2025 Transition Policy for CarePlus Part D Prescription Drug Coverage

CarePlus wants to be sure that you, as a new or existing member, safely transition into the 2025 plan year. In 2025, you may not be able to receive your current drug therapy if the medicine:

- Is not on CarePlus' drug list (i.e. is "non-formulary" or "not covered") or
- Has utilization management requirements, such as prior authorization, quantity limits, or step therapy requirements

One-time transition supply at a retail or mail-order pharmacy

Beginning Jan. 1, 2025, when you have limited ability to receive your current prescription therapy:

- CarePlus will cover a one-time, 30 day supply of a Part D covered drug unless the prescription is written for less than 30 days (in which case, CarePlus will allow multiple fills to provide up to a total of 30 days of medications) during the first 90 days of your eligibility for the current plan year, or during the first 90 days of your enrollment beginning on your effective day of coverage, when your current prescription therapy is filled at a retail/mail order pharmacy. CarePlus will provide refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved productlabeling.

- After you receive a transition supply, you'll receive a letter that explains the temporary nature of the transition medication supply. After you receive the letter, talk to your prescriber and decide if you should switch to an alternative drug or request an exception or prior authorization. CarePlus may not pay for refills of temporary supply drugs until an exception or prior authorization has been requested and approved.

Transition supply for residents of long-term care facilities

CarePlus assists members in long-term care facilities who transition between plans, have both Medicare and full Medicaid benefits, or submit an exception or an appeal request. For long term care residents, CarePlus will cover a 31 day supply unless the prescription is written for less than 31 days (in which case CarePlus will allow multiple fills to provide up to a total of 31 days of medication) of a Part D covered drug. This coverage is offered anytime during the first 90 days of your eligibility for the current plan year or during the first 90 days of your enrollment, which begins on your effective date of coverage, when your current prescription

therapy is filled at a long-term care pharmacy. If your ability to receive your drug therapy is limited, but you're past the first 90 days of membership in your plan, CarePlus will cover a 31 day emergency supply unless the prescription is written for less than 31 days. In that case, CarePlus will allow multiple fills to provide up to a total of 31 days of a Part D covered drug so you can continue therapy while you pursue an exception or prior authorization. If you are being admitted to or discharged from a long-term care facility, you will be allowed to access a refill upon admission or discharge, and early refill edits will not apply.

Transition supply for current members

Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:

- Members discharged from a hospital or skilled nursing facility to a homesetting
- Members admitted to a hospital or skilled nursing facility from a home setting
- Members who transfer from one skilled nursing facility to another and serviced by a different pharmacy
- Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit
- Members who give up Hospice status and revert back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, CarePlus will cover up to a 31 day supply of a Part D covered drug. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug.

CarePlus will review these requests for continuation of therapy on a case-by-case basis when you have a stabilized drug regimen that, if altered, is known to have risks.

Transition across contract years

CarePlus provides a transition process for current members consistent with the transition process required for new members. For current members whose drugs will be affected by negative formulary changes in the upcoming year, CarePlus will effectuate a meaningful transition providing a transition process at the start of the new contract year. CarePlus also extends the transition policy across contract years should a member enroll into a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

Distinguishing brand new prescriptions

CarePlus ensures it will apply all transition processes to a brand-new prescription for drugs not on CarePlus's formulary drug list or that have utilization management requirements, if it cannot

make the distinction between a brand-new prescription and an ongoing prescription at the point-of-sale. To distinguish ongoing therapy, members must have a minimum of a 108 day claims history. CarePlus will look-back 180 days from the member effective date or the beginning of the current plan year, for prior utilization of the drug when claims history is available.

Transition member notices

CarePlus's policy is to ensure a notice of the transition event is sent to the member for the transition claim. Members who complete their transition supply in multiple fills will receive a notification for the first transition fill only. All transition policy notification letters are mailed to members via U.S. first class mail within three (3) business days of the transition fill event being recognized by the point of sale adjudication system. These letters contain the following language elements:

- The transition supply provided is temporary and may not be refilled outside the transition period unless a formulary exception or other authorization is approved;
- The member should work with CarePlus as well as his or her prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on CarePlus's formulary and that will likely reduce their costs;
- The member has the right to request a formulary exception, the timeframes for processing the exception, and the member's right to request an appeal if the sponsor issues an unfavorable decision; and
- CarePlus's procedures for requesting exceptions.

For long-term care (LTC) residents dispensed multiple supplies of a Part D drug in increments of 14 (or less) days, the transition policy notification letter will be mailed within three (3) business days after processing of the first temporary fill.

Transition prescriber notices

CarePlus's policy is to ensure a notice of the transition event is sent to the prescriber on record for the transition claim. Providers will receive a notification for the first transition fill only when members complete their transition supply in multiple fills. The prescriber letter provides the following information:

- Member Name
- Member Date of Birth
- Drug Name
- Date of Fill
- Utilization Management Edit
- Directions on how to use CarePlus's Provider Drug List Search tool
- Information on CarePlus's Coverage Determination Process

Cost-sharing for drugs provided through the transition policy

- If you're eligible for the low-income subsidy (LIS) (also called "Extra Help") in 2025, your copayment or coinsurance for a temporary supply of drugs provided during your

transition period won't exceed your LIS limit.

- For non-LIS enrollees, the copayment or coinsurance will be based on the approved drug cost- sharing tiers for your plan and is consistent with the cost-sharing tier CarePlus would charge for non-formulary drugs approved under a coverage exception and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met.

Transition extension

CarePlus makes arrangements to continue to provide necessary drugs to you via an extension of the transition period, on a case-by-case basis, to the extent that your exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

Pharmacy and therapeutics committee

The Pharmacy and Therapeutics (P&T) committee has oversight of CarePlus's Part D drug list and associated policies. The P&T committee designed these polices for certain Part D drugs. These policies are designed to make sure the drug is used based on medically accepted clinical guidelines for indications where the drug has been proven safe and effective and is prescribed according to manufacturer recommendations.

After you receive your temporary supply of a Part D drug, your medication may require medical review if:

- It's not on the drug list or
- Has utilization management requirements, such as prior authorization, quantity limits, or step therapy requirements

If you're stabilized on a drug not on the drug list or a drug requiring prior authorization, quantity limits, or have tried other drug alternatives, your prescriber can provide CarePlus with a statement of your clinical history to help with the prior authorization or exception request process.

Procedures for requesting an exception or changing prescriptions

How do I request an exception?

The first step in requesting an exception is for you or your prescriber to contact us. Your prescriber must submit a statement supporting your request. The prescriber's statement must indicate that the requested drug is medically necessary for treating your condition because none of the drugs we cover would be as effective as the requested drug or would have adverse effects for you. If the exception involves a prior authorization, quantity limit, or other limit we have placed on that drug, the prescriber's statement must indicate that the prior authorization, or limit, would not be appropriate given your condition or would have adverse effects for you.

Once the prescriber's statement is submitted, we must notify you of our decision no later than 24 hours (expedited) or 72 hours (standard) from the date and time the prescriber's statement is received. Your request will be expedited if we determine, or your prescriber informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if my request is denied?

If your drug is not covered on our formulary, or is covered on our formulary but we have placed a utilization management requirement such as prior authorization, step therapy, or quantity limit on it, you can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, we encourage you to ask your prescriber if these drugs that we cover are an option for you.

If your request is denied, you also have the right to appeal by asking for a review of the denial decision. You must request this appeal within 60 calendar days from the date of the written denial notice.

If you need assistance in requesting an exception or appeal, help in switching to an alternative drug, or for more information about our transition policy, call Member Services at **1-800-794-5907; TTY: 711**. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Prior authorization and exception request forms are available to you and your prescribing physician on CarePlus's website at **www.CarePlusHealthPlans.com**, or by calling Member Services to have it mailed or faxed.

Public notice of transition policy

This Transition Policy is available on CarePlus's website, **www.CarePlusHealthPlans.com**, in the same area where the Part D Formulary is displayed.

IMPORTANT

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, **1-800-794-5907 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711).

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. Hours of operation: October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.

CarePlus HEALTH PLANS®

Multi-Language Insert

Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-794-5907 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-794-5907 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-794-5907 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-794-5907 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고있습니다 . 통역 서비스를 이용하려면 전화 1-800-794-5907 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-794-5907 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (برقياً: 711) 1-800-794-5907. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه هي خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके कसिी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषयिा सेवाएँ उपलब्ध हैं. एक दुभाषयिा प्राप्त करने के लिए, बस हमें 1-800-794-5907 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हदिी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-794-5907 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-794-5907 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-794-5907 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-794-5907 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。