EXPRESS SCRIPTS®
Medicare (PDP)

| Value Plan | Choice Plan |

S5660 & S5983

Summary of Benefits

January 1, 2017 – December 31, 2017

This booklet gives you a summary of what **Express Scripts Medicare®** (PDP) Value and Choice plans cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us or view the *Evidence of Coverage* online.

Contact information
If you are not a member of this plan, call toll free **1.866.477.5704;** TTY: **1.800.716.3231,**
24 hours a day, 7 days a week, except Thanksgiving and Christmas.
Or visit our website: **http://www.express-scriptsmedicare.com**

If you are a member of this plan, call toll free **1.800.758.4574** (New York State residents: **1.800.758.4570**); TTY: **1.800.716.3231,** 24 hours a day, 7 days a week.
Or visit our website: **http://www.express-scripts.com**

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at http://www.medicare.gov or get a copy by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Information about Express Scripts Medicare (PDP)

Who can join our plan?

- To join Express Scripts Medicare (PDP), you must be entitled to Medicare Part A and/or be enrolled in Medicare Part B and live in our service area. Our service area includes the following: All 50 states, the District of Columbia and Puerto Rico.

Which drugs are covered?

- You can see the complete plan formulary (list of covered Part D prescription drugs) and any restrictions on our website (**http://www.express-scriptsmedicare.com/documents**).

What pharmacies can I use?

- We have a network of pharmacies (both standard and preferred) and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can check to see if your pharmacy is in our network at our website (**http://www.express-scriptsmedicare.com/finder**).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/ coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1.800.758.4574;** New York residents: **1.800.758.4570** (TTY: **1.800.716.3231**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.758.4574;** para residentes de New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

This information is available in braille, large print and other formats for people with disabilities. Please contact Customer Service if you need plan information in another format.

Index of Benefit Information by State

What will I pay for covered services (premium, deductible and cost-sharing)?

Our plan groups each medication into one of five "tiers." The amount you pay depends on the drug's tier, the pharmacy you use (standard or preferred), whether the prescription is for a 31-day or 90-day supply and which of the following stages of the benefit you have reached:

- **Deductible:** You pay a set amount before your plan begins to pay its share of the cost.
- **Initial Coverage:** This stage begins after you pay your yearly deductible. You remain in this stage until your total yearly drug costs reach $3,700. (Total yearly drug costs include the total drug costs paid by you and any Part D plan since the calendar year began.)
- **Coverage Gap (or Donut Hole):** This stage begins after your total yearly drug costs exceed $3,700. **Most members do not reach the Coverage Gap.** If you reach this stage, you will pay 51% of the cost for generic drugs and 40% of the cost for brand drugs, excluding dispensing and any vaccine administration fees, until your out-of-pocket costs total $4,950.
- **Catastrophic Coverage:** This stage begins after your year-to-date out-of-pocket costs exceed $4,950. During this stage, you pay the greater of $3.30 or 5% of the cost for generic drugs (including brand drugs treated as generics) and the greater of $8.25 or 5% of the cost for all other drugs.

Cost-sharing amounts may change depending on the type of pharmacy used, the drug tier and the stage of the Part D benefit. For more information, please call us or view our *Evidence of Coverage* on our website (**http://www.express-scriptsmedicare.com/documents**).

Cost-sharing amounts at long-term care, home infusion and out-of-network pharmacies are the same as at a **standard** retail pharmacy.

Benefit information varies by region/state. See the Index on page 2 to locate the page number for the premium, deductible and cost-sharing amounts for your state.

Region 1: Maine, New Hampshire

	Value Plan			**Choice Plan**		
Monthly Premium	**$41.70**			**$86.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayments or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 Days**	**31 Days**	**90 Days**	**31 Days**	**31 Days**	**90 Days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$37 copay	$42 copay	$111 copay	21% of the cost	23% of the cost	23% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 2: Connecticut, Massachusetts, Rhode Island, Vermont

	Value Plan			Choice Plan		
Monthly Premium	**$43.10**			**$80.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayments or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 Days**	**31 Days**	**90 Days**	**31 Days**	**31 Days**	**90 Days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$36 copay	$41 copay	$108 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 3: New York

	Value Plan			Choice Plan		
Monthly Premium	**$38.40**			**$83.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayments or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 Days**	**31 Days**	**90 Days**	**31 Days**	**31 Days**	**90 Days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$41 copay	$46 copay	$123 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 4: New Jersey

	Value Plan			Choice Plan		
Monthly Premium	**$37.50**			**$82.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$36 copay	$41 copay	$108 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 5: Delaware, District of Columbia, Maryland

	Value Plan			Choice Plan		
Monthly Premium	**$30.40**			**$85.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$38 copay	$43 copay	$114 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 6: Pennsylvania, West Virginia

	Value Plan			Choice Plan		
Monthly Premium	**$35.00**			**$88.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$31 copay	$36 copay	$93 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 7: Virginia

	Value Plan			Choice Plan		
Monthly Premium	**$54.50**			**$80.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$39 copay	$44 copay	$117 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 8: North Carolina

	Value Plan			Choice Plan		
Monthly Premium	**$39.20**			**$86.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$6 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$11 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 9: South Carolina

	Value Plan			Choice Plan		
Monthly Premium	**$44.00**			**$84.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$40 copay	$45 copay	$120 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 10: Georgia

	Value Plan			Choice Plan		
Monthly Premium	**$40.60**			**$88.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$7 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$12 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 11: Florida

	Value Plan			Choice Plan		
Monthly Premium	**$75.10**			**$91.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$40 copay	$45 copay	$120 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 12: Alabama, Tennessee

	Value Plan			Choice Plan		
Monthly Premium	**$29.60**			**$82.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$41 copay	$46 copay	$123 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 13: Michigan

	Value Plan			Choice Plan		
Monthly Premium	**$39.30**			**$79.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$40 copay	$45 copay	$120 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 14: Ohio

	Value Plan			Choice Plan		
Monthly Premium	**$47.80**			**$68.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	Copayment or Coinsurance					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 15: Indiana, Kentucky

	Value Plan			Choice Plan		
Monthly Premium	**$31.20**			**$81.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	Copayment or Coinsurance					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$36 copay	$41 copay	$108 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 16: Wisconsin

	Value Plan			Choice Plan		
Monthly Premium	**$52.20**			**$88.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$16 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 17: Illinois

	Value Plan			Choice Plan		
Monthly Premium	**$39.10**			**$81.90**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$4 copay	$20 copay	$8 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 18: Missouri

	Value Plan			Choice Plan		
Monthly Premium	**$51.20**			**$83.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$15 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 19: Arkansas

	Value Plan			Choice Plan		
Monthly Premium	**$31.40**			**$80.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Day's Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$18 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 20: Mississippi

	Value Plan			Choice Plan		
Monthly Premium	**$34.40**			**$88.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$4 copay	$20 copay	$8 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 21: Louisiana

	Value Plan			Choice Plan		
Monthly Premium	**$31.00**			**$76.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Day's Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$41 copay	$46 copay	$123 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 22: Texas

	Value Plan			Choice Plan		
Monthly Premium	**$47.20**			**$98.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$20 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 23: Oklahoma

	Value Plan			Choice Plan		
Monthly Premium	**$36.30**			**$85.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$7 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$12 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 24: Kansas

	Value Plan			Choice Plan		
Monthly Premium	**$48.70**			**$87.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 25: Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming

	Value Plan			Choice Plan		
Monthly Premium	**$52.00**			**$88.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$40 copay	$45 copay	$120 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 26: New Mexico

	Value Plan			Choice Plan		
Monthly Premium	**$49.00**			**$78.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$5 copay	$20 copay	$10 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 27: Colorado

	Value Plan			Choice Plan		
Monthly Premium	**$59.10**			**$88.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$38 copay	$43 copay	$114 copay	22% of the cost	24% of the cost	24% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 28: Arizona

	Value Plan			Choice Plan		
Monthly Premium	**$31.50**			**$84.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$41 copay	$46 copay	$123 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 29: Nevada

	Value Plan			Choice Plan		
Monthly Premium	**$48.00**			**$86.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$41 copay	$46 copay	$123 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 30: Oregon, Washington

	Value Plan			Choice Plan		
Monthly Premium	**$49.00**			**$81.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$37 copay	$42 copay	$111 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 31: Idaho, Utah

	Value Plan			Choice Plan		
Monthly Premium	**$36.50**			**$82.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$34 copay	$39 copay	$102 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 32: California

	Value Plan			Choice Plan		
Monthly Premium	**$59.10**			**$91.40**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$7 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$12 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 33: Hawaii

	Value Plan			Choice Plan		
Monthly Premium	**$34.70**			**$68.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$7 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$12 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	22% of the cost	24% of the cost	24% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 34: Alaska

	Value Plan			Choice Plan		
Monthly Premium	**$50.00**			**$88.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$5 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$3 copay	$10 copay	$6 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$35 copay	$40 copay	$105 copay	22% of the cost	24% of the cost	24% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

Region 38: Puerto Rico

	Value Plan			Choice Plan		
Monthly Premium	**$53.10**			**$74.50**		
	You must continue to pay your Medicare Part B premium.					
Yearly Deductible	**$400** (all tiers)			**$0** for Tiers 1 & 2 generics **$350** for Tiers 3, 4, & 5		
Initial Coverage	**Copayment or Coinsurance**					
Pharmacy Type	**Preferred Retail**	**Standard Retail**	**Preferred Mail**	**Preferred Retail**	**Standard Retail**	**Preferred Mail**
Days' Supply	**31 days**	**31 days**	**90 days**	**31 days**	**31 days**	**90 days**
Tier 1 Preferred Generic Drugs	$0 copay	$10 copay	$3 copay	$2 copay	$10 copay	$0 copay
Tier 2 Generic Drugs	$5 copay	$20 copay	$10 copay	$7 copay	$20 copay	$4 copay
Tier 3 Preferred Brand Drugs	$42 copay	$47 copay	$126 copay	23% of the cost	25% of the cost	25% of the cost
Tier 4 (31-day supply only) Non-Preferred Drugs	48% of the cost	50% of the cost	50% of the cost	48% of the cost	50% of the cost	50% of the cost
Tier 5 (31-day supply only) Specialty Drugs	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost

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(رقم هاتف الصم والبكم: **1-800-716-3231**).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-**800.758.4574;** নিউ ইয়র্কের বাসিন্দারা ফোন করুন: ১-**800.758.4570** (TTY: ১-**800.716.3231**)।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1.800.758.4574;** អ្នកស្នាក់នៅបូរីញ្ហវយ៉ក ទូរស័ព្ទមកលេខ៖ **1.800.758.4570** (TTY: **1.800.716.3231**)។

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1.800.758.4574;**
纽约居民请致电：**1.800.758.4570**（TTY：**1.800.716.3231**）。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1.800.758.4574;** résidents de New York : **1.800.758.4570** (ATS : **1.800.716.3231**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1.800.758.4574;** Einwohner von New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1.800.758.4574** Κάτοικοι της Νέας Υόρκης: **1.800.758.4570** (TTY: **1.800.716.3231**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.800.758.4574; ન્યુયોર્કના રહેવાસીઓ માટે: કોલ નંબર: **1.800.758.4570** (TTY: **1.800.716.3231**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1.800.758.4574;** moun ki abite New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1.800.758.4574;** per i residenti a New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1.800.758.4574;** 뉴욕 거주자는 다음의 번호로 전화하십시오:**1.800.758.4570** (TTY: **1.800.716.3231**)번으로 전화해 주십시오.

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1.800.758.4574;** Nei Yarrick Leit: **1.800.758.4570** (TTY: **1.800.716.3231**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1.800.758.4574;** mieszkańcy Nowego Jorku: **1.800.758.4570** (TTY: **1.800.716.3231**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1.800.758.4574;** para residentes em Nova Iorque:**1.800.758.4570** (TTY: **1.800.716.3231**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните +**1.800.758.4574**; Жителям Нью-Йорка следует звонить по следующему номеру: **+1.800.758.4570** (телетайп: +**1.800.716.3231**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.758.4574;** para residentes de New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1.800.758.4574;** mga residente ng New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

دھیان دیں: اگر آپ اردو بولتے/ بولتی ہیں، تو آپ کو زبان سے متعلق امداد کی خدمات، مفت میں دستیاب ہیں۔
1.800.758.4574 ؛ New York کے باشندے: **1.800.758.4570** (TTY: **1.800.716.3231**) پر کال کریں۔

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1.800.758.4574;** cư dân New York: **1.800.758.4570** (TTY: **1.800.716.3231**).

אויפמערקזאם: אויב איר רעדט אידיש, עס זענען פארהאן פאר אייך שפראך הילף דינסטן אומזיסט. רופט **1.800.758.4574**; איינווינער פֿון ניו יאָרק: **1.800.758.4570** (TTY: **1.800.716.3231**).

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Civil Rights Coordinator
Express Scripts Medicare
P.O. Box 4083
Dublin, Ohio 43016

También puede comunicarse con el Departamento de Salud y Servicios Humanos de los EE. UU., Oficina de Derechos Civiles por estos medios:

- En línea: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Por correo postal: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Teléfono: 1.800.368.1019 o 1.800.537.7697 (TDD)

Puede encontrar los formularios de quejas en http://www.hhs.gov/ocr/office/file/index.html.

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Our goal is to treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We do not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card. If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint.
To file a complaint, please contact our Civil Rights Coordinator at:

Civil Rights Coordinator
Express Scripts Medicare
P.O. Box 4083
Dublin, Ohio 43016

You can also contact the U.S. Department of Health and Human Services, Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.