparison  
for some commonly  
prescribed medications*

## Your Plan Comparison

Select the tabs below for more detailed information about the plan health benefits, drug costs and coverage and star ratings.

**Zip Code:** 05641  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 4285842944  
**Password Date:** 04/05/2016  
**Important Coverage Information**

**Symbols**

Nationwide Coverage

\* Estimated

### Aetna Medicare Rx Saver (PDP)

(S5810-036) Plan Type: PDP  
**Organization:** Aetna Medicare

**Members:** 1-877-238-6211  
711(TTY/TDD)  
**Non Members:** 1-855-338-7030  
711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare

### Transamerica MedicareRx Classic (PDP)

(S9579-002) Plan Type: PDP  
**Organization:** Transamerica Life Insurance Company

**Members:** 1-888-672-7206  
711(TTY/TDD)  
**Non Members:** 1-877-527-1958  
711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



<input type="checkbox"/> <b>Fixed Costs</b>			
Monthly Drug Plan Premium	\$25.60	Monthly Drug Plan Premium	\$118.80
Monthly Health Plan Premium	N/A	Monthly Health Plan Premium	N/A
Annual Drug Deductible	\$360.00	Annual Drug Deductible	\$360.00
<u>Medicare costs at a glance</u>		<u>Medicare costs at a glance</u>	
<input type="checkbox"/> <b>Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs</b>			
<b>Cost at Kinney Drugs</b>		<b>Cost at Hannaford Food And Drug</b>	
Enrollment Today	\$6,023.73	Enrollment Today	\$6,743.71
<b>Cost at Hannaford Food And Drug</b>		<b>Cost at Kinney Drugs</b>	
Enrollment Today	\$6,023.73	Enrollment Today	\$6,743.71

<b>Cost at mail order pharmacy</b>		<b>Cost at mail order pharmacy</b>	
<b>Enrollment Today</b>	<b>\$6,470.92</b>	<b>Enrollment Today</b>	<b>\$6,716.55</b>
<u>Lower your drug costs</u>		<u>Lower your drug costs</u>	

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**Estimated Monthly Drug Costs**

**Monthly Drug Costs at Retail Pharmacies**  
[View Drug Cost Summary](#)

MILESTONES	MONTH	YOUR COST
Donut Hole reached	1st	\$2,784.06
	2nd	\$462.81
	3rd	\$462.81
	4th	\$462.81
	5th	\$462.81
	6th	\$462.81
	7th	\$462.81
	8th	\$462.81
	9th	\$462.81
	10th	\$462.81
	11th	\$462.81
	12th	\$462.81

**Monthly Drug Costs at Retail Pharmacies**  
[View Drug Cost Summary](#)

MILESTONES	MONTH	YOUR COST
Donut Hole reached	1st	\$2,912.33
	2nd	\$547.34
	3rd	\$547.34
	4th	\$547.34
	5th	\$547.34
	6th	\$547.34
	7th	\$547.34
	8th	\$547.34
	9th	\$547.34
	10th	\$547.34
	11th	\$547.34
	12th	\$547.34

**Monthly Drug Costs Estimator**

View monthly costs comparison charts.

[View monthly drug cost details by selected drugs](#)  
Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.

**Monthly Drug Costs Estimator**

View monthly costs comparison charts.

[View monthly drug cost details by selected drugs](#)  
Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.

**Drug Coverage Information**

All of your drugs are covered on the plan's formulary.

**Citalopram Hydrobromide TAB 20MG**

**Quantity Limit**

Tier 1: Preferred Generic

**Humira INJ 40MG/0.8**

Prior Authorization

**Quantity Limit**

Tier 5: Specialty Tier

**Novolog Flexpen INJ FLEXPEN**

No restrictions

Tier 3: Preferred Brand

All of your drugs are covered on the plan's formulary.

**Citalopram Hydrobromide TAB 20MG**

**Quantity Limit**

Tier 1: Preferred Generic

**Humira INJ 40MG/0.8**

Prior Authorization

Tier 5: Specialty Tier

**Novolog Flexpen INJ FLEXPEN**

**Quantity Limit**

Tier 3: Preferred Brand

**Proair HFA AER**

<b>Proair HFA AER</b> <u>Quantity Limit</u> Tier 3: Preferred Brand <b>Spiriva Handihaler CAP HANDIHLR</b> <u>Quantity Limit</u> Tier 3: Preferred Brand	No restrictions Tier 3: Preferred Brand <b>Spiriva Handihaler CAP HANDIHLR</b> No restrictions Tier 3: Preferred Brand
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[Print My Drug List](#)    [Print Comparison Report](#)

**Pharmacy & Mail Order Information**

Mail Order is available. <b>Pharmacy Network</b> 5 network pharmacies in your ZIP code Preferred pharmacy network available	Mail Order is available. <b>Pharmacy Network</b> 5 network pharmacies in your ZIP code Preferred pharmacy network available
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**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
CITALOPRAM HYDROBROMIDE TAB 20MG	30	Every 1 Month Retail Pharmacy	Already Generic (You originally entered Celexa) <a href="#">Switch Back</a>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
HUMIRA INJ 40MG/0.8	4 X 1 Box of 1 solutions (sold in a package of 2 solutions)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
NOVOLOG FLEXPEN INJ FLEXPEN	5 X 3ML Pen (sold in a package of 5 pens)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
PROAIR HFA AER	1 X 8.5GM Inhaler	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
SPIRIVA HANDIHALER CAP HANDIHLR	1 X 1 Box of 30 aerosols	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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## Quantity Limit Details for Transamerica MedicareRx Classic (PDP) (S9579-002)

 Quantity Limit Details

Please view the quantity limit details for the drugs you've selected for Transamerica MedicareRx Classic (PDP).  
Contact the plan for more information about any drugs with a quantity limit restriction.

SELECTED DRUGS	QUANTITY LIMITS [2]	QUANTITY LIMIT AMOUNT	QUANTITY LIMIT FREQUENCY
Citalopram Hydrobromide TAB 20MG	Yes	30 TABS	Every 30 Day(s)
Humira INJ 40MG/0.8			
Novolog Flexpen INJ FLEXPEN	Yes	2 packages of 5 (3ML) pens (30ML total)	Every 28 Day(s)
Proair HFA AER			
Spiriva Handihaler CAP HANDIHLR			

w02

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Zip Code: 05641

Current Coverage: Unknown

Current Subsidy: No Extra Help [?]

Drug List ID: 4285842944

Password Date: 04/05/2016

**Important Coverage Information**

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Symbols**

Some Dental Coverage      Some Vision Coverage      Nationwide Coverage

Some Hearing Coverage

\* Estimated

<p><b>Aetna Medicare Rx Saver (PDP)</b> (S5810-036-0)</p> <p><b>Organization:</b> Aetna Medicare</p> <p><b>Plan Type:</b> PDP</p> <p></p>	<p>P.O. Box 14088 Lexington, KY 40512</p> <p><b>Members:</b> 1-877-238-6211 711 (TTY/TDD)</p> <p><b>Non Members:</b> 1-855-338-7030 711 (TTY/TDD)</p>	<p><b>Overall Star Rating:</b> [?]</p> <p>3 out of 5 stars</p>	<p><b>Enroll</b></p>
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**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

Monthly Drug Plan Premium [?]	\$25.60
Monthly Health Plan Premium [?]	N/A
Annual Drug Deductible [?]	\$360.00

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	Cost For Rest of Year (based on enrollment today) [?]
Hannaford Food And Drug	\$6,023.73
Medicine Shoppe	\$5,976.56
Mail Order Pharmacy	\$6,470.92

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

- |                                         |                                 |                                     |
|-----------------------------------------|---------------------------------|-------------------------------------|
| <a href="#">Hannaford Food And Drug</a> | <a href="#">Medicine Shoppe</a> | <a href="#">Mail Order Pharmacy</a> |
|-----------------------------------------|---------------------------------|-------------------------------------|

Medicine Shoppe - Preferred Retail Cost Sharing

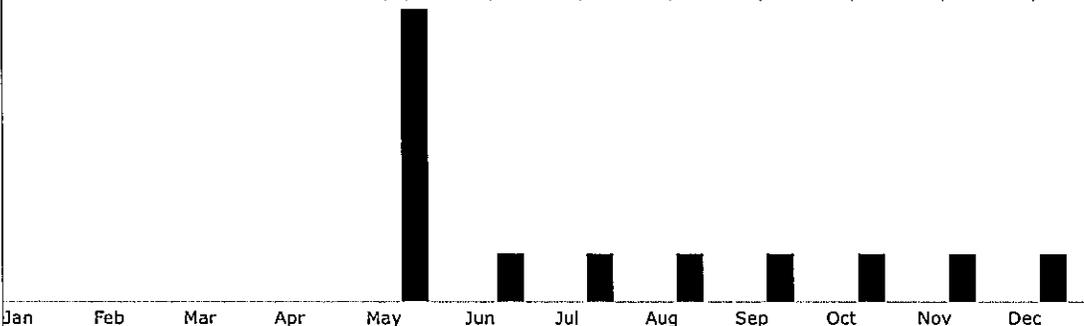
SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	What You Pay			
			Deductible[?]	Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
Citalopram Hydrobromide TAB 20MG	\$1.66	Every 1 Month	\$1.66	\$1.00	\$0.96	\$1.66
Humira INJ 40MG/0.8	\$7,655.85	Every 1 Month	\$7,655.85	\$1,913.96	\$3,445.13	\$382.79
Novolog Flexpen INJ FLEXPEN	\$461.66	Every 1 Month	\$461.66	\$35.00	\$207.75	\$23.08
Proair HFA AER	\$54.34	Every 1 Month	\$54.34	\$35.00	\$24.45	\$7.40
Spiriva Handihaler CAP HANDIHLR	\$319.10	Every 1 Month	\$319.10	\$35.00	\$143.60	\$15.96
<b>MONTHLY TOTALS:</b>	<b>\$8,492.61</b>		<b>\$8,492.61</b>	<b>\$2,019.96</b>	<b>\$3,821.89</b>	<b>\$430.89</b>

**Estimated Monthly Drug Costs**

<b>Hannaford Food And Drug</b>	<b>Medicine Shoppe</b>	<b>Mail Order Pharmacy</b>
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Monthly Costs for the Rest of the Year (based on enrollment today)

N/A   N/A   N/A   N/A   \$2,781   \$456   \$456   \$456   \$456   \$456   \$456   \$456



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions		
		PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAPY [?]
Citalopram Hydrobromide TAB 20MG	Tier 1: Preferred Generic		<u>Yes</u>	
Humira INJ 40MG/0.8	Tier 5: Specialty Tier	Yes	<u>Yes</u>	
Novolog Flexpen INJ FLEXPEN	Tier 3: Preferred Brand			
Proair HFA AER	Tier 3: Preferred Brand		<u>Yes</u>	
Spiriva Handihaler CAP HANDIHLR	Tier 3: Preferred Brand		<u>Yes</u>	

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

**Pharmacy & Mail Order Information**

Mail Order is available.

[Pharmacy Network \[?\]](#)

5 network pharmacies in your ZIP code

Preferred pharmacy network available [?]

**Drug List**

**Add/Edit Drugs**

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
CITALOPRAM HYDROBROMIDE TAB 20MG	30	Every 1 Month Retail Pharmacy	Already Generic (You originally entered Celexa) <b>Switch Back</b>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
HUMIRA INJ 40MG/0.8	4 X 1 Box of 1 solutions (sold in a package of 2 solutions)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
NOVOLOG FLEXPEN INJ FLEXPEN	5 X 3ML Pen (sold in a package of 5 pens)	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
PROAIR HFA AER	1 X 8.5GM Inhaler	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
SPIRIVA HANDIHALER CAP HANDIHLR	1 X 1 Box of 30 aerosols	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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## Quantity Limit Details for Aetna Medicare Rx Saver (PDP) (S5810-036)

 **Quantity Limit Details**

Please view the quantity limit details for the drugs you've selected for Aetna Medicare Rx Saver (PDP). Contact the plan for more information about any drugs with a quantity limit restriction.

SELECTED DRUGS	QUANTITY LIMITS [2]	QUANTITY LIMIT AMOUNT	QUANTITY LIMIT FREQUENCY
Citalopram Hydrobromide TAB 20MG	Yes	60 TABS	Every 30 Day(s)
Humira INJ 40MG/0.8	Yes	3 packages of 2 solutions (6 solutions total)	Every 28 Day(s)
Novolog Flexpen INJ FLEXPEN			
Proair HFA AER	Yes	2 packages of 8.5GM inhalers (17GM total)	Every 30 Day(s)
Spiriva Handihaler CAP HANDIHLR	Yes	0.33 packages of 90 aerosols (30 aerosols total)	Every 30 Day(s)

w01

Type the name of your drug:



Or Browse A-Z:

**Medicare.gov** **A B C D E F G H I J K L M**  
**N O P Q R S T U V W X Y Z**

The Official U.S. Government Site for Medicare

[Help with common drug abbreviations](#)

[Hints on how to enter drug information](#)

[Why can't I find my drug?](#)

**Retrieve My Saved Drug List:**

Your drug list has been saved. You can retrieve your selected drugs and pharmacies on future visits using this Drug List ID and Password Date.

Your personal information cannot be accessed using your drug ID list. Medicare doesn't share the drug information you enter.

Drug List ID: **3256309568**

Password Date: **10/13/2012**

**(change date)**

Zip Code: **05602**

**Use a different drug list ID**

**My Drug List (Maximum 25 Drugs)**

Total Drugs in My Drug List: 11

[Print My Drug List](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
Acyclovir TAB 400MG	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Apriso CAP 0.375GM	360	Every 3 Months Mail Order Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Carbidopa/Levodopa TAB 25/100MG ER	1	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Carbidopa/Levodopa TAB 25-100MG	1	Every 3 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Clobetasol Propionate E (Cream) CRE 0.05%	1 X 60GM Tube	Every 12 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Ondansetron Hcl TAB 4MG	6	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Bramipexole Dihydrochloride TAB 1MG	810	Every 3 Months Mail Order Pharmacy	Already Generic (You originally entered Mirabex) <b>Switch Back</b>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Rimantadine Hcl TAB 100MG	360	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Rytary CAP 23.75-95MG	2250	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Stalevo 75 TAB	1	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
Trazodone Hcl TAB 50MG	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

**NorthWestPharmacy.com**  
**(//www.northwestpharmacy.com)**

*high-cost  
medications not  
on consumer formulary*

TOLL FREE PHONE: 1-866-539-5330

TOLL FREE FAX: 1-866-539-5331

**Apriso ER - Mesalamine - Prices & Information**

A prescription is **required** for this item.

 **3-in-1 Guarantee** **FREE**

 ID Protection  Purchase  **Lowest Price**

Generic alternative is not available at this time.

BRAND LISTING - Apriso ER (Mesalamine) [Price Guarantee](#)

Dosage	Pack	Price	Qty	Shipping
.375gm	120.00 caps	\$623.79	1 ▼	

Please read the important disclosure at the bottom of the page.

This listing is being updated. Thank you for your patience.

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**NorthWestPharmacy.com**  
 ([//www.northwestpharmacy.com](http://www.northwestpharmacy.com))

TOLL FREE PHONE: 1-866-539-5330

TOLL FREE FAX: 1-866-539-5331

**Rytary - Carbidopa/Levodopa Extended Release - Prices & Information**

A prescription is required for this item.

 **3-in-1 Guarantee** **FREE**

 ID Protection  Purchase  Lowest Price

Generic alternative is not available at this time.

BRAND LISTING - Rytary (Carbidopa/Levodopa Extended Release) <a href="#">Price Guarantee</a>				
Dosage	Pack	Price	Qty	Shipping
23.75mg/95mg	100.00 capsules	\$285.59	1 ▼	
36.25mg/145mg	100.00 capsules	\$285.59	1 ▼	
48.75mg/195mg	100.00 capsules	\$285.59	1 ▼	
61.25mg/245mg	100.00 capsules	\$353.99	1 ▼	

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affiliate with our authorized pharmacies and international fulfillment centers that procure products through reputable sources. For more information, please visit our [Drug Safety & Authenticity \(https://www.northwestpharmacy.com/drug-safety-and-authenticity.aspx\)](https://www.northwestpharmacy.com/drug-safety-and-authenticity.aspx) and [FAQ \(https://www.northwestpharmacy.com/Faq.aspx\)](https://www.northwestpharmacy.com/Faq.aspx) sections. If you should have any questions, please contact us.

The logo features the words "buy safe" in a bold, sans-serif font. "buy" is in white on a black background, and "safe" is in black on a white background, with a diagonal line separating the two words.

INSPECTED  
& MONITORED

GUARANTEED 

# Medicare.gov

The Official U.S. Government Site for Medicare



*Refined Search*

## Medicare.gov

The Official U.S. Government Site for Medicare

# Step 4 of 4: Refine Your Plan Results

This is a summary of the types of plans available in your area. Use the checkboxes to select the types of plans you'd like to view. You may also use the filters on the left to narrow your search. Using filters may eliminate some options, including plans with the lowest estimated annual costs.

**Zip Code:** 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3256309568  
**Password Date:** 10/13/2012  
**Important Coverage Information**

### Refine Your Search

[Remove Filtering](#)

[Limit Your Monthly Premium](#)

Show me plans within the

[Limit Your Annual Drug Deductible](#)

Show me plans within the

[Select Drug Options](#)

\$0

\$360

360

have an any drugs on formulary (applies only to plans with drug benefits)

provide mail order pricing for drugs (applies only to plans with drug benefits)

[Select Star Ratings](#)

Overall Star Rating -

[Select Coverage Options](#)

0

Stars

5

Stars

[Select Special Needs Plans](#)

0.0

[Change Health Status](#)

Exclude plans that do not have an Overall Star Rating

[Select Plans By and Company](#)

Plans for people with certain conditions would like to look from a [Remove Filtering](#)

### Summary of Your Search Results

There are a total of 27 plans available in your area including Original Medicare.

Please select one or more plan types to continue.

#### Select Available Plans Based On Your Filters

All

Number of Plans Available: 0

Prescription Drug Plans (with Original Medicare) [?]

0 plan(s) of 21 available

Medicare Health Plans with drug coverage [?]

0 plan(s) of 5 available

Medicare Health Plans without drug coverage [?]

0 plan(s) of 0 available

**Medicare.gov**

The Official U.S. Government Site for Medicare

# Your Plan Comparison

Select the tabs below for more detailed information about the plan health benefits, drug costs and coverage and star ratings.

Zip Code: 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3256309568  
**Password Date:** 10/13/2012

**Important Coverage Information**

**Symbols**

Nationwide Coverage

\* Estimated

Search by plan

**SilverScript Choice (PDP)**

(S5601-004) Plan Type: PDP  
**Organization:** SilverScript

**Members:** 1-866-235-5660  
 711(TTY/TDD)  
**Non Members:** 1-866-552-6106  
 711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



**Aetna Medicare Rx Saver (PDP)**

(S5810-036) Plan Type: PDP  
**Organization:** Aetna Medicare

**Members:** 1-877-238-6211  
 711(TTY/TDD)  
**Non Members:** 1-855-338-7030  
 711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



**WellCare Classic (PDP)**

(S5967-139) Plan Type: PDP  
**Organization:** WellCare

**Members:** 1-888-550-5252  
 1-888-816-5252(TTY/TDD)  
**Non Members:** 1-888-293-5151  
 1-888-816-5252(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



**Fixed Costs**

<b>Monthly Drug Plan Premium</b>	<b>\$24.90</b>	<b>Monthly Drug Plan Premium</b>	<b>\$25.60</b>	<b>Monthly Drug Plan Premium</b>	<b>\$30.90</b>
<b>Monthly Health Plan Premium</b>	<b>N/A</b>	<b>Monthly Health Plan Premium</b>	<b>N/A</b>	<b>Monthly Health Plan Premium</b>	<b>N/A</b>
<b>Annual Drug Deductible</b>	<b>\$0.00</b>	<b>Annual Drug Deductible</b>	<b>\$360.00</b>	<b>Annual Drug Deductible</b>	<b>\$360.00</b>
<b>Medicare costs at a glance</b>		<b>Medicare costs at a glance</b>		<b>Medicare costs at a glance</b>	

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

<b>Cost at Montpelier Pharmacy</b>		<b>Cost at Wal-Mart Pharmacy 10-2682</b>		<b>Cost at Montpelier Pharmacy</b>	
<b>Enrollment Today</b>	<b>\$19,848.41</b>	<b>Enrollment Today</b>	<b>\$4,047.71</b>	<b>Enrollment Today</b>	<b>\$20,130.44</b>
<b>Cost at Wal-Mart Pharmacy 10-2682</b>		<b>Cost at Montpelier Pharmacy</b>		<b>Cost at Wal-Mart Pharmacy 10-2682</b>	
<b>Enrollment Today</b>	<b>\$19,848.41</b>	<b>Enrollment Today</b>	<b>\$4,213.03</b>	<b>Enrollment Today</b>	<b>\$20,130.44</b>

Cost at mail order pharmacy		Cost at mail order pharmacy		Cost at mail order pharmacy	
Enrollment Today	\$19,949.01	Enrollment Today	\$3,782.56	Enrollment Today	\$20,247.38
<a href="#">Lower your drug costs</a>		<a href="#">Lower your drug costs</a>		<a href="#">Lower your drug costs</a>	

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**Estimated Monthly Drug Costs**

Monthly Drug Costs at Retail Pharmacies			Monthly Drug Costs at Retail Pharmacies			Monthly Drug Costs at Retail Pharmacies		
<a href="#">View Drug Cost Summary</a>			<a href="#">View Drug Cost Summary</a>			<a href="#">View Drug Cost Summary</a>		
MILESTONES	MONTH	YOUR COST	MILESTONES	MONTH	YOUR COST	MILESTONES	MONTH	YOUR COST
Donut Hole reached	1st	\$6,151.96	Donut Hole reached	1st	\$2,691.65	Deductible met	1st	\$6,432.66
	2nd	\$131.60		2nd	\$234.61		2nd	\$138.88
	3rd	\$131.60		3rd	\$234.61		3rd	\$138.88
	4th	\$6,091.48	Catastrophic met	4th	\$376.38	4th	\$6,098.75	
	5th	\$266.52		5th	\$59.37	Donut Hole reached	5th	\$247.97
	6th	\$371.88		6th	\$59.37		6th	\$371.23
	7th	\$6,331.49		7th	\$332.35	7th	\$6,330.84	
	8th	\$371.88		8th	\$59.37	8th	\$371.23	
	9th	\$371.88		9th	\$59.37	9th	\$371.23	
	10th	\$6,331.49		10th	\$332.35	10th	\$6,330.84	
	11th	\$371.88		11th	\$59.37	11th	\$371.23	
	12th	\$371.88		12th	\$59.37	Catastrophic met	12th	\$312.44

**Monthly Drug Costs Estimator**

View monthly costs comparison charts.

[View monthly drug cost details by selected drugs](#)

Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.

**Monthly Drug Costs Estimator**

View monthly costs comparison charts.

[View monthly drug cost details by selected drugs](#)

Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.

**Monthly Drug Costs Estimator**

View monthly costs comparison charts.

[View monthly drug cost details by selected drugs](#)

Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.

**Drug Coverage Information**

<b>9 out of 11 of your drugs are covered on the plan's formulary.</b>	<b>10 out of 11 of your drugs are covered on the plan's formulary.</b>	<b>9 out of 11 of your drugs are covered on the plan's formulary.</b>
<b>Acyclovir TAB 400MG</b>	<b>Acyclovir TAB 400MG</b>	<b>Acyclovir TAB 400MG</b>
No restrictions	No restrictions	No restrictions
Tier 2: Generic	Tier 2: Generic	Tier 2: Generic
<b>Apriso CAP 0.375GM</b>	<b>Apriso CAP 0.375GM</b>	<b>Apriso CAP 0.375GM</b>
No restrictions	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 3: Preferred Brand	Tier 3: Preferred Brand

<b>Carbidopa/Levodopa TAB 25/100MG ER</b>	<b>Carbidopa/Levodopa TAB 25/100MG ER</b>	<b>Carbidopa/Levodopa TAB 25/100MG ER</b>
No restrictions	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 2: Generic	Tier 3: Preferred Brand
<b>Carbidopa/Levodopa TAB 25-100MG</b>	<b>Carbidopa/Levodopa TAB 25-100MG</b>	<b>Carbidopa/Levodopa TAB 25-100MG</b>
No restrictions	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 2: Generic	Tier 2: Generic
<b>Clobetasol Propionate E (Cream) CRE 0.05%</b>	<b>Clobetasol Propionate E (Cream) CRE 0.05%</b>	<b>Clobetasol Propionate E (Cream) CRE 0.05%</b>
No restrictions	No restrictions	No restrictions
Tier 4: Non-Preferred Brand	Tier 2: Generic	Tier 4: Non-Preferred Brand
<b>Ondansetron Hcl TAB 4MG</b>	<b>Ondansetron Hcl TAB 4MG</b>	<b>Ondansetron Hcl TAB 4MG</b>
Prior Authorization	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 2: Generic	Tier 3: Preferred Brand
<b>Pramipexole Dihydrochloride TAB 1MG</b>	<b>Pramipexole Dihydrochloride TAB 1MG</b>	<b>Pramipexole Dihydrochloride TAB 1MG</b>
No restrictions	No restrictions	No restrictions
Tier 2: Generic	Tier 2: Generic	Tier 2: Generic
<b>Rimantadine Hcl TAB 100MG</b>	<b>Rimantadine Hcl TAB 100MG</b>	<b>Rimantadine Hcl TAB 100MG</b>
No restrictions	No restrictions	No restrictions
Tier 3: Preferred Brand	Tier 2: Generic	Tier 3: Preferred Brand
<b>Rytary CAP 23.75-95MG</b>	<b>Rytary CAP 23.75-95MG</b>	<b>Rytary CAP 23.75-95MG</b>
No restrictions	No restrictions	No restrictions
NOT ON FORMULARY <sup>15</sup>	Tier 4: Non-Preferred Brand	NOT ON FORMULARY <sup>15</sup>
<b>Stalevo 75 TAB</b>	<b>Stalevo 75 TAB</b>	<b>Stalevo 75 TAB</b>
No restrictions	No restrictions	No restrictions
NOT ON FORMULARY <sup>15</sup>	NOT ON FORMULARY <sup>15</sup>	NOT ON FORMULARY <sup>15</sup>
<b>Trazodone Hcl TAB 50MG</b>	<b>Trazodone Hcl TAB 50MG</b>	<b>Trazodone Hcl TAB 50MG</b>
No restrictions	No restrictions	No restrictions
Tier 2: Generic	Tier 2: Generic	Tier 1: Preferred Generic

[Print My Drug List](#)    [Print Comparison Report](#)

<sup>15</sup>Any amount you spend for a non-formulary drug is not counted towards the deductible, initial coverage limit or out-of-pocket costs UNLESS the plan approves a formulary exception. If an exception is approved, the non-formulary drug will be covered. The drug cost displayed is only an estimate and actual cost may vary. Please contact the plan for more information.

**Pharmacy & Mail Order Information**

<b>Mail Order is available.</b>	<b>Mail Order is available.</b>	<b>Mail Order is available.</b>
<b>Pharmacy Network</b>	<b>Pharmacy Network</b>	<b>Pharmacy Network</b>
<u>4 network pharmacies</u> in your ZIP code Preferred pharmacy network available	<u>4 network pharmacies</u> in your ZIP code Preferred pharmacy network available	<u>4 network pharmacies</u> in your ZIP code Preferred pharmacy network available

**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
<b>ACYCLOVIR TAB 400MG</b>	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
				<a href="#">Change dose</a> <a href="#">Add</a>

APRISO CAP 0.375GM	360	Every 3 Months Mail Order Pharmacy	Generic Not Available	<a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25/100MG ER	1	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25- 100MG	1	Every 3 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CLOBETASOL PROPIONATE E (CREAM) CRE 0.05%	1 X 60GM Tube	Every 12 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
ONDANSETRON HCL TAB 4MG	6	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
PRAMIPEXOLE DIHYDROCHLORIDE TAB 1MG	810	Every 3 Months Mail Order Pharmacy	Already Generic (You originally entered Mirapex) <a href="#">Switch Back</a>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
RIMANTADINE HCL TAB 100MG	360	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
RYTARY CAP 23.75-95MG	2250	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
STALEVO 75 TAB	1	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
TRAZODONE HCL TAB 50MG	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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**Medicare.gov**  
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Medicare.gov

A federal government website managed by the Centers for  
Medicare & Medicaid Services  
7500 Security Boulevard, Baltimore, MD 21244



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**Medicare**  
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*One example of costs for the same meds.*

**Zip Code:** 05602

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3256309568  
**Password Date:** 10/13/2012

**Important Coverage Information**

**Symbols**

Some Dental Coverage      Some Vision Coverage      Nationwide Coverage

Some Hearing Coverage

\* Estimated

<b>WellCare Classic (PDP)</b> (S5967-139-0)  <b>Organization:</b> WellCare <b>Plan Type:</b> PDP 	PO BOX 31370 TAMPA, FL 33631	<b>Overall Star Rating:</b> [?] 2.5 out of 5 stars	<a href="#">Enroll</a>
	<b>Members:</b> 1-888-550-5252 1-888-816-5252 (TTY/TDD)	<b>Non Members:</b> 1-888-293-5151 1-888-816-5252 (TTY/TDD)	

**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

<b>Monthly Drug Plan Premium [?]</b>	\$30.90
<b>Monthly Health Plan Premium [?]</b>	N/A
<b>Annual Drug Deductible [?]</b>	\$360.00

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	<b>Cost For Rest of Year (based on enrollment today) [?]</b>
Montpelier Pharmacy	\$20,130.44
Wal-Mart Pharmacy 10-2682	\$20,130.44
Mail Order Pharmacy	\$20,247.38

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

<a href="#">Montpelier Pharmacy</a>	<a href="#">Wal-Mart Pharmacy 10-2682</a>	<a href="#">Mail Order Pharmacy</a>
-------------------------------------	-------------------------------------------	-------------------------------------

Montpelier Pharmacy - Standard Retail Cost Sharing

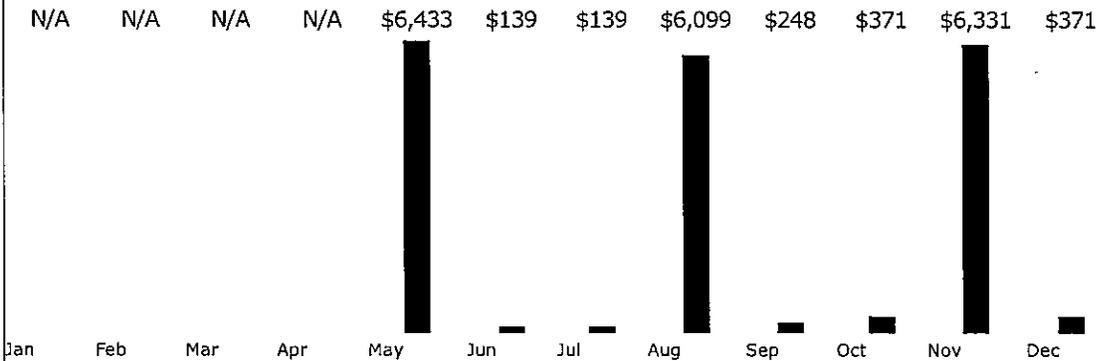
SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	What You Pay			
			Deductible[?]	Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
Acyclovir TAB 400MG <sup>14</sup>	\$4.05	Every 1 Month	\$4.05	\$4.05	\$2.35	\$2.95
Apriso CAP 0.375GM <sup>14</sup>	\$425.40	Every 1 Month	\$425.40	\$47.00	\$191.43	\$21.27
Carbidopa/Levodopa TAB 25/100MG ER <sup>14</sup>	\$0.60	Every 1 Month	\$0.60	\$0.60	\$0.35	\$0.60
Carbidopa/Levodopa TAB 25-100MG	\$0.63	Every 3 Months	\$0.63	\$0.63	\$0.37	\$0.63
Clobetasol Propionate E (Cream) CRE 0.05%	\$140.61	Every 12 Months	\$140.61	\$70.30	\$81.55	\$7.40
Ondansetron Hcl TAB 4MG	\$3.33	Every 1 Month	\$3.33	\$3.33	\$1.93	\$3.33
Pramipexole Dihydrochloride TAB 1MG <sup>14</sup>	\$25.34	Every 1 Month	\$25.34	\$6.00	\$14.70	\$2.95
Rimantadine Hcl TAB 100MG <sup>14</sup>	\$220.96	Every 1 Month	\$220.96	\$47.00	\$128.16	\$11.05
Rytary CAP 23.75-95MG	\$5,951.75	Every 3 Months	\$5,951.75	\$5,951.75	\$5,951.75	\$5,951.75
Stalevo 75 TAB	\$7.49	Every 3 Months	\$7.49	\$7.49	\$7.49	\$7.49
Trazodone Hcl TAB 50MG <sup>14</sup>	\$2.43	Every 1 Month	\$0.00	\$0.00	\$1.41	\$2.43
<b>MONTHLY TOTALS:</b>	<b>\$6,782.59</b>		<b>\$6,780.16</b>	<b>\$6,138.15</b>	<b>\$6,381.49</b>	<b>\$6,011.85</b>

<sup>14</sup> You selected that you get this medicine from a mail order pharmacy. The cost displayed is what you would pay at a retail pharmacy.

**Estimated Monthly Drug Costs**

Montpelier Pharmacy	Wal-Mart Pharmacy 10-2682	Mail Order Pharmacy
---------------------	---------------------------	---------------------

Monthly Costs for the Rest of the Year (based on enrollment today)



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY)	Restrictions		
		PRIOR AUTHORIZATION	QUANTITY LIMITS [?]	STEP THERAPY

	STATUS) [?]	[?]	[?]
<b>Acyclovir TAB 400MG</b>	Tier 2: Generic		
<b>Apriso CAP 0.375GM</b>	Tier 3: Preferred Brand		
<b>Carbidopa/Levodopa TAB 25/100MG ER</b>	Tier 3: Preferred Brand		
<b>Carbidopa/Levodopa TAB 25-100MG</b>	Tier 2: Generic		
<b>Clobetasol Propionate E (Cream) CRE 0.05%</b>	Tier 4: Non-Preferred Brand		
<b>Ondansetron Hcl TAB 4MG</b>	Tier 3: Preferred Brand		
<b>Pramipexole Dihydrochloride TAB 1MG</b>	Tier 2: Generic		
<b>Rimantadine Hcl TAB 100MG</b>	Tier 3: Preferred Brand		
<b>Rytary CAP 23.75-95MG</b>	Not on Formulary <sup>15</sup>		
<b>Stalevo 75 TAB</b>	Not on Formulary <sup>15</sup>		
<b>Trazodone Hcl TAB 50MG</b>	Tier 1: Preferred Generic		

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

<sup>15</sup>Any amount you spend for a non-formulary drug is not counted towards the deductible, initial coverage limit or out-of-pocket costs UNLESS the plan approves a formulary exception. If an exception is approved, the non-formulary drug will be covered at Tier 4. The drug cost displayed is only an estimate and actual cost may vary. Please contact the plan for more information.

**Pharmacy & Mail Order Information**

Mail Order is available.

**Pharmacy Network [?]**

**4 network pharmacies** in your ZIP code  
Preferred pharmacy network available [?]

**Drug List**

Add/Edit Drugs

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
ACYCLOVIR TAB 400MG	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
APRISO CAP 0.375GM	360	Every 3 Months Mail Order Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25/100MG ER	1	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25-100MG	1	Every 3 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

<b>CLOBETASOL PROPIONATE E (CREAM) CRE 0.05%</b>	1 X 60GM Tube	Every 12 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>ONDANSETRON HCL TAB 4MG</b>	6	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>PRAMIPEXOLE DIHYDROCHLORIDE TAB 1MG</b>	810	Every 3 Months Mail Order Pharmacy	Already Generic (You originally entered Mirapex) <b>Switch Back</b>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>RIMANTADINE HCL TAB 100MG</b>	360	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>RYTARY CAP 23.75-95MG</b>	2250	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>STALEVO 75 TAB</b>	1	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>TRAZODONE HCL TAB 50MG</b>	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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*preferred pharmacies vs. cost share*

Zip Code: 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3256309568  
**Password Date:** 10/13/2012  
**Important Coverage Information**

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Symbols**

Some Dental Coverage      Some Vision Coverage      Nationwide Coverage

Some Hearing Coverage

\* Estimated

<b>Aetna Medicare Rx Saver (PDP)</b> (S5810-036-0)  <b>Organization:</b> Aetna Medicare <b>Plan Type:</b> PDP 	P.O. Box 14088 Lexington, KY 40512	<b>Overall Star Rating:</b> [?]  3 out of 5 stars	<b>Enroll</b>
	<b>Members:</b> 1-877-238-6211 711 (TTY/TDD)	<b>Non Members:</b> 1-855-338-7030 711 (TTY/TDD)	

**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

<b>Monthly Drug Plan Premium [?]</b>	\$25.60
<b>Monthly Health Plan Premium [?]</b>	N/A
<b>Annual Drug Deductible [?]</b>	\$360.00

Medicare costs at a glance

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	Cost For Rest of Year (based on enrollment today) [?]
Montpelier Pharmacy	\$4,213.03
Wal-Mart Pharmacy 10-2682	\$4,047.71
Mail Order Pharmacy	\$3,782.56

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

<b>Montpelier Pharmacy</b>	<b>Wal-Mart Pharmacy 10-2682</b>	<b>Mail Order Pharmacy</b>
----------------------------	----------------------------------	----------------------------

Wal-Mart Pharmacy 10-2682 - Preferred Retail Cost Sharing

SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	What You Pay			
			Deductible[?]	Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
Acyclovir TAB 400MG <sup>14</sup>	\$2.00	Every 1 Month	\$2.00	\$2.00	\$1.16	\$2.00
Apriso CAP 0.375GM <sup>14</sup>	\$426.39	Every 1 Month	\$426.39	\$35.00	\$191.88	\$21.32
Carbidopa/Levodopa TAB 25/100MG ER <sup>14</sup>	\$1.01	Every 1 Month	\$1.01	\$1.01	\$0.59	\$1.01
Carbidopa/Levodopa TAB 25-100MG	\$1.01	Every 3 Months	\$1.01	\$1.01	\$0.59	\$1.01
Clobetasol Propionate E (Cream) CRE 0.05%	\$35.04	Every 12 Months	\$35.04	\$2.00	\$20.32	\$2.95
Ondansetron Hcl TAB 4MG	\$1.54	Every 1 Month	\$1.54	\$1.54	\$0.89	\$1.54
Pramipexole Dihydrochloride TAB 1MG <sup>14</sup>	\$9.99	Every 1 Month	\$9.99	\$2.00	\$5.79	\$2.95
Rimantadine Hcl TAB 100MG <sup>14</sup>	\$13.00	Every 1 Month	\$13.00	\$2.00	\$7.54	\$2.95
Rytary CAP 23.75-95MG	\$5,279.50	Every 3 Months	\$5,279.50	\$2,164.60	\$2,375.78	\$263.98
Stalevo 75 TAB	\$7.99	Every 3 Months	\$7.99	\$7.99	\$7.99	\$7.99
Trazodone Hcl TAB 50MG <sup>14</sup>	\$2.00	Every 1 Month	\$2.00	\$2.00	\$1.16	\$2.00
<b>MONTHLY TOTALS:</b>	<b>\$5,779.47</b>		<b>\$5,779.47</b>	<b>\$2,221.15</b>	<b>\$2,613.69</b>	<b>\$309.70</b>

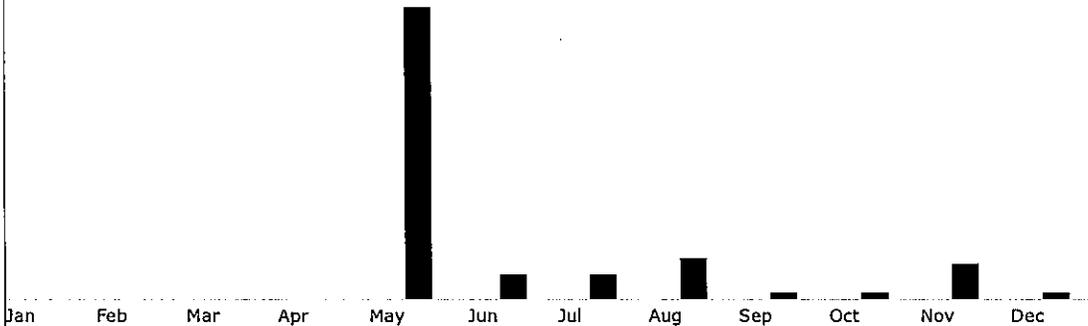
<sup>14</sup> You selected that you get this medicine from a mail order pharmacy. The cost displayed is what you would pay at a retail pharmacy.

**Estimated Monthly Drug Costs**

Montpelier Pharmacy	Wal-Mart Pharmacy 10-2682	Mail Order Pharmacy
---------------------	---------------------------	---------------------

Monthly Costs for the Rest of the Year (based on enrollment today)

N/A   N/A   N/A   N/A   \$2,692   \$235   \$235   \$376   \$59   \$59   \$332   \$59



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary.

[View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY)	Restrictions		
		PRIOR AUTHORIZATION	QUANTITY LIMITS [?]	STEP THERAPY

	STATUS) [?]	[?]	[?]
<b>Acyclovir TAB 400MG</b>	Tier 2: Generic		
<b>Apriso CAP 0.375GM</b>	Tier 3: Preferred Brand		
<b>Carbidopa/Levodopa TAB 25/100MG ER</b>	Tier 2: Generic		
<b>Carbidopa/Levodopa TAB 25-100MG</b>	Tier 2: Generic		
<b>Clobetasol Propionate E (Cream) CRE 0.05%</b>	Tier 2: Generic		
<b>Ondansetron Hcl TAB 4MG</b>	Tier 2: Generic		
<b>Pramipexole Dihydrochloride TAB 1MG</b>	Tier 2: Generic		
<b>Rimantadine Hcl TAB 100MG</b>	Tier 2: Generic		
<b>Rytary CAP 23.75-95MG</b>	Tier 4: Non-Preferred Brand		
<b>Stalevo 75 TAB</b>	Not on Formulary <sup>15</sup>		
<b>Trazodone Hcl TAB 50MG</b>	Tier 2: Generic		

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

<sup>15</sup>Any amount you spend for a non-formulary drug is not counted towards the deductible, initial coverage limit or out-of-pocket costs UNLESS the plan approves a formulary exception. If an exception is approved, the non-formulary drug will be covered at Tier 4. The drug cost displayed is only an estimate and actual cost may vary. Please contact the plan for more information.

**Pharmacy & Mail Order Information**

Mail Order is available.

[Pharmacy Network \[?\]](#)

4 network pharmacies in your ZIP code

Preferred pharmacy network available [?]

**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
ACYCLOVIR TAB 400MG	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
APRISO CAP 0.375GM	360	Every 3 Months Mail Order Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25/100MG ER	1	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
CARBIDOPA/LEVODOPA TAB 25-100MG	1	Every 3 Months Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
				<a href="#">Change dose</a>

Your Medicare Health Plan Details

<b>CLOBETASOL PROPIONATE E (CREAM) CRE 0.05%</b>	1 X 60GM Tube	Every 12 Months Retail Pharmacy	Already Generic	<a href="#">Add</a> <a href="#">Remove</a>
<b>ONDANSETRON HCL TAB 4MG</b>	6	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>PRAMIPEXOLE DIHYDROCHLORIDE TAB 1MG</b>	810	Every 3 Months Mail Order Pharmacy	Already Generic (You originally entered Mirapex) <a href="#">Switch Back</a>	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>RIMANTADINE HCL TAB 100MG</b>	360	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>RYTARY CAP 23.75-95MG</b>	2250	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>STALEVO 75 TAB</b>	1	Every 3 Months Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>
<b>TRAZODONE HCL TAB 50MG</b>	90	Every 3 Months Mail Order Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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## Medicare.gov



Type the name of your drug:

Or Browse A-Z:

**Medicare.gov** **A B C D E F G H I J K L M**  
**N O P Q R S T U V W X Y Z**

The Official U.S. Government Site for Medicare

[Help with common drug abbreviations](#)

[Hints on how to enter drug information](#)

[Why can't I find my drug?](#)

### Retrieve My Saved Drug List:

Your drug list has been saved. You can retrieve your selected drugs and pharmacies on future visits using this Drug List ID and Password Date.

Your personal information cannot be accessed using your drug ID list. Medicare doesn't share the drug information you enter.

Drug List ID: **2091713440**

Password Date: **4/5/2016 (change date)**

Zip Code: **05602**

[Use a different drug list ID](#)

## My Drug List (Maximum 25 Drugs)

Total Drugs in My Drug List: 1 [Print My Drug List](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
Cialis TAB TOMC	20	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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## Step 4 of 4: Refine Your Plan Results

This is a summary of the types of plans available in your area. Use the checkboxes to select the types of plans you'd like to view. You may also use the filters on the left to narrow your search. Using filters may eliminate some options, including plans with the lowest estimated annual costs.

**Zip Code:** 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 2091713440  
**Password Date:** 04/05/2016  
**Important Coverage Information**

### Refine Your Search

**Remove Filtering**

**Limit Your Monthly Premium**

Show me plans within the

**Limit Your Annual Drug Deductible**

Show me plans within the

**Select Drug Options**

\$0

\$360

360

have all my drugs on formulary (applies only to plans with drug benefits)

provide mail order pricing for drugs (applies only to plans with drug benefits)

**Select Star Ratings**

Overall Star Rating -

**Select Coverage Options**

0

Stars

5 Stars

**Select Special Needs Plans**

0.0

**Change Health Status**

Exclude plans that do not have an Overall Star Rating

**Select Plans By and Company**

Plan for people with certain conditions would like to pick from a **Remove Filtering**

### Summary of Your Search Results

There are a total of 27 plans available in your area including Original Medicare.

Please select one or more plan types to continue.

**Select Available Plans Based On Your Filters**  
All

**Prescription Drug Plans (with Original Medicare) [?]**

**Number of Plans Available: 0**

0 plan(s) of 21 available

**Medicare Health Plans with drug coverage [?]**

0 plan(s) of 5 available

**Medicare Health Plans without drug coverage [?]**

0 plan(s) of 0 available

# Your Plan Comparison

Select the tabs below for more detailed information about the plan health benefits, drug costs and coverage and star ratings.

**Zip Code:** 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]   
**Drug List ID:** 2091713440  
**Password Date:** 04/05/2016  
**Important Coverage Information**

<p><b>Symbols</b></p> <p><input type="checkbox"/> Nationwide Coverage</p> <p>* Estimated</p>	<p><i>costs for one medication</i></p>
----------------------------------------------------------------------------------------------	----------------------------------------

**SilverScript Choice (PDP)**

(S5601-004) Plan Type: PDP  
**Organization:** SilverScript  
**Members:** 1-866-235-5660  
 711(TTY/TDD)  
**Non Members:** 1-866-552-6106  
 711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



**Humana Walmart Rx Plan (PDP)**

(S5884-149) Plan Type: PDP  
**Organization:** Humana Insurance Company  
**Members:** 1-800-281-6918  
 711(TTY/TDD)  
**Non Members:** 1-800-706-0872  
 711(TTY/TDD)

**Coverage:** Provides drug coverage only.  
**NOTE:** Health Plan Benefits are based on Original Medicare



<input type="checkbox"/> <b>Fixed Costs</b>			
<b>Monthly Drug Plan Premium</b>	\$24.90	<b>Monthly Drug Plan Premium</b>	\$18.40
<b>Monthly Health Plan Premium</b>	N/A	<b>Monthly Health Plan Premium</b>	N/A
<b>Annual Drug Deductible</b>	\$0.00	<b>Annual Drug Deductible</b>	\$360.00
<u>Medicare costs at a glance</u>		<u>Medicare costs at a glance</u>	
<input type="checkbox"/> <b>Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs</b>			
<b>Cost at Osco Pharmacy</b>		<b>Cost at Wal-Mart Pharmacy 10-2682</b>	
<b>Enrollment Today</b>	\$8,635.92	<b>Enrollment Today</b>	\$8,587.92
<b>Cost at Wal-Mart Pharmacy 10-2682</b>		<b>Cost at Osco Pharmacy</b>	
<b>Enrollment Today</b>	\$8,635.92	<b>Enrollment Today</b>	\$8,587.92
<b>Cost at mail order pharmacy</b>		<b>Cost at mail order pharmacy</b>	

Enrollment Today	\$9,686.01	Enrollment Today	\$9,637.01
<a href="#">Lower your drug costs</a>		<a href="#">Lower your drug costs</a>	

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**Estimated Monthly Drug Costs**

Monthly Drug Costs at Retail Pharmacies			Monthly Drug Costs at Retail Pharmacies		
<a href="#">View Drug Cost Summary</a>			<a href="#">View Drug Cost Summary</a>		
MILESTONES	MONTH	YOUR COST	MILESTONES	MONTH	YOUR COST
	1st	\$1,079.49		1st	\$1,073.49
	2nd	\$1,079.49		2nd	\$1,073.49
	3rd	\$1,079.49		3rd	\$1,073.49
	4th	\$1,079.49		4th	\$1,073.49
	5th	\$1,079.49		5th	\$1,073.49
	6th	\$1,079.49		6th	\$1,073.49
	7th	\$1,079.49		7th	\$1,073.49
	8th	\$1,079.49		8th	\$1,073.49
	9th	\$1,079.49		9th	\$1,073.49
	10th	\$1,079.49		10th	\$1,073.49
	11th	\$1,079.49		11th	\$1,073.49
	12th	\$1,079.49		12th	\$1,073.49

Monthly Drug Costs Estimator		Monthly Drug Costs Estimator	
View monthly costs comparison charts.		View monthly costs comparison charts.	
<p><a href="#">View monthly drug cost details by selected drugs</a>                      Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.</p>		<p><a href="#">View monthly drug cost details by selected drugs</a>                      Starting January 1, 2011, if you reach the coverage gap (also called the "donut hole") in your Medicare prescription drug coverage, you will get approximately a 50% discount on covered brand drugs. Medicare has also increased its coverage of generic drugs for beneficiaries in the coverage gap so that beginning in 2011 you will pay less for generic drugs as well. The drugs eligible for the brand discount or the additional generic savings may change based on the information we have available.</p>	

**Drug Coverage Information**

<p>None of your drugs are covered on the plan's formulary</p> <p><b>Cialis TAB 10MG</b></p> <p>No restrictions</p> <p>NOT ON FORMULARY <sup>4</sup></p>	<p>None of your drugs are covered on the plan's formulary</p> <p><b>Cialis TAB 10MG</b></p> <p>No restrictions</p> <p>NOT ON FORMULARY <sup>4</sup></p>
---------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------

[Print My Drug List](#)      [Print Comparison Report](#)

<sup>4</sup>This type of drug is excluded from coverage under the Medicare program. This plan does not offer a supplement benefit for this type of drug. Any amount that you spend for this type of drug is not counted toward any deductibles, initial coverage or out-of-pocket limits. The drug cost displayed is only an estimate and actual cost may vary.

**Pharmacy & Mail Order Information**

<p>Mail Order is available.</p> <p><b>Pharmacy Network</b></p> <p><a href="#">4 network pharmacies</a> in your ZIP code</p>	<p>Mail Order is available.</p> <p><b>Pharmacy Network</b></p> <p><a href="#">4 network pharmacies</a> in your ZIP code</p>
-----------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------

Preferred pharmacy network available		Preferred pharmacy network available		
<input type="checkbox"/> <b>Drug List</b>				
<a href="#">Add/Edit Drugs</a>				
MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
CIALIS TAB 10MG	20	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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**NorthWestPharmacy.com**  
 ([//www.northwestpharmacy.com](http://www.northwestpharmacy.com))

TOLL FREE PHONE: 1-866-539-5330

TOLL FREE FAX: 1-866-539-5331

*cost for the same medication at a mail order pharmacy*

**Cialis - Tadalafil - Prices & Information**

A prescription is **required** for this item.

 **3-in-1 Guarantee** **FREE**  
 ID Protection  Purchase **\$\$** Lowest Price

**GENERIC ALTERNATIVE LISTING - Tadalafil Price Guarantee**

Dosage	Pack	Price	Qty	Shipping
2.5mg	30.00 pills	\$27.89	1 ▼	
5mg	30.00 pills	\$31.19	1 ▼	
10mg	4.00 pills	\$31.19	1 ▼	
10mg	8.00 pills	\$35.49	1 ▼	
10mg	12.00 pills	\$43.99	1 ▼	
10mg	20.00 pills	\$62.89	1 ▼	
10mg	32.00 pills	\$72.69	1 ▼	
10mg	40.00 pills	\$83.49	1 ▼	
10mg	48.00 pills	\$99.99	1 ▼	
10mg	60.00 pills	\$125.09	1 ▼	
10mg	80.00 pills	\$159.79	1 ▼	
10mg	92.00 pills	\$174.89	1 ▼	
10mg	100.00 pills	\$190.59	1 ▼	
20mg	4.00 pills	\$35.49	1 ▼	



**INSPECTED & MONITORED**  
**GUARANTEED** 

20mg	8.00 pills	\$42.09	<input type="text" value="1"/> ▼
20mg	12.00 pills	\$46.49	<input type="text" value="1"/> ▼
20mg	20.00 pills	\$62.89	<input type="text" value="1"/> ▼
20mg	24.00 pills	\$70.49	<input type="text" value="1"/> ▼
20mg	28.00 pills	\$82.29	<input type="text" value="1"/> ▼
20mg	36.00 pills	\$96.59	<input type="text" value="1"/> ▼
20mg	40.00 pills	\$107.29	<input type="text" value="1"/> ▼
20mg	60.00 pills	\$160.99	<input type="text" value="1"/> ▼
20mg	80.00 pills	\$189.99	<input type="text" value="1"/> ▼
20mg	100.00 pills	\$216.69	<input type="text" value="1"/> ▼

**BRAND LISTING - Cialis (Tadalafil) Price Guarantee**

<b>Dosage</b>	<b>Pack</b>	<b>Price</b>	<b>Qty</b>	<b>Shipping</b>
2.5mg	28.00 pills	\$135.99	<input type="text" value="1"/> ▼	
2.5mg	56.00 pills	\$248.39	<input type="text" value="1"/> ▼	
2.5mg	84.00 pills	\$371.09	<input type="text" value="1"/> ▼	
5mg	28.00 pills	\$132.09	<input type="text" value="1"/> ▼	
10mg	4.00 pills	\$76.39	<input type="text" value="1"/> ▼	
10mg	8.00 pills	\$135.99	<input type="text" value="1"/> ▼	
10mg	12.00 pills	\$195.49	<input type="text" value="1"/> ▼	
10mg	24.00 pills	\$375.49	<input type="text" value="1"/> ▼	
10mg	36.00 pills	\$563.29	<input type="text" value="1"/> ▼	
10mg	48.00 pills	\$750.89	<input type="text" value="1"/> ▼	
10mg	60.00 pills	\$938.49	<input type="text" value="1"/> ▼	
20mg	4.00 pills	\$70.49	<input type="text" value="1"/> ▼	
20mg	8.00 pills	\$119.59	<input type="text" value="1"/> ▼	
20mg	12.00 pills	\$152.29	<input type="text" value="1"/> ▼	
20mg	32.00 pills	\$406.09	<input type="text" value="1"/> ▼	

Please read the important disclosure at the bottom of the page.

## **CIALIS (TADALAFIL)**

### **Cialis Description**

Cialis belongs to a group of medications called phosphodiesterase type 5 inhibitors, which means that it relaxes muscles and improves blood flow in certain parts of the body. The medication is most often prescribed to men experiencing erectile dysfunction (ED), and should be taken by mouth prior to expected sexual activity. It is also available by its generic name, Tadalafil. To use it, you will need a valid prescription from your doctor. The generic alternative is not manufactured by the company that makes the brand product.

### **Conditions Treated by Cialis**

Cialis is effective for treating erectile dysfunction, which often develops as a symptom of other cardiovascular conditions that block blood flow to the penis. Men who have ED generally experience an ongoing inability to achieve and keep erections, and their sex lives may suffer as a result. By relaxing the muscles surrounding the penis and improving circulation, Cialis should temporarily allow them to maintain an erection during sexual arousal.

### **Warnings for Cialis**

It is important for your doctor to review your complete health record before you start taking Cialis. In particular, they should know whether you have a history of cardiovascular, eye, liver, or kidney disease. You should also let them know if you have been told not to have sex for medical reasons or if you have a physical deformity of the penis. During treatment, you will need to watch for serious side effects like sudden vision loss or an erection that lasts more than 4 hours; tell your doctor immediately if they occur.

Some medications and foods can cause negative interactions when combined with Cialis. These include nitrate-containing products, as well as grapefruit, alcohol, and certain anti-fungal, antibiotic, or blood pressure drugs, and should only be taken as per your doctor's instructions.

### **Possible Side Effects of Cialis**

- Headache
- Reddening of the face, neck, or chest
- Cough and cold symptoms
- Stomach upset
- Pain in the back, legs, or arms

### **Drugs Similar to Cialis**

- [Levitra \(https://www.northwestpharmacy.com/product/levitra\)](https://www.northwestpharmacy.com/product/levitra)
- [Stendra \(https://www.northwestpharmacy.com/product/stendra\)](https://www.northwestpharmacy.com/product/stendra)

Viagra (<https://www.northwestpharmacy.com/product/viagra>)

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## Step 4 of 4: Refine Your Plan Results

This is a summary of the types of plans available in your area. Use the checkboxes to select the types of plans you'd like to view. You may also use the filters on the left to narrow your search. Using filters may eliminate some options, including plans with the lowest estimated annual costs.

**Zip Code:** 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3699894752  
**Password Date:** 04/05/2016

### Important Coverage Information

*cost and plan availability for one medication*

### Refine Your Search

#### Remove Filtering

**Limit Your Monthly Premium**

Show me plans within the

**Limit Your Annual Drug Deductible**

Show me plans within the

**Select Drug Options**

\$0

\$360

360

have all my drugs on formulary (applies only to plans with drug benefits)

provide mail order pricing for drugs (applies only to plans with drug benefits)

**Select Star Ratings**

Overall Star Rating -

**Select Coverage Options**

0 Stars

5 Stars

**Select Special Needs Plans**

0.0

**Change Health Status**

Exclude plans that do not have an Overall Star Rating

**Select Plans By and Company**

Plans for people with certain conditions would like to seek from a

### Summary of Your Search Results

There are a total of 27 plans available in your area including Original Medicare.

Please select one or more plan types to continue.

#### Select Available Plans Based On Your Filters

All

#### Number of Plans Available: 16

11 plan(s) of 21 available

Prescription Drug Plans (with Original Medicare) [?]

Medicare Health Plans with drug coverage [?]

5 plan(s) of 5 available

Medicare Health Plans without drug coverage [?]

0 plan(s) of 0 available

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Medicare.gov

Type the name of your drug:



Or Browse A-Z:

Medicare.gov **A B C D E F G H I J K L M**  
**N O P Q R S T U V W X Y Z**

The Official U.S. Government Site for Medicare

[Help with common drug abbreviations](#)

[Hints on how to enter drug information](#)

[Why can't I find my drug?](#)

### Retrieve My Saved Drug List:

Your drug list has been saved. You can retrieve your selected drugs and pharmacies on future visits using this Drug List ID and Password Date.

Your personal information cannot be accessed using your drug ID list. Medicare doesn't share the drug information you enter.

Drug List ID: **3699894752**

Password Date: **4/5/2016 (change date)**

Zip Code: **05602**

[Use a different drug list ID](#)

## My Drug List (Maximum 25 Drugs)

Total Drugs in My Drug List: 1 [Print My Drug List](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
Premarin Vaginal CRE 0.625MG	1 X 30GM Tube	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

**Medicare**  
The Official U.S. Government Site for Medicare



**Medicare**  
The Official U.S. Government Site for Medicare

Medicare.gov  
The Official U.S. Government Site for Medicare

A federal government website managed by the Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Baltimore, MD 21244



Medicare.gov  
The Official U.S. Government Site for Medicare

*cost share  
pharmacy*

**Zip Code:** 05602

**Current Coverage:** Unknown

**Current Subsidy:** No Extra Help [?]

**Drug List ID:** 3699894752

**Password Date:** 04/05/2016

**Important Coverage Information**

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Symbols**

Some Dental Coverage       Some Vision Coverage       Nationwide Coverage

Some Hearing Coverage

\* Estimated

<p><b>AARP MedicareRx Preferred (PDP)</b> (S5820-002-0)</p> <p><b>Organization:</b> UnitedHealthcare</p> <p><b>Plan Type:</b> PDP</p> <p><input checked="" type="radio"/></p>	<p>P.O. Box 29300 Hot Springs, AR 71903</p> <p><b>Members:</b> 1-888-867-5575 711 (TTY/TDD)</p> <p><b>Non Members:</b> 1-888-867-5564 711 (TTY/TDD)</p>	<p><b>Overall Star Rating:</b> [?]</p> <p>3 out of 5 stars</p>	<p><b>Enroll</b></p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------	----------------------

**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

<b>Monthly Drug Plan Premium [?]</b>	\$55.40
<b>Monthly Health Plan Premium [?]</b>	N/A
<b>Annual Drug Deductible [?]</b>	\$0.00

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	<b>Cost For Rest of Year (based on enrollment today) [?]</b>
Montpelier Pharmacy	\$811.20
Osco Pharmacy	\$731.20
Mail Order Pharmacy	\$722.20

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

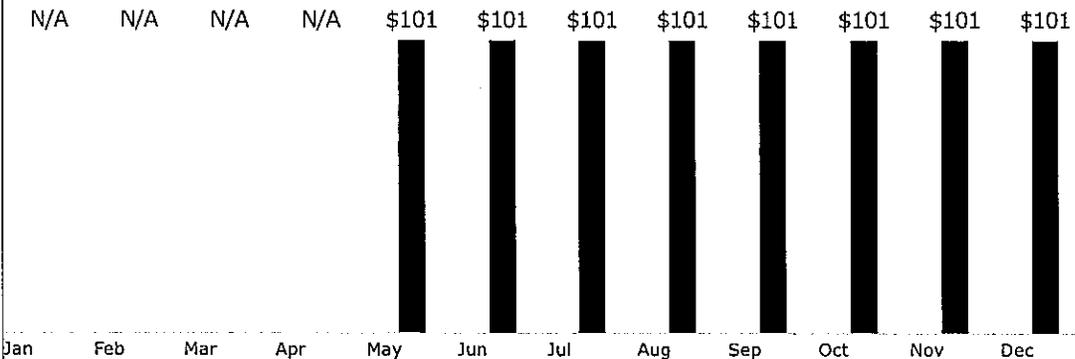
<a href="#">Montpelier Pharmacy</a>	<a href="#">Osco Pharmacy</a>	<a href="#">Mail Order Pharmacy</a>
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Montpelier Pharmacy - Standard Retail Cost Sharing					
SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Initial Coverage Level[?]	What You Pay	
				Coverage Gap[?]	Catastrophic Coverage[?]
Premarin Vaginal CRE 0.625MG	\$287.84	Every 1 Month	\$46.00	\$129.53	\$14.39
<b>MONTHLY TOTALS:</b>	<b>\$287.84</b>		<b>\$46.00</b>	<b>\$129.53</b>	<b>\$14.39</b>

**Estimated Monthly Drug Costs**

Montpelier Pharmacy	Osco Pharmacy	Mail Order Pharmacy
---------------------	---------------	---------------------

Monthly Costs for the Rest of the Year (based on enrollment today)



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions		
		PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAPY [?]
Premarin Vaginal CRE 0.625MG	Tier 3: Preferred Brand			

[Print My Drug List](#)   
 [Print Plan Report](#)   
 [View Drug Benefit Summary](#)

**Pharmacy & Mail Order Information**

Mail Order is available.

**Pharmacy Network [?]**

**4 network pharmacies** in your ZIP code  
 Preferred pharmacy network available [?]

**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
PREMARIN VAGINAL CRE 0.625MG	1 X 30GM Tube	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

## Pharmacy List: AARP

### MedicareRx Preferred (PDP)(S5820-002)

We found 4 network pharmacies within  miles of 05602 for AARP MedicareRx Preferred (PDP)(S5820-002)

If you make any changes to your selected pharmacies, please refresh the drug costs & coverage page to view updated pricing information.

Selected Pharmacies	Pharmacy Type <a href="#">?</a>	Preferred <a href="#">?</a>
<b>Montpelier Pharmacy</b> 69 Main St Montpelier, VT 05602 1-802-223-4633 <a href="#">Remove Pharmacy</a>	Retail	No
<b>Rite Aid Pharmacy 04581</b> 29 31 Main Street Montpelier, VT 05602 1-802-223-4787 <a href="#">Remove Pharmacy</a>	Retail	No

Pharmacy Name	Pharmacy Type <a href="#">?</a>	Preferred <a href="#">?</a>
<b>Oscos Pharmacy</b> Paine Turnpike N Berlin Comers, VT 05602 1-802-223-8599 <a href="#">Add Pharmacy</a>	Retail	Yes
<b>Wal-Mart Pharmacy 10-2682</b> 282 Berlin Mall Road Unit 1 Berlin, VT 05602 1-802-229-8049 <a href="#">Add Pharmacy</a>	Retail	Yes



*cost at a preferred pharmacy*

Zip Code: 05602

**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 3699894752  
**Password Date:** 04/05/2016

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Important Coverage Information**

**Symbols**

Some Dental Coverage       Some Vision Coverage       Nationwide Coverage

Some Hearing Coverage

\* Estimated

<p><b>AARP MedicareRx Preferred (PDP)</b> (S5820-002-0)</p> <p><b>Organization:</b> UnitedHealthcare</p> <p><b>Plan Type:</b> PDP</p> <p><input checked="" type="radio"/></p>	<p>P.O. Box 29300 Hot Springs, AR 71903</p> <p><b>Members:</b> 1-888-867-5575 711 (TTY/TDD)</p> <p><b>Non Members:</b> 1-888-867-5564 711 (TTY/TDD)</p>	<p><b>Overall Star Rating:</b> [?] 3 out of 5 stars</p>	<p><b>Enroll</b></p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------	----------------------

**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

Monthly Drug Plan Premium [?]	\$55.40
Monthly Health Plan Premium [?]	N/A
Annual Drug Deductible [?]	\$0.00

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	Cost For Rest of Year (based on enrollment today) [?]
Montpelier Pharmacy	\$811.20
Osco Pharmacy	\$731.20
Mail Order Pharmacy	\$722.20

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

<a href="#">Montpelier Pharmacy</a>	<a href="#">Osco Pharmacy</a>	<a href="#">Mail Order Pharmacy</a>
-------------------------------------	-------------------------------	-------------------------------------

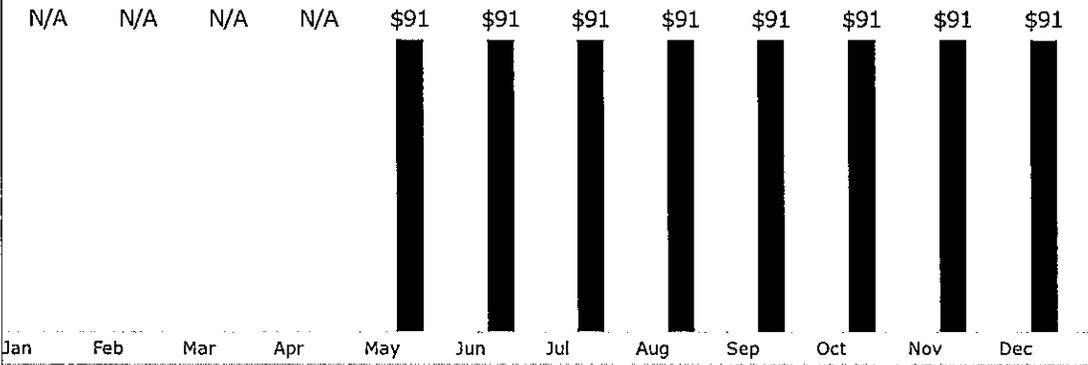
Oscor Pharmacy - Preferred Retail Cost Sharing

SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Initial Coverage Level[?]	What You Pay Coverage Gap[?]	Catastrophic Coverage[?]
Premarin Vaginal CRE 0.625MG	\$283.17	Every 1 Month	\$36.00	\$127.43	\$14.16
<b>MONTHLY TOTALS:</b>	<b>\$283.17</b>		<b>\$36.00</b>	<b>\$127.43</b>	<b>\$14.16</b>

**Estimated Monthly Drug Costs**

<a href="#">Montpelier Pharmacy</a>	<a href="#">Oscor Pharmacy</a>	<a href="#">Mail Order Pharmacy</a>
-------------------------------------	--------------------------------	-------------------------------------

Monthly Costs for the Rest of the Year (based on enrollment today)



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAPY [?]
Premarin Vaginal CRE 0.625MG	Tier 3: Preferred Brand			

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

**Pharmacy & Mail Order Information**

Mail Order is available.

**Pharmacy Network [?]**

4 network pharmacies in your ZIP code  
Preferred pharmacy network available [?]

**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
PREMARIN VAGINAL CRE 0.625MG	1 X 30GM Tube	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

**NorthWestPharmacy.com**  
 ([//www.northwestpharmacy.com](http://www.northwestpharmacy.com))

TOLL FREE PHONE: 1-866-539-5330

TOLL FREE FAX: 1-866-539-5331

## Premarin Vaginal Cream - Conjugated Estrogens - Prices & Information

A prescription is **required** for this item.

 **3-in-1 Guarantee** **FREE**  
 ID Protection  Purchase **\$\$** Lowest Price

Generic alternative is not available at this time.

BRAND LISTING - Premarin Vaginal Cream (Conjugated Estrogens) [Price Guarantee](#)

Dosage	Pack	Price	Qty	Shipping
.625mg/gm (14gm)	1.00 tube	\$24.09	1 ▼	

Please read the important disclosure at the bottom of the page.

### PREMARIN VAGINAL CREAM (CONJUGATED ESTROGENS)

#### Premarin Vaginal Cream Description

Menopause can come with problems for some women, in the form of painful sexual intercourse due to vaginal dryness, irritation, and inflammation. Now is the time you should visit your doctor and discuss a prescription for Premarin Vaginal Cream. The active ingredients of Premarin Vaginal Cream are Conjugated Estrogens, meaning that there is a blend of estrogens that can help to rebuild vaginal tissue that can change after menopause when estrogen has decreased or stopped its production.

When inserted vaginally as directed, Premarin Vaginal Cream is absorbed into your vaginal tissues where estrogen will work to replenish the tissues that have become thinner, dryer, and less resilient as menopause advances. As your non-child bearing years are upon you, estrogen levels drop as you are no longer ovulating to prepare for a possible baby. Many menopausal women are still sexually active but may be experiencing pain during intercourse because of atrophy and shrinkage of their vagina and vulva. The hormonal changes are not always kind and you may experience itching and inflammation as a result of your depleted estrogen levels.

#### Conditions Treated by Premarin Vaginal Cream

As hormone levels decrease, the tissues of your vulva and vaginal lining may become thinner, drier, and less flexible than before menopause. This is referred to as vulvovaginal atrophy. Less estrogen means your vaginal secretions are reduced so there is little to no lubrication, making intercourse quite painful. Your vaginal pH levels are also affected by the reduced estrogen levels, making the environment less acidic. This raises your risk of possible infections as the lowered acidity cannot repel certain bacteria.

Premarin Vaginal Cream can help alleviate some of your menopausal symptoms and allow you to think about other things you could be doing, such as travelling, playing with your grandchildren, starting a new hobby, or focusing more on you and your partner or spouse.

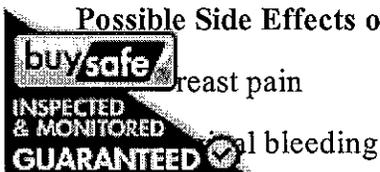
### Before You Use Premarin Vaginal Cream

If you have not had a hysterectomy, your doctor may recommend that a progestin be added to reduce your risk of endometrial cancer. Discuss other medical conditions and allergies with your doctor and list all over the counter and Rx drugs you are taking, including dietary and vitamin supplements or herbal remedies. This will allow your doctor to make an informed decision as to whether Premarin Vaginal Cream is the right medication for you.

### Warnings for Premarin Vaginal Cream

Treatment for administering Premarin Vaginal Cream will usually consist of twice weekly intravaginal applications of the lowest dosage available depending on your individual response and needs and will last for 21 days with the next 7 days off. Although chances are very low of being or becoming pregnant, tell your doctor if it is a possibility.

### Possible Side Effects of Premarin Vaginal Cream



- Painful urination
- Diarrhea

### Drugs Similar to Premarin Vaginal Cream

- [Estrace Cream \(https://www.northwestpharmacy.com/product/estrace-cream\)](https://www.northwestpharmacy.com/product/estrace-cream)
- [Vagifem \(https://www.northwestpharmacy.com/product/vagifem\)](https://www.northwestpharmacy.com/product/vagifem)
- [Prempro \(https://www.northwestpharmacy.com/product/prempro\)](https://www.northwestpharmacy.com/product/prempro)

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*Medication  
costs and quantity  
allowed list*

Medicare.gov



Type the name of your drug:

Or Browse A-Z:

**Medicare.gov** A B C D E F G H I J K L M  
N O P Q R S T U V W X Y Z

The Official U.S. Government Site for Medicare

[Help with common drug abbreviations](#)

[Hints on how to enter drug information](#)

[Why can't I find my drug?](#)

Retrieve My Saved Drug List:

Your drug list has been saved. You can retrieve your selected drugs and pharmacies on future visits using this Drug List ID and Password Date.

Your personal information cannot be accessed using your drug ID list. Medicare doesn't share the drug information you enter.

Drug List ID: **2091713440**

Password Date: **4/5/2016** ([change date](#))

Zip Code: **05602**

[Use a different drug list ID](#)

## My Drug List (Maximum 25 Drugs)

Total Drugs in My Drug List: 1

[Print My Drug List](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
Oxycodone/Apap TAB 7.5-325	120	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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Medicare.gov  
The Official U.S. Government Site for Medicare

A federal government website managed by the Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Baltimore, MD 21244



Medicare.gov  
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The Official U.S. Government Site for Medicare

# Medicare.gov

The Official U.S. Government Site for Medicare

## Step 4 of 4: Refine Your Plan Results

This is a summary of the types of plans available in your area. Use the checkboxes to select the types of plans you'd like to view. You may also use the filters on the left to narrow your search. Using filters may eliminate some options, including plans with the lowest estimated annual costs.

**Zip Code:** 05602  
**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 2091713440  
**Password Date:** 04/05/2016  
**Important Coverage Information**

### Refine Your Search

**Remove Filtering**

**Limit Your Monthly Premium**

Show me plans within the range  **Limit Your Annual Drug Deductible**

Show me plans within the range  **Select Drug Options**

**\$0** **\$360**

**360**

have all my drugs on formulary (applies only to plans with drug benefits)

provide mail order pricing for drugs (applies only to plans with drug benefits)

**Select Star Ratings**

Overall Star Rating -

**Select Coverage Options**

**0 Stars** **5 Stars**

**Select Special Needs Plans**

**0.0**

**Change Health Status**

Exclude plans that do not have an Overall Star Rating

**Select Plans By and Company**

Plans for people with certain conditions like diabetes from a **Remove Filtering**

### Summary of Your Search Results

There are a total of 27 plans available in your area including Original Medicare.

Please select one or more plan types to continue.

Select Available Plans Based On Your Filters  
**All**

**Prescription Drug Plans (with Original Medicare) [?]**

**Number of Plans Available: 26**

21 plan(s) of 21 available

**Medicare Health Plans with drug coverage [?]**

5 plan(s) of 5 available

**Medicare Health Plans without drug coverage [?]**

0 plan(s) of 0 available



**Zip Code:** 05602

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Current Coverage:** Unknown  
**Current Subsidy:** No Extra Help [?]  
**Drug List ID:** 2091713440  
**Password Date:** 04/05/2016

**Important Coverage Information**

**Symbols**

Some Dental Coverage       Some Vision Coverage       Nationwide Coverage

Some Hearing Coverage

\* Estimated

<p><b>EnvisionRx Plus Clear Choice (PDP)</b> (S7694-118-0)</p> <p><b>Organization:</b> EnvisionRx Plus  <b>Plan Type:</b> PDP</p> <p><input checked="" type="radio"/></p>	<p>2181 E. Aurora Road, Suite 201 Twinsburg, OH 44087</p> <p><b>Members:</b> 1-866-250-2005 711 (TTY/TDD)</p> <p><b>Non Members:</b> 1-866-250-2005 711 (TTY/TDD)</p>	<p><b>Overall Star Rating:</b> [?] 3 out of 5 stars</p>	<p><b><u>Enroll</u></b></p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------	-----------------------------

**NOTE: Health Plan Benefits are based on Original Medicare**

**Fixed Costs**

<b>Monthly Drug Plan Premium [?]</b>	\$33.50
<b>Monthly Health Plan Premium [?]</b>	N/A
<b>Annual Drug Deductible [?]</b>	\$0.00

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	<b>Cost For Rest of Year (based on enrollment today) [?]</b>
Osco Pharmacy	\$316.00
Montpelier Pharmacy	\$316.00
Mail Order Pharmacy	\$322.00

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

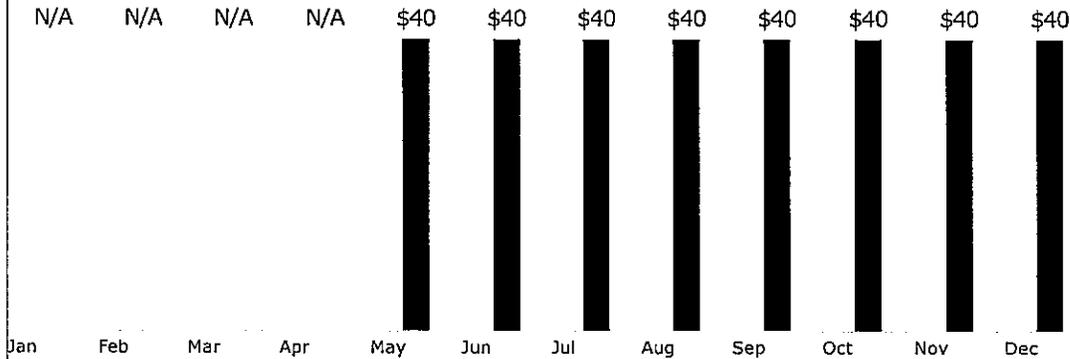
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<a href="#">Osco Pharmacy</a> <a href="#">Montpelier Pharmacy</a> <a href="#">Mail Order Pharmacy</a>		<a href="#">Osco Pharmacy - Preferred Retail Cost Sharing</a>			
SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Initial Coverage Level[?]	What You Pay	
				Coverage Gap[?]	Catastrophic Coverage[?]
Oxycodone/Apap TAB 7.5-325	\$72.61	Every 1 Month	\$6.00	\$42.11	\$3.63
<b>MONTHLY TOTALS:</b>	<b>\$72.61</b>		<b>\$6.00</b>	<b>\$42.11</b>	<b>\$3.63</b>

**Estimated Monthly Drug Costs**

<a href="#">Osco Pharmacy</a>	<a href="#">Montpelier Pharmacy</a>	<a href="#">Mail Order Pharmacy</a>
-------------------------------	-------------------------------------	-------------------------------------

Monthly Costs for the Rest of the Year (based on enrollment today)



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions		
		PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAPY [?]
Oxycodone/Apap TAB 7.5-325	Tier 2: Generic		Yes	

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

**Pharmacy & Mail Order Information**

Mail Order is available.

**Pharmacy Network [?]**

[3 network pharmacies](#) in your ZIP code

Preferred pharmacy network available [?]

**Drug List**

[Add/Edit Drugs](#)

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
OXYCODONE/APAP TAB 7.5-325	120	Every 1 Month Retail Pharmacy	Already Generic	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

# Medicare.gov

The Official U.S. Government Site for Medicare

[Return to previous page](#)

## Quantity Limit Details for EnvisionRx Plus Clear Choice (PDP) (S7694-118)

Quantity Limit Details

Please view the quantity limit details for the drugs you've selected for EnvisionRx Plus Clear Choice (PDP). Contact the plan for more information about any drugs with a quantity limit restriction.

SELECTED DRUGS	QUANTITY LIMITS [?]	QUANTITY LIMIT AMOUNT	QUANTITY LIMIT FREQUENCY
Oxycodone/Apap TAB 7.5-325	Yes	370 TABS	Every 30 Day(s)

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w01

*"How do you say 'thank you' to an organization that gives you life, peace of mind, and a future?"*

*—Cliff (Faith, NC)*

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## Diseases and Medications

The HealthWell Foundation assists people dealing with a variety of disease states and medications. Below is a list of the disease states we support and the medications we cover. Please note that this list is subject to change, depending on funding at any given time. Also, we are always seeking new funding to support additional disease states, so please check our site often for an updated list.

### Diseases

#### Open Funds

The following funds are open to new and re-enrolling patient applications. You may start the application process through our online service or by calling the HealthWell Foundation at 800-675-8416 to determine eligibility. Customer service representatives are available Monday – Friday from 9 am to 5 pm Eastern Time.

- [ANCA-Associated Vasculitis, Wegeners and Granulomatosis with Polyangiitis](#)
- [Carcinoid Tumors and Associated Symptoms - Medicare Access](#)
- [Cystic Fibrosis](#)
- [Dupuytren's Disease](#)
- [Gout - Medicare Access](#)
- [Hepatitis C](#)
- [Melanoma](#)
- [Multiple Sclerosis - Medicare Access](#)
- [Non-Small Cell Lung Cancer - Medicare Access](#)
- [Pediatric Assistance](#)
- [Peyronie's Disease](#)
- [Porphyrias](#)
- [Pulmonary Fibrosis](#)
- [Systemic Lupus Erythematosus](#)
- [Urea Cycle Disorders](#)
- [Urticaria](#)
- [Wilms' Tumor](#)

#### Closed Funds

As a charity, HealthWell relies solely on donations to keep funds open. Please know that closing any fund at any time is a heartbreaking decision for us and one we do not make or accept easily. Unfortunately, at this time, we do not have enough funding to keep up with demand; therefore the following funds are currently closed to new and re-enrolling patient applications. However, we continue to manage existing grants. If you have already been approved for a grant this year, please continue to submit for reimbursement and access your grant. It is always our goal to keep funds open, so please continue to refer to this listing as these funds may re-open in the future.

- [Anemia Associated with Chronic Renal Insufficiency/Failure](#)
- [Asthma](#)



"Faces of HealthWell"

[Show Transcript](#)

### Contact Us

Phone: (800) 675-8416  
Fax: (800) 282-7692

[Grants@HealthWellFoundation.org](mailto:Grants@HealthWellFoundation.org)

[Corporate/Donor Inquiries](#)

### Connect with us:

#### Recent News

[Real World Health Care Interview with Dr. Bonnie Westra](#)  
Here, she discusses the importance of ...[more](#)

[Closing the Healthcare Gap: The Critical Role of Non-Identified Information](#)  
Closing the Healthcare Gap: The Critical Role ...[more](#)

[Big Data & Health Care: Speaking with Dr. Hallie Prescott](#)  
Big Data & Health Care: Speaking with Dr. ...[more](#)

[Big Data in Healthcare: Speaking with Dr. Philip Bourne, National Institutes of Health](#)  
Big Data in Healthcare: Speaking with Dr. ...[more](#)

[New HealthWell Foundation Fund Assists Underinsured Patients Suffering from Diabetic Foot Ulcers](#)  
... will provide up to \$1,500 in copayment ...[more](#)

### Our impact:

- 8,900+ callers assisted each month

controlled or influenced by any of its donors. As generous as our donors are, not all manufacturers participate in copayment assistance programs like HealthWell. Without full participation from all manufacturers, patient need and strong demand can quickly deplete even the most generous of donations. It's important to know that closing any fund at any time is an extremely difficult decision for us and one we do not make or accept easily. We work tirelessly to streamline our program to ensure the maximum amount of each donation gets directly to patients while at the same time identifying new donors to support our program so we can be there for patients when they need us the most.

Did you know that you can help strengthen our funding? If you are looking for assistance with a medication and it is not listed on HealthWell's website, we encourage you to contact the manufacturer to alert them to the situation and encourage them to contact HealthWell.

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P.O. Box 4133  
Gaithersburg, MD 20885  
Email Us

Hours: M-F 9am-5pm EST  
Phone: (800) 676-8416  
Fax: (800) 282-7932

The HealthWell Foundation is committed to providing an accessible website, regardless of technology or ability.



The HealthWell Foundation® is a 501(c)(3) independent non-profit organization providing financial assistance to adults and children to cover the cost of prescription drug coinsurance, copayments, deductibles, health insurance premiums, and other selected out-of-pocket healthcare costs.

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*Patient Assistance Programs*

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- [FAQ](#)
- [Pharma Companies](#)

**Registered Users Log-in:**

E-mail Address:

Password:

Login

[Forgot Password?](#)

[Registration](#)

**Patient Assistance Information**

 A three-step process for patient assistance is shown with images and text:
 

- Step 1**: **Locate and Review Program Guidelines and Requirements**. Image shows a woman smiling.
- Step 2**: **Apply Online or Print Application and Complete By Hand**. Image shows hands filling out a form.
- Step 3**: **Mail or Fax Completed Application**. Image shows a hand putting a letter into a mailbox.

[Return to Medication Search](#)

**1 Program for NovoLog FlexPen**

**Novo Nordisk Diabetes Patient Assistance Program**

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PO Box 181640  
 Louisville, KY 40261  
 Phone : (866)310-7549  
 Fax: (866)441-4190

**Eligibility**

- > Patient cannot have or qualify for any government prescription coverage such as Medicare, Medicaid, Veteran's Administration or any state or local programs. Patient cannot have or qualify for any private prescription coverage. Patient's total household income must be at or below 200% of the Federal Poverty Level.

**Who Can Apply**

- > The doctor and patient must complete the application process.

**Required**

- > The application must be completed and signed by the healthcare practitioner and the patient. Proof of income must also accompany the application.

**Supply**

- > Approved patients will receive a 90 day supply of medication.

**Ship To**

- > If approved the medication will be shipped to the healthcare practitioner's office or pharmacy.

**Note**

- > Novo Nordisk reserves the right to modify or cancel this program at any time without notice. All requests are subject to product availability and patient eligibility verification.

**Includes Support for This Drug**

*NOTE: Linked drugs are available for Prescribers to **Apply Online** now.*

***Click drug logo or drug name to start online application.***

Novolog FlexPen

**Printable Application Forms**

*Applications that patients can fill out and bring to their doctor.*

[Download printable Form Novo Nordisk Diabetes Patient Assistance Program](#)

(Requires [Acrobat Reader](#)) 

# Cornerstones4Care™ Patient Assistance Program Application



The Cornerstones4Care™ Patient Assistance Program (PAP) provides medication to qualifying applicants at no charge. If the applicant qualifies under the Cornerstones4Care™ PAP guidelines, a 90-day supply of the requested medication(s) or device(s) will be shipped to the applicant's licensed practitioner for dispensing.

## PATIENT ELIGIBILITY

- Patient must be a US citizen or legal resident
- Patient cannot have or qualify for:
  - Any private prescription coverage, such as an HMO or PPO
  - Any federal, state or local program such as Medicare or Medicaid. Exceptions include patients who have entered the coverage gap (donut hole) in Medicare Part D and patients who have applied for and been denied Medicare Extra Help/Low Income Subsidy (LIS) and are Medicare eligible
  - Department of Veterans Affairs (VA) prescription benefits
- Patient's total household income must be at or below 200% of the federal poverty level

Household Size	Total Household Income for 48 Contiguous States & DC
	200%
1	\$22,980
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
	For families with more than 8 persons, add \$8,040 for each additional person

\*Different guidelines apply for Alaska and Hawaii. For the complete federal poverty guidelines, please visit the Families USA Web site at <http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html>.

**For a full list of products covered, please visit one of the following:**

- Our company Web site at [NovoNordisk-US.com](http://NovoNordisk-US.com) (Patients/Patient Assistance Program section)
- Our health care professional Web site at [NovoMedLink.com](http://NovoMedLink.com) (Product Information/Patient Assistance Program section)
- Our patient Web site at [Cornerstones4Care.com](http://Cornerstones4Care.com)

**Complete ALL fields to avoid return of incomplete application.**

- Make sure the application is signed by the prescriber AND dated
- Remember to include disposable pen needle in the order information if applicable
- Make sure the patient signs the certification section AND, if a Medicare Part D enrollee, the patient should also sign the Medicare Part D certification
- Fax the completed application to (866) 441-4190
- Allow 7 to 10 business days for processing

# Cornerstones4Care™ Patient Assistance Program Application



PO Box 181640  
Louisville, KY 40261

Phone: (866) 310-7549  
Fax: (866) 441-4190

New Application  
 Annual Renewal

## Applicant Information

Patient's Name:	Date of Birth: / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: - -

Patient's Street Address:

Patient's City, State, & ZIP:

Phone: ( ) - E-mail:

<p>Attach a copy of the patient's most recent federal income tax return (1040). If not available, please provide other income documentation, such as:</p> <ul style="list-style-type: none"> <li>• Social Security Form SSA-1099</li> <li>• Form W-2</li> <li>• Pay stubs from the last month</li> </ul> <p>A notice of award letter must be provided with the patient's SSA-1099.</p>	<p>If the patient is Medicare eligible but does not have Medicare Part D coverage, the patient must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration (SSA). To apply for LIS, please contact the SSA at (800) 772-1213 (TTY 800-325-0778) or go to <a href="http://www.socialsecurity.gov/prescriptionhelp/">www.socialsecurity.gov/prescriptionhelp/</a>.</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>Annual household adjusted gross income from most recent federal tax return: \$ _____</p> <p>Number of people in household (including patient): _____</p>	<p><b>New and annual renewal applications without proof of income documentation are considered incomplete.</b></p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------

Does the patient qualify for private, local, or state prescription insurance coverage?  Yes  No

Is the patient enrolled in Medicaid?  Yes  No

<p>Is the patient enrolled in Medicare Part A and/or Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Medicare ID Number:</p>
-------------------------------------------------------------------------------------------------------------------------------	----------------------------

Is the patient enrolled in a Medicare Part D Plan?  Yes  No

Medicare Part D enrollees must have entered the coverage gap (donut hole) for the relevant benefit year, before submitting this application. Please attach to this application a photocopy of documentation from the patient's Part D plan that the patient has entered the coverage gap (donut hole) for the relevant benefit year, such as a letter from the patient's Part D plan, a monthly statement of benefits, or an explanation of benefits (EOB).

**Patient's signature or legal guardian's signature is required on page 3.**

## Licensed Health Care Practitioner Information

Practitioner's Name:	State License Number: Expiration Date:
----------------------	-------------------------------------------

Practitioner's Shipping Street Address (no PO Box number):

Practitioner's Shipping City, State, & ZIP:

Phone: ( ) - Fax: ( ) -

E-mail:

## Order Information (include disposable pen/needle order, if applicable)

Product Name	How Supplied (circle)	Max Dose Per Day (in units)	Sig
	<input type="checkbox"/> Vial <input type="checkbox"/> FlexPen®		
	<input type="checkbox"/> Vial <input type="checkbox"/> FlexPen®		
	<input type="checkbox"/> Vial <input type="checkbox"/> FlexPen®		

All prescriptions requested will be filled with a 90-day supply. A refill request must be made to receive an additional prescription.

**Practitioner's signature is required on page 3.**

# Cornerstones4Care™ Patient Assistance Program Application



## For Health Care Practitioner

Patient's Name:

Date of Birth: / /

My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive and dispense the requested medication(s) listed on the attached prescription(s) shipped from Novo Nordisk. I further certify all information provided in the Licensed Health Care Practitioner Information section is correct and agree to submit appropriate verification of such information upon Novo Nordisk's reasonable request. I agree that medication(s) provided to me by Novo Nordisk for the applicant named in the Applicant Information section will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person. I consent that Novo Nordisk may contact the applicant named in the Applicant Information section for verification of applicant status and receipt of the indicated medication(s). I further consent that Novo Nordisk may perform an on-site audit of Cornerstones4Care™ Patient Assistance Program (PAP) records related to the applicant named above on this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Cornerstones4Care™ PAP from any government program or third party insurer and will not apply any Cornerstones4Care™ PAP medication towards the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under the PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time.

Practitioner's Signature (no photocopies or power of attorney signature):

Date:

**PRACTITIONER SIGNATURE**

## For Patient

I certify that I do not have the ability to pay for the medication(s) requested by my licensed health care practitioner on the attached prescription(s) and all information provided in this application is correct. I understand that the Cornerstones4Care™ Patient Assistance Program (PAP) is entitled at any time to request verification of any such information which I agree to provide. I consent that the Cornerstones4Care™ PAP may contact me for verification of my application status and receipt of the indicated medication(s). I understand that if approved, I am not eligible to seek reimbursement for the medication(s) requested from any government program or third party insurer. I understand eligibility under the Cornerstones4Care™ PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time.

**HIPAA AUTHORIZATION:** I authorize my health care practitioner to provide Protected Health Information (PHI) (as such term is defined in the Health Insurance Portability and Accountability Act [HIPAA] and regulations thereunder, as well as other state or federally protected personal information), to the Cornerstones4Care™ PAP or third parties engaged, as required to assist Novo Nordisk in administering the Cornerstones4Care™ PAP. I authorize the Cornerstones4Care™ PAP to disclose my PHI to Centers for Medicare and Medicaid Services (CMS) for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in the Cornerstones4Care™ PAP to my Medicare Part D plan, (if applicable). I understand that my PHI will consist of my name, address, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Cornerstones4Care™ PAP and to ship appropriate medication(s) as prescribed by my licensed health care practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in the Cornerstones4Care™ PAP that I may be notified of such by the Cornerstones4Care™ PAP. I understand that upon the furnishing of my PHI to the Cornerstones4Care™ PAP, my PHI will not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to Novo Nordisk at the address set forth above. My revocation will become effective on the date my written notice is received and processed by the Cornerstones4Care™ PAP and at such time I will no longer be qualified to receive medication assistance from the Cornerstones4Care™ PAP. I understand that I have the right to receive a copy of this authorization from my health care practitioner. I understand that my health care practitioner will treat me even if I do not sign this form, but that I will not be able to participate in the program.

Patient's or Legal Guardian's Signature (no photocopies or power of attorney signature):

Date:

**PATIENT SIGNATURE**

**Required for MEDICARE PART D ENROLLEE:** I understand that if I am approved for the Cornerstones4Care™ Patient Assistance Program (PAP), I will receive a 90-day supply of medication(s) and/or device(s) from the Cornerstones4Care™ PAP. I understand that I will continue to be approved to receive subsequent three-month supplies of medication(s) through the end of the current calendar year by submitting a new application, regardless of whether I no longer meet the eligibility criteria for the Cornerstones4Care™ PAP for that calendar year subsequent to my initial application. I agree that I will not seek the requested Novo Nordisk medication(s) from my Medicare Part D prescription plan while receiving the medication(s) from the Cornerstones4Care™ PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Cornerstones4Care™ PAP from any government program or third party insurer and will not apply any Cornerstones4Care™ PAP medication(s) towards True-Out-Of-Pocket (TrOOP) costs.

Patient's or Legal Guardian's Signature (no photocopies or power of attorney signature):

Date:

**PATIENT SIGNATURE**

Cornerstones4Care™ is a trademark of Novo Nordisk A/S.  
FlexPen® is a registered trademark of Novo Nordisk A/S.

**Medicare.gov**

The Official U.S. Government Site for Medicare

## **BasiCare with Part D (PPO) (MAPD) (H9615-008)**

[Create Custom Report](#)

*An Advantage Plan costs*

**Monthly premium, deductible, and limits on how much you pay for covered services**

<b>How much is the monthly premium?</b>	<b>\$29.90</b> per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	<b>\$360</b> per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 6 which are excluded from the deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• <b>\$4,000</b> for services you receive from in-network providers.</li> <li>• <b>\$10,000</b> for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

**Covered Medical and Hospital Benefits**

Note:

- Services with a <sup>1</sup> may require prior authorization.
- Services with a <sup>2</sup> may require a referral from your doctor.

**Outpatient Care and Services**

Acupuncture	Not covered
Ambulance <sup>1</sup>	<ul style="list-style-type: none"> <li>• <b>In-network: \$200</b> copay</li> <li>• <b>Out-of-network: \$200</b> copay</li> </ul>
Chiropractic Care <sup>1</sup>	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> <li>• <b>In-network: \$20</b> copay</li> <li>• <b>Out-of-network: \$20</b> copay</li> </ul>
Dental Services <sup>1</sup>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <ul style="list-style-type: none"> <li>• <b>In-network: \$50</b> copay</li> <li>• <b>Out-of-network: \$60</b> copay</li> </ul>
Diabetes Supplies and Services <sup>1</sup>	<p>Diabetes monitoring supplies:</p> <ul style="list-style-type: none"> <li>• <b>In-network: 10-20%</b> of the cost, depending on the supply</li> </ul> <p>Diabetes self-management training:</p> <ul style="list-style-type: none"> <li>• <b>In-network: You pay nothing</b></li> </ul> <p>Therapeutic shoes or inserts:</p> <ul style="list-style-type: none"> <li>• <b>In-network: 20%</b> of the cost</li> <li>• <b>Out-of-network: 40%</b> of the cost</li> <li>• <b>Out-of-network: 40%</b> of the cost</li> </ul>

- **Out-of-network: You pay nothing**

Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may be different if received in an outpatient surgery setting)<sup>1</sup>

Diagnostic radiology services (such as MRIs, CT scans):

- **In-network: \$100** copay

Diagnostic tests and procedures:

- **In-network: You pay nothing**

Lab services:

- **In-network: \$0-20** copay, depending on the service

Outpatient x-rays:

- **In-network: \$50** copay

Therapeutic radiology services (such as radiation treatment for cancer):

- **In-network: You pay nothing**
- **Out-of-network: 40%** of the cost
- **Out-of-network: \$60** copay

Doctor's Office Visits<sup>1</sup>

Primary care physician visit:

- **In-network: \$35** copay

Specialist visit:

- **In-network: \$50** copay
- **Out-of-network: \$60** copay
- **Out-of-network: \$60** copay

Durable Medical Equipment (wheelchairs, oxygen, etc.)<sup>1</sup>

- **In-network: 20%** of the cost

If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.

- **Out-of-network: 40%** of the cost

Emergency care

**\$75** copay

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section for other costs.

Foot Care (podiatry services)<sup>1</sup>

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:

- **In-network: \$50** copay
- **Out-of-network: \$60** copay

## Hearing services

Exam to diagnose and treat hearing and balance issues:

- **In-network:** \$50 copay

Routine hearing exam (for up to 1 every year):

- **In-network:** \$50 copay

Hearing aid fitting/evaluation (for up to 3 every year):

- **In-network:** You pay nothing

Hearing aid:

- **In-network:** \$699-999 copay for each hearing aid, depending on the type
- **Out-of-network:** \$60 copay
- **Out-of-network:** \$60 copay
- **Out-of-network:** \$60 copay
- **Out-of-network:** \$999-1,399 copay for each hearing aid, depending on the type

Home Health Care<sup>1</sup>

- **In-network:** You pay nothing

- **Out-of-network:** 40% of the cost

Mental Health Care<sup>1</sup>

Inpatient visit:

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

- **In-network:**
  - \$295 copay per day for days 1 through 5
  - You pay nothing per day for days 6 through 90
- **Out-of-network:**
  - 40% of the cost per stay

Outpatient group therapy visit:

- **In-network:** \$40 copay

Outpatient individual therapy visit:

- **In-network:** \$40 copay
- **Out-of-network:** \$60 copay
- **Out-of-network:** \$60 copay

Outpatient Rehabilitation<sup>1</sup> Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- **In-network:** \$50 copay

Occupational therapy visit:

	<ul style="list-style-type: none"> <li>• <b>In-network:</b> \$40 copay</li> </ul>
	Physical therapy and speech and language therapy visit: <ul style="list-style-type: none"> <li>• <b>In-network:</b> \$40 copay</li> <li>• <b>Out-of-network:</b> \$60 copay</li> <li>• <b>Out-of-network:</b> \$60 copay</li> <li>• <b>Out-of-network:</b> \$60 copay</li> </ul>
Outpatient Substance Abuse <sup>1</sup>	<p>Group therapy visit:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> \$50 copay</li> </ul> <p>Individual therapy visit:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> \$50 copay</li> <li>• <b>Out-of-network:</b> \$60 copay</li> <li>• <b>Out-of-network:</b> \$60 copay</li> </ul>
Outpatient Surgery <sup>1</sup>	<p>Ambulatory surgical center:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> \$300 copay</li> </ul> <p>Outpatient hospital:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> \$600 copay</li> <li>• <b>Out-of-network:</b> 40% of the cost</li> <li>• <b>Out-of-network:</b> 40% of the cost</li> </ul>
Over-the-counter items	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.) <sup>1</sup>	<p>Prosthetic devices:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> 20% of the cost</li> </ul> <p>Related medical supplies:</p> <ul style="list-style-type: none"> <li>• <b>In-network:</b> You pay nothing</li> <li>• <b>Out-of-network:</b> 40% of the cost</li> <li>• <b>Out-of-network:</b> 40% of the cost</li> </ul>
Renal Dialysis <sup>1</sup>	<ul style="list-style-type: none"> <li>• <b>In-network:</b> You pay nothing</li> <li>• <b>Out-of-network:</b> You pay nothing</li> </ul>
Transportation	Not covered
Urgently needed services	\$50 copay

## Vision services

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):

- **In-network:** \$50 copay

Routine eye exam (for up to 1 every year):

- **In-network:** \$50 copay

Eyeglasses or contact lenses after cataract surgery:

- **In-network:** 20% of the cost
- **Out-of-network:** 40% of the cost
- **Out-of-network:** \$60 copay
- **Out-of-network:** \$60 copay

## Hospice

**You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

## Preventive Care

## Preventive care

- **In-network:** **You pay nothing**

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

- **Out-of-network:** **You pay nothing**

## Inpatient Care

Inpatient Hospital Care<sup>1</sup>

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no

limit to the number of benefit periods.  
 Our plan covers an unlimited number of days for an inpatient hospital stay.

- **In-network:**
  - **\$295** copay per day for days 1 through 5
  - **You pay nothing** per day for days 6 through 90
  - **You pay nothing** per day for days 91 and beyond
- **Out-of-network:**
  - **40%** of the cost per stay

Inpatient mental health care

For inpatient mental health care, see the "Mental Health Care" section.

Skilled Nursing Facility (SNF)<sup>1</sup>

Our plan covers up to 100 days in a SNF.

- **In-network:**
  - **You pay nothing** per day for days 1 through 20
  - **\$160** copay per day for days 21 through 100
- **Out-of-network:**
  - **40%** of the cost per stay

## Prescription Drug Benefits

### How much do I pay?

For Part B drugs such as chemotherapy drugs<sup>1</sup>:

- **In-network: 0-20%** of the cost depending on the drug

Other Part B drugs<sup>1</sup>:

- **In-network: 0-20%** of the cost depending on the drug
- **Out-of-network: 40%** of the cost
- **Out-of-network: 40%** of the cost

### Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **\$3,310**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

#### Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$3 copay	\$9 copay
Tier 2 (Generic)	\$15 copay	\$45 copay
Tier 3 (Preferred Brand)	\$45 copay	\$135 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$285 copay
Tier 5 (Specialty Tier)	25% of the cost	Not Offered
Tier 6 (Vaccines)	\$0	Not Offered

#### Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred)	\$3 copay	\$6 copay

Generic)		
Tier 2 (Generic)	\$15 copay	\$30 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay
Tier 5 (Specialty Tier)	25% of the cost	Not Offered
Tier 6 (Vaccines)	\$0	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **\$3,310**.

After you enter the coverage gap, you pay **45%** of the plan's cost for covered brand name drugs and **58%** of the plan's cost for covered generic drugs until your costs total **\$4,850**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$4,850**, you pay the greater of:

- **5%** of the cost, or
- **\$2.95** copay for generic (including brand drugs treated as generic) and a **\$7.40** copayment for all other drugs.

Choice of Doctors? Any Doctor

### Optional Benefits (you must pay an extra premium each month for these benefits)

No

# Medicare.gov

The Official U.S. Government Site for Medicare

**Zip Code:** 05602

**Current Coverage:** Unknown

**Current Subsidy:** No Extra Help [?]

**Drug List ID:** 2091713440

**Password Date:** 04/05/2016

**Important Coverage Information**

Select the tabs below for more detailed information about the plan health benefits, drug costs and more coverage and star ratings.

**Symbols**

Some Dental Coverage      Some Vision Coverage      Nationwide Coverage

Some Hearing Coverage

\* Estimated

<p><b>BasiCare with Part D (PPO)</b> (H9615-008-0)<sup>1</sup></p> <p><b>Organization:</b> MVP HEALTH CARE</p> <p><b>Plan Type:</b> Local Preferred Provider Organization</p> <p> </p>	<p>220 Alexander St., Gold Sales Rochester, NY 14607</p> <p><b>Members:</b> 1-800-665-7924 1-800-662-1220 (TTY/TDD)</p> <p><b>Non Members:</b> 1-800-324-3899 1-800-662-1220 (TTY/TDD)</p>	<p><b>Overall Star Rating:</b> [?] 4.5 out of 5 stars</p>	<p><b>Enroll</b></p>
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**Fixed Costs**

<b>Monthly Drug Plan Premium [?]</b>	<b>\$0.00</b>
<b>Monthly Health Plan Premium [?]</b>	<b>\$29.90</b>
<b>Annual Drug Deductible [?]</b>	<b>\$360.00</b>

**Medicare costs at a glance**

**Estimate of What YOU Will Pay for Drug Plan Premium and Drug Costs**

	<b>Cost For Rest of Year (based on enrollment today) [?]</b>
Wal-Mart Pharmacy 10-2682	\$8,440.72
Osco Pharmacy	\$8,440.72
Mail Order Pharmacy	\$9,486.81

**Lower your drug costs**

**Estimated Full Cost the Plan Charges Medicare for Your Drugs**

**What You Pay**

<b>Wal-Mart Pharmacy 10-2682</b>	<b>Osco Pharmacy</b>	<b>Mail Order Pharmacy</b>
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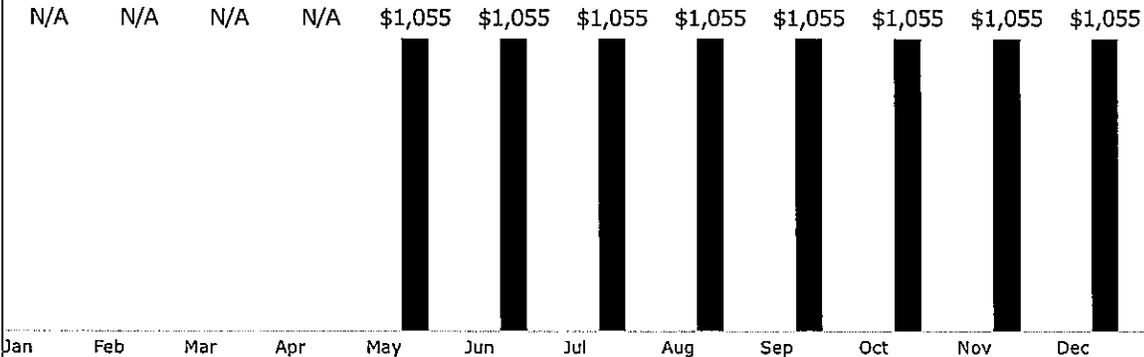
Wal-Mart Pharmacy 10-2682 - Standard Retail Cost Sharing

SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Deductible[?]	What You Pay		
				Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
<b>Cialis TAB 10MG</b>	\$1,055.09	Every 1 Month	\$1,055.09	\$1,055.09	\$1,055.09	\$1,055.09
<b>MONTHLY TOTALS:</b>	<b>\$1,055.09</b>		<b>\$1,055.09</b>	<b>\$1,055.09</b>	<b>\$1,055.09</b>	<b>\$1,055.09</b>

**Estimated Monthly Drug Costs**

<a href="#">Wal-Mart Pharmacy 10-2682</a>	<a href="#">Osco Pharmacy</a>	<a href="#">Mail Order Pharmacy</a>
-------------------------------------------	-------------------------------	-------------------------------------

**Monthly Costs for the Rest of the Year (based on enrollment today)**



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary. [View a more detailed explanation of these costs.](#)

**Drug Coverage Information**

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions		
		PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAPY [?]
<b>Cialis TAB 10MG</b>	Not on Formulary <sup>4</sup>			

[Print My Drug List](#)   [Print Plan Report](#)   [View Drug Benefit Summary](#)

<sup>4</sup>This type of drug is excluded from coverage under the Medicare program. This plan does not offer a supplement benefit for this type of drug. Any amount that you spend for this type of drug is not counted toward any deductibles, initial coverage or out-of-pocket limits. The drug cost displayed is only an estimate and actual cost may vary.

**Pharmacy & Mail Order Information**

Mail Order is available.

Pharmacy Network [?]

4 network pharmacies in your ZIP code

**Drug List**

**Add/Edit Drugs**

MEDICINE NAME	QUANTITY	FREQUENCY & PHARMACY	GENERIC OPTIONS	ACTION
<b>CIALIS TAB 10MG</b>	20	Every 1 Month Retail Pharmacy	Generic Not Available	<a href="#">Change dose</a> <a href="#">Add</a> <a href="#">Remove</a>

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# Shopping For Medicare Supplemental Insurance

1. What is Medicare Supplement Insurance?
2. How Do I Know if I Need Medicare Supplement Insurance?
3. Standard Plans and Basic Benefits
4. What is it Going to Cost?
5. Frequently Asked Questions
6. Where Can I Buy A Policy?
7. Important Tips
8. Where to Get Your Medicare Questions Answered

## 1. What is Medicare Supplement Insurance?

Medicare Supplement insurance policies (sometimes called “Medigap” policies) are specifically designed to cover certain expenses not covered by your Original Medicare hospital insurance (Part A) and medical insurance (Part B) coverage. The expenses not covered by your Original Medicare are costs that you must pay yourself.

- A Medicare Supplement insurance policy may cover some, but not all, of the gaps in your Original Medicare Part A and Part B coverage.
- Medicare Supplement insurance does not cover long-term care (care in a nursing home), vision or dental care, hearing aids, eyeglasses and private-duty nursing.
- Medicare Supplement insurance policies are sold by private insurance companies.
- Medicare doesn’t pay any of the cost for you to get a Medicare Supplement insurance policy.

A full description of basic and extra benefits covered under Medicare Supplement insurance policies can be found in Medicare’s publication, “Choosing a Medigap Policy.” Contact Medicare at 1-800-MEDICARE or

you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Deductibles for medical bills under Medicare Part B are applied one time per calendar year.

Co-insurance: The percentage of hospital and medical bills you pay after Medicare pays their portion and your deductibles have been met. For example, you may pay 20% of the Medicare-approved amount for some services after you meet the deductible. Some Medicare Supplement insurance policies will pick up the difference, which can be significant.

A Medicare Supplement insurance policy may help lower these costs. It is important to think about your current and future health care needs when considering and selecting an appropriate Medicare Supplement insurance policy. Other things to consider include the policy's benefits, premium costs, and customer service, and your own financial situation.

### 3. Standard Plans and Basic Benefits

Do all plans offer the same benefits?

Medicare Supplement Insurance plans are identified by letters. The plans are "standardized" - each plan offers the same basic benefits regardless of which insurance company is offering the policy. This allows you to compare policies so you can choose which one best meets your health care and financial needs.

What are the basic benefits?

All Medicare Supplement Insurance plans cover at least some portion of hospitalization expenses, medical expenses, blood and cost-sharing for all Medicare Part-A eligible hospice and respite care expenses.

### 4. What Does Medicare Supplement Insurance Cost?

The Vermont Department of Financial Regulation reviews and approves rates (also known as premiums) for each insurance company, for each Medicare Supplement insurance policy that they offer. Medicare Supplement insurance policies are community rated.

Community rating means that everyone age 65 and older who purchases a Medicare Supplement insurance policy during their initial enrollment period will pay the same rate for each Medicare Supplement insurance policy offered by each insurance company, regardless of age, health condition or gender. Rates for disabled Vermonters under age 65 may be higher than for people over age 65, but will be the same for all persons with disabilities.

Note: Rates will increase over time.

Rates are different from one insurer to the next for the same Medicare Supplement insurance plan. Rates

you become eligible for Medicaid (the Medicare Supplement insurance policy can be suspended for a period not to exceed 24 months). However, you are only entitled to this suspension if you notify the issuer of the Medicare Supplement insurance policy within a specific time period.

- Insurers are prohibited from requesting, requiring, or purchasing genetic information. Family members are also afforded these protections.
- Unlike with a Medicare Advantage plan, you have the ability to visit any doctor, hospital, or specialist that accepts Medicare.

How does Medicare Supplement insurance coverage work?

- To buy a Medicare Supplement insurance policy, you must have Medicare Part A and Part B.
- A Medicare Supplement insurance policy covers one person. If you and your spouse both want coverage, you each need to buy separate policies.
- Many Medicare Supplement insurance policies are accepted by health care professionals throughout the country; this is an advantage if you travel or live part of the year out-of-state. Some policies even provide additional benefits for those traveling to foreign countries.

When is the best time to buy a policy?

The best time to buy a Medicare Supplement policy is during your initial enrollment period. This period lasts for 6 months and begins on the first day of the month in which you are both: age 65 (or older) and enrolled in Medicare Part B.

Why is important to buy a policy when I am first eligible?

It's very important to understand your initial enrollment period. During this period, an insurance company can't use "medical underwriting." Medical underwriting is a process that an insurance company uses to decide, based on your medical history, whether or not to issue an insurance policy.

How do I apply?

Applying for Medicare Supplement insurance is similar to applying for traditional health insurance. All insurance companies that offer Medicare Supplement insurance policies to people who are 65 years or older must now offer the same policies to people who are disabled and under 65 years old, during the first 6 months after they become eligible for Medicare. Even if you had Medicare before age 65, once you reach age 65 you have another 6-month initial enrollment period during which you can buy a Medicare Supplement insurance policy or change policies.

Can I switch plans and companies?

Take your time. Do not be pressured into buying a Medicare Supplement insurance policy by an agent.

Be careful about replacing coverage. Don't cancel an existing policy until a replacement policy is in effect, because you may not be accepted by another company.

Check for pre-existing condition exclusions and waiting periods.

Do not over-buy Medicare Supplement insurance. One policy will meet your needs. Buy a policy that you are able to afford, anticipating premium increases over time.

Ask questions about the policy's coverage for important services, such as:

- Inpatient and outpatient medical coverage
- Part A hospital and Part B medical deductibles
- Mental health coverage

Consider your options and shop carefully because prices for the same plan can vary widely in the marketplace.

Complete the application carefully. Be certain that all information has been properly recorded. Intentional omissions of medical conditions on your Medicare Supplement insurance policy application may result in cancellation of your policy (your policy can not be canceled if you become sick and had made an unintentional mistake on your application). Review the application carefully before you sign it.

## 8. Where to Get Your Medicare Questions Answered

### Vermont's State Health Insurance Program

Vermont's State Health Insurance Program (SHIP) counselors are located within the Area Agency on Aging that serves your area. The SHIP counselors provide free and confidential help. You can go to the specific websites listed below, or call 1-800-642-5119 (toll-free) to be connected to SHIP.

#### Area Agency on Aging for Northeastern Vermont

481 Summer Street, Suite 101

St. Johnsbury, VT 05819 802-748-5182

800-642-5119 (toll free)

[www.nevaaa.org](http://www.nevaaa.org)

#### Central Vermont Council on Aging

30 Washington Street

Barre, VT 05641

or

109 Professional Drive, Suite 1

Morrisville, VT 05661 802-479-0531

877-379-2600 (toll free)

802-888-2504

**Coordination of Benefits Contractor**

To get information on whether Medicare or your other insurance pays first and to report changes in your insurance information. 1-800-999-1118

TTY 1-800-318-8782

**Department of Defense**

To get information about TRICARE for Life. 1-866-773-0404

TTY 1-866-773-0405

**Department of Health and Human Services****Office of Inspector General**

If you suspect billing fraud. 1-800-447-8477

TTY 1-800-377-4950

**Office for Civil Rights**

If you think you were discriminated against or if your health information privacy rights were violated. 1-800-368-1019

TTY 1-800-537-7697

**Department of Veterans Affairs**

If you are a veteran or have served in the U.S. military. 1-800-827-1000

TTY 1-800-829-4833

**Office of Personnel Management**

To get information about the Federal Employee Health Benefits Program for current and retired Federal employees. 1-888-767-6738

TTY 1-800-878-5707

[www.opm.gov](http://www.opm.gov)

Attachment	Size
 Med-Supp-Rates-65-and-Older.pdf	33.4 KB
 Med-Supp-Rates-Disabled-Under-age-65.pdf	33.12 KB

**I Want To ...**

[Ask A Question](#)

[File an Insurance Complaint](#)

[Appeal a Health Insurance Claim Denial](#)

[Get Insurance Consumer Information](#)

# 2016 Medicare Supplement Plans For People Ages 65 and Older

Name	A	B	C	D	F	FHD	G	K	L	M	N
<b>Individual Insurance through Insurer</b>											
Blue Cross Blue Shield of Vermont Blue 65	\$151.32		\$221.76		\$222.94						
Blue Cross Blue Shield of Vermont Medigap Blue	\$122.27		\$157.48	\$140.66	\$158.32						\$132.18
<b>Individual Insurance Through Agents</b>											
American Progressive	\$135.34	\$167.08	\$247.20	\$205.04							\$163.49
Colonial Penn Life	\$149.39	\$183.54			\$204.72	\$49.89	\$188.55	\$70.20	\$121.80	\$163.60	\$119.37
Continental Life Insurance Co./Aetna	\$114.95	\$144.86	\$159.94	\$146.27							\$119.95
First Health Life & Health Ins Co	\$129.53	\$158.27			\$189.01		\$176.26				\$139.28
Globe Life And Accident Insurance Co.	\$108.06	\$157.17	\$186.91		\$188.06	\$41.45					
Humana Healthy Living	\$172.35				\$209.77	\$89.28		\$130.32			\$172.92
Humana Insurance Company	\$152.19	\$165.64	\$196.69		\$200.71	\$69.93		\$111.07	\$142.25		\$139.60
Liberty National Life	\$146.00	\$211.00	\$246.00								\$194.00
Mutual of Omaha	\$123.66	\$228.02	\$244.33	\$275.61	\$279.00		\$224.06				
State Farm Insurance	\$126.71		\$194.48		\$196.47						
United American Insurance Company	\$125.00	\$184.00	\$217.00	\$204.00	\$228.00	\$42.00					\$169.00
USAA Life	\$92.48				\$174.93						
<b>Group Insurance Through Association Member Plans</b>											
United Healthcare (AARP)	\$117.50	\$184.75	\$215.00		\$215.00			\$72.75	\$124.75		\$142.00

The rates published are current as of the date of publication. However, rates are approved on a continuous basis. You should check with the insurer for the most current terms and rates before design on a particular policy.

# 2016 Medicare Supplement Plans For People Who Are Disabled and Under Age 65

Name	A	B	C	D	F	FHD	G	K	L	M	N
<b>Individual Insurance through Insurer</b>											
Blue Cross Blue Shield of Vermont Blue 65	\$151.32		\$221.76		\$222.94						
Blue Cross Blue Shield of Vermont Medigap Blue	\$215.69		\$281.36	\$256.40	\$282.11						\$238.52
<b>Individual Insurance Through Agents</b>											
American Progressive	\$169.18	\$209.78	\$309.00	\$256.31							\$230.78
Colonial Penn Life	\$156.07	\$191.75			\$214.91	\$49.89	\$193.25	\$70.20	\$133.88	\$163.60	\$133.57
Continental Life Insurance Co/Aetna	\$214.15	\$269.19	\$297.83	\$272.42							\$217.84
First Health Life & Health Insurance Co	\$226.74	\$276.89			\$330.78		\$308.54				\$243.74
Globe Life And Accident Insurance Co.	\$108.06	\$157.17	\$186.91		\$188.06	\$41.45					\$240.96
Humana Healthy Living	\$240.15				\$293.28	\$122.18		\$180.45			\$197.65
Humana Insurance Company	\$215.46	\$234.50	\$278.48		\$284.16	\$99.00		\$157.25	\$201.40		\$242.00
Liberty National Life	\$183.00	\$264.00	\$307.00				\$280.07				
Mutual of Omaha	\$154.58	\$285.01	\$305.40	\$344.53	\$348.76						
State Farm Insurance	\$135.72		\$208.35		\$210.43						
United American Insurance Company	\$156.00	\$230.00	\$271.00	\$255.00	\$284.00	\$52.00					\$211.00
USAA Life	\$92.48				\$174.93						
<b>Group Insurance Through Association Member Plans</b>											
United Healthcare (AARP)	\$147.00	\$231.00	\$268.75		\$268.75			\$91.00	\$156.00		\$177.50

The rates published are current as of the date of publication. However, rates are approved on a continuous basis. You should check with the insurer for the most current terms and rates before design on a particular policy.

The chart below shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

**Note:** You'll need more details than this chart provides to compare and choose a policy. See page 104 to find out where to get more information.

**Medicare Supplement Insurance (Medigap) plans**

Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% **
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%

Out-of-pocket limit in 2015	
\$4,940	\$2,470

\* Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,180 in 2015 before your policy pays anything.

\*\* Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.