



HOW TO READ YOUR PLAN FINDER RESULTS

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Reviewing the Plan Details

An official website of the United States government. [Here's how you know](#)

Medicare.gov

Aetna Medicare
SilverScript SmartSaver (PDP)

Plan type: Drug plan (Part D)
Plan ID: S5601-191-0
Plan website | Non-members: 1-833-526-2445 | Members: 1-866-235-5660

What you'll pay

Total monthly premium	Retail pharmacy: 2024 estimated total drug costs	Mail order pharmacy: 2024 estimated total drug costs
\$9.80	\$2,350.87 Covers 6 of 6 drugs	\$2,160.53 Covers 6 of 6 drugs

Overview

PREMIUMS

Total monthly premium	\$9.80
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DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Drug deductible	\$280.00
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CONTACT INFORMATION

Plan address	P.O. Box 30016 Pittsburgh, PA 15222
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[Feedback](#)

- 1** Insurance company and plan name
- 2** Plan ID code, link to plans website, and plans phone numbers.
- 3** Monthly Premium – this is paid directly to the insurance company
- 4** Annual Deductible – this is paid at the pharmacy when you go to pick up your drugs. You pay the full price of your drugs until you have paid this amount.
- 5** Contact Information – provides the address for the plan.

Pharmacies

6

Pharmacy List - this section tells you if your pharmacy is Out of network, Preferred, Standard, or Mail order.

Drug Coverage

[See if there's help to lower costs for drugs you take.](#)

PHARMACIES

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

FORT ATKINSON HOMETOWN PHARMACY	 In-network
THE DRUG STORE AND MUELLER DRUGS INC	 Out-of-network
WALGREENS #1976	 Out-of-network
WALMART PHARMACY 10-3499	 Preferred  In-network
Mail Order Pharmacy	 Preferred  In-network

Costs vary based on the specific mail-order pharmacy

Pharmacy descriptions:

- ❖ Out-of-network pharmacy – this plan does not work with this pharmacy. If you use this pharmacy with this plan, you will pay full price from prescriptions.
- ❖ Preferred in-network pharmacy – this is the pharmacy this plan would prefer you to use. You will have the lowest cost sharing at a preferred pharmacy.
- ❖ Standard in-network pharmacy – this is a pharmacy you can use with your plan, but you will pay higher copays for your prescriptions.
- ❖ Mail order pharmacy – Mail order pricing is for a 3-month supply. Sometimes mail order is lower cost than standard or preferred pharmacies, but not always.

Yearly Drug Costs by Pharmacy

7

YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. [Can my drug costs change by pharmacy?](#)

	Fort Atkinson Hometown Pharmacy  In-network	The Drug Store And Mueller Drugs Inc  Out-of-network	Walgreens #1976  Out-of-network	Walmart Pharmacy 10-3499  Preferred	Mail Order Pharmacy  Preferred
Hydrochlorothiazide 25mg tablet	\$4.10	\$67.80	\$67.80	\$0.14	\$0.06
Lantus 100unit/ml solution pen injector	\$420.00	\$6,182.04	\$6,182.04	\$420.00	\$420.00
Losartan potassium 100mg tablet	\$7.29	\$1,087.32	\$1,087.32	\$0.21	\$0.10
Metformin hydrochloride 1000mg tablet	\$7.78	\$1,023.00	\$1,023.00	\$0.21	\$0.12
Simvastatin 20mg tablet	\$6.75	\$2,599.56	\$2,599.56	\$0.21	\$0.08
Trelegy 100-62.5-25mcg/act aerosol powder	\$1,927.69	\$9,194.64	\$9,194.64	\$1,930.10	\$1,740.17
Total yearly drug cost	\$2,373.61	\$20,154.36	\$20,154.36	\$2,350.87	\$2,160.53

7

The Yearly Drug Costs by Pharmacy section breaks down the cost of each medication at each pharmacy for the rest of the calendar year.

- ❖ This pricing DOES NOT INCLUDE the monthly plan premium.
- ❖ Note: this section may go onto the next page depending on the number of prescriptions listed.

Estimated Total Drug + Premium Cost

ESTIMATED TOTAL DRUG + PREMIUM COST					
	Fort Atkinson Hometown Pharmacy ✓ In-network	The Drug Store And Mueller Drugs Inc ✗ Out-of-network	Walgreens #1976 ✗ Out-of-network	Walmart Pharmacy 10-3499 ✓ Preferred	Mail Order Pharmacy ✓ Preferred
Total drug + premium cost (for the rest of 2024)	\$2,491.21	\$20,271.96	\$20,271.96	\$2,468.47	\$2,278.13
When you'll meet your deductible	January 2024	January 2024	January 2024	January 2024	January 2024
When you'll enter the coverage gap	May 2024	April 2024	April 2024	May 2024	April 2024
When you'll get out of the coverage gap	You won't get out of the coverage gap in 2024	May 2024	May 2024	You won't get out of the coverage gap in 2024	You won't get out of the coverage gap in 2024

8

Estimated Total Drug + Premium Cost -

- ❖ This section gives you the total cost for this plan at each pharmacy for the drugs entered for the whole year. **When comparing plans this is the number you want to pay attention to!** It includes all of your prescription costs including the premium for the plan for the whole year.

9

This section also tells you:

9

What month you'll meet your deductible

10

What month you'll enter the coverage gap

11

What month you'll exit the coverage gap and will be entering catastrophic coverage

Estimated Total Monthly Drug Cost

ESTIMATED TOTAL MONTHLY DRUG COST					
12	Fort Atkinson Hometown Pharmacy ✓ In-network	The Drug Store And Mueller Drugs Inc ⊖ Out-of-network	Walgreens #1976 ⊖ Out-of-network	Walmart Pharmacy 10-3499 ✓ Preferred	Mail Order Pharmacy ✓ Preferred
January	\$402.44	\$1,679.53	\$1,679.53	\$398.60	\$770.18
February	\$189.64	\$1,679.53	\$1,679.53	\$185.80	-
March	\$189.64	\$1,679.53	\$1,679.53	\$185.80	-
April	\$189.64	\$1,679.53	\$1,679.53	\$185.80	\$570.66
May	\$192.51	\$1,679.53	\$1,679.53	\$188.50	-
June	\$193.05	\$1,679.53	\$1,679.53	\$192.20	-
July	\$193.05	\$1,679.53	\$1,679.53	\$192.20	\$576.41
August	\$193.05	\$1,679.53	\$1,679.53	\$192.20	-
September	\$193.05	\$1,679.53	\$1,679.53	\$192.20	-
October	\$193.05	\$1,679.53	\$1,679.53	\$192.20	\$243.28
November	\$193.05	\$1,679.53	\$1,679.53	\$192.20	-
December	\$51.44	\$1,679.53	\$1,679.53	\$53.17	-

ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

[Learn more about coverage phases.](#)

12

Estimated Total Monthly Drug Cost -

This section estimates how much you will spend on drugs each month in this plan at each pharmacy included in results.

*Mail order pharmacy is for a 3-month supply.

NOTE: Please note that the Plan Finder is an estimate on currently listed drugs and drug costs can change at any time. Estimates may also change if your doctor adds or removes drugs.

Pharmacy Details

Next you will see estimated cost breakdowns for each pharmacy selected for comparison. Each pharmacy has + before the name.

13

+ THE DRUG STORE AND MUELLER DRUGS INC

You may have to pay the full cost for drugs. Choose an in-network pharmacy to get drugs at a lower cost. [Find an in-network pharmacy](#)

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Hydrochlorothiazide 25mg tablet	\$5.65	\$5.65	\$5.65	\$5.65	\$5.65
Lantus 100unit/ml solution pen injector	\$515.17	\$515.17	\$515.17	\$515.17	\$515.17
Losartan potassium 100mg tablet	\$90.61	\$90.61	\$90.61	\$90.61	\$90.61
Metformin hydrochloride 1000mg tablet	\$85.25	\$85.25	\$85.25	\$85.25	\$85.25
Simvastatin 20mg tablet	\$216.63	\$216.63	\$216.63	\$216.63	\$216.63
Trelegy 100-62.5-25mcg/act aerosol powder	\$766.22	\$766.22	\$766.22	\$766.22	\$766.22
Monthly totals	\$1,679.53	\$1,679.53	\$1,679.53	\$1,679.53	\$1,679.53

13

Example of an Out-of-Network Pharmacy:

In this example you can see that the cost of each drug is the same in every column. This means the pharmacy is Out of Network and the plan is not helping pay for these drugs at all.

When you see this... DO NOT use this plan at that pharmacy!

Note: Yellow box also highlights that you would pay full price unless you chose an in-network pharmacy to get the lowest costs.

Pharmacy Details

14

+ FORT ATKINSON HOMETOWN PHARMACY

	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Hydrochlorothiazide 25mg tablet	\$0.61	\$0.61	\$0.61	\$0.15	\$0.00
Lantus 100unit/ml solution pen injector	\$431.11	\$35.00	\$35.00	\$35.00	\$0.00
Losartan potassium 100mg tablet	\$1.08	\$1.08	\$1.08	\$0.27	\$0.00
Metformin hydrochloride 1000mg tablet	\$1.15	\$1.15	\$1.15	\$0.29	\$0.00
Simvastatin 20mg tablet	\$1.00	\$1.00	\$1.00	\$0.25	\$0.00
Trelegy 100-62.5-25mcg/act aerosol powder	\$628.35	\$628.35	\$150.80	\$157.09	\$0.00
Monthly totals	\$1,063.31	\$667.19	\$189.64	\$193.05	\$0.00

Example of a Standard in-network pharmacy: You will notice that drug pricing is usually higher at a standard pharmacy than a preferred pharmacy.

14

These pharmacy charts provide drug cost details at each phase of Part D coverage phases.

- ❖ Deductible phase
- ❖ Initial coverage Level (Copay) phase ("Cost after deductible")
- ❖ Coverage Gap (Donut Hole) phase
- ❖ Catastrophic Coverage phase

Coverage phase descriptions on next page

Descriptions of Coverage Phases

Retail Cost:

This is a negotiated price between this plan and this pharmacy. This number will be different on a different plan or at a different pharmacy.

Cost before Deductible:

(Deductible) This is the price you pay for your drugs at the pharmacy until you have paid out the deductible amount. Don't worry if the total at the bottom of this column is more than the deductible. You move to the next phase once you have met the deductible.

Cost after deductible:

(Copay/Initial Coverage) these are the copays you pay for each drug after your deductible has been met; Before you reach the coverage gap. Pricing is based on tiering structure set by the plan.

Pharmacy Details

Example of a Preferred in-network pharmacy:

- ❖ Drug Pricing is usually lower at a preferred pharmacy than a standard pharmacy.

+ WALMART PHARMACY 10-3499					
	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Hydrochlorothiazide 25mg tablet	\$0.09	\$0.00	\$0.00	\$0.02	\$0.00
Lantus 100unit/ml solution pen injector	\$431.11	\$35.00	\$35.00	\$35.00	\$0.00
Losartan potassium 100mg tablet	\$0.12	\$0.00	\$0.00	\$0.03	\$0.00
Metformin hydrochloride 1000mg tablet	\$0.13	\$0.00	\$0.00	\$0.03	\$0.00
Simvastatin 20mg tablet	\$0.11	\$0.00	\$0.00	\$0.03	\$0.00
Trelegy 100-62.5-25mcg/act aerosol powder	\$628.35	\$628.35	\$150.80	\$157.09	\$0.00
Monthly totals	\$1,059.91	\$663.35	\$185.80	\$192.20	\$0.00

Pharmacy Details

+ MAIL ORDER PHARMACY					
	Retail cost	Cost before deductible	Cost after deductible	Cost in coverage gap	Cost after coverage gap
Hydrochlorothiazide 25mg tablet	\$0.13	\$0.00	\$0.00	\$0.03	\$0.00
Lantus 100unit/ml solution pen injector	\$1,293.17	\$105.00	\$105.00	\$105.00	\$0.00
Losartan potassium 100mg tablet	\$0.22	\$0.00	\$0.00	\$0.05	\$0.00
Metformin hydrochloride 1000mg tablet	\$0.23	\$0.00	\$0.00	\$0.06	\$0.00
Simvastatin 20mg tablet	\$0.18	\$0.00	\$0.00	\$0.04	\$0.00
Trelegy 100-62.5-25mcg/act aerosol powder	\$1,884.91	\$1,884.91	\$452.38	\$471.23	\$0.00
Monthly totals	\$3,178.83	\$1,989.91	\$557.38	\$576.41	\$0.00

Example of a Mail Order pharmacy:

Note:

- ❖ Mail order is listed in 3 month (90 day) supply of prescriptions. This will increase the "retail cost" for each drug listed.
- ❖ Pay attention as sometimes mail order costs are less than a local pharmacy, but sometimes they will be higher.

****Always check with the plan directly for the most up to date pricing on prescriptions****

Costs by Drug Tier

COSTS BY DRUG TIER			
	Initial coverage phase	Gap coverage phase	Catastrophic coverage phase
Preferred Generic	\$0.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: \$0 copay Brand-name drugs: \$0 copay
Generic	\$5.00 copay	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: \$0 copay Brand-name drugs: \$0 copay
Preferred Brand	24%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: \$0 copay Brand-name drugs: \$0 copay
Non-Preferred Drug	50%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: \$0 copay Brand-name drugs: \$0 copay
Specialty Tier	29%	Generic drugs: 25% Brand-name drugs: 25%	Generic drugs: \$0 copay Brand-name drugs: \$0 copay

This section provides general information about how the plan's tiering structure works for each of the Medicare Part D phases.

15 Initial Coverage Phase - (Cost after deductible/Copay) these are the copays you pay for each drug after your deductible has been met; Before you reach the coverage gap. This is the tiering structure set by the plan.

16 Gap Coverage phase - (Cost in coverage gap/Donut Hole) the prices you pay in this phase should be 25% of the retail cost for your drugs.

17 Catastrophic Coverage - (Cost after coverage gap) In this phase Medicare limits your cost sharing to \$0.

Other Drug Information

18

Tier assignment - this shows what tier this plan assigned your drugs to as this is different from plan to plan. It will also show if your drug is not covered by the plan.

OTHER DRUG INFORMATION				
	Tier	Prior authorization	Quantity limits	Step therapy
Hydrochlorothiazide 25mg tablet	Tier 1	–	–	–
Lantus 100unit/ml solution pen injector	Tier 3	–	–	–
Losartan potassium 100mg tablet	Tier 1	–	Yes	–
Metformin hydrochloride 1000mg tablet	Tier 1	–	Yes	–
Simvastatin 20mg tablet	Tier 1	–	Yes	–
Trelegy 100-62.5-25mcg/act aerosol powder	Tier 3	–	Yes	–

19

19

Restrictions - If your plan has placed a restriction on your drug you will see a "Yes" in this chart

- ❖ Prior Authorization - Your doctor must provide additional paperwork before you can fill this drug.
- ❖ Quantity Limits - This plan restricts how much of this drug you can pick up each time you fill it.
- ❖ Step Therapy - This plan would like you to try other drugs instead of the drug your doctor prescribed.

My Drug List

20

Your drugs are listed here with the details of how they were entered into the Plan Finder.

MY DRUG LIST				
	Package	Quantity	Frequency	Brand/Generic
Hydrochlorothiazide 25mg tablet		60	Every month	Generic
Lantus 100unit/ml solution pen injector	3ml pen (sold in pack of 5)	1	Every month	Brand
Losartan potassium 100mg tablet		30	Every month	Generic
Metformin hydrochloride 1000mg tablet		60	Every month	Generic
Simvastatin 20mg tablet		45	Every month	Generic
Trelegy 100-62.5-25mcg/act aerosol powder	Disposable pack of 60 aerosol powders	1	Every month	Brand

This includes:

- ❖ Package size
- ❖ Quantity
- ❖ Frequency
- ❖ Brand/generic

NOTE: Make sure that the dosage, quantity, and frequency are correct.

Star Ratings

21

Star Ratings - the more stars a plan has the higher they have been rated by Medicare.

21

Star Ratings

[+ Expand All Ratings](#)

Overall star rating

Overall rating is based on the categories below.



[+ Drug plan star rating](#)

Summary rating of drug plan quality



