2026 Transition Policy for CarePlus Part D Prescription Drug Coverage

CarePlus wants to make sure that members like you get the medicine you need in the coming plan year. Starting January 1, 2026, you may not be able to get the drug you get now if:

- The drug is not on our approved list, or
- We need to approve it in advance

If your drug is not on our approved list or we need to approve it in advance, you can keep getting your drug for a little while. This is called a transition supply.

You cannot get a transition supply for some drugs. Examples of these drugs are:

- Drugs where we need to determine Part A or B versus D coverage.
- Drugs that may not be eligible for Part D coverage. We may need to know what you are using your drug for before it can be covered by us.
- Drugs where we may need information to know if it is being used safely.

One-Time Transition Supply at a Retail or Mail-Order Pharmacy

Beginning Jan. 1, 2026, 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 medication) 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 date 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 product labeling.

- 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 home setting
- 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 their 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) in 2026, 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 formulary drug list and associated policies. The P&T committee designed these polices for certain Part D drugs. The 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 formulary 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 formulary 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 if the request has been expedited or no later than 72 hours if the request is a standard request. 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 drug list, or is covered on our formulary drug list 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 65 calendar days from the date of the denial decision.

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, please call our Member Services Department at **1-800-794-5907**. If you use a TTY, call **711**. You can call us seven

days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at CarePlusHealthPlans.com.

Prior authorization and exception request forms are available to you and your prescriber on CarePlus's website, CarePlusHealthPlans.com/RxDecisions, or by calling customer service to have it mailed, faxed, or emailed.

Public Notice of Transition Policy

This Transition Policy is available on CarePlus's Website, CarePlusHealthPlans.com/prescriptiondrugguides, in the same area where the Medicare policies and forms are displayed.

Notice of Non-Discrimination

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. CarePlus Health Plans, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-794-5907 (TTY: 711)**. If you believe that CarePlus Health Plans, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with CarePlus Health Plans, Inc. Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **800-794-5907 (TTY: 711)**, or **Accessibility1@CarePlus-HP.com**. If you need help filing a grievance, CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD).**

CarePlus HEALTH PLANS.

This notice is available at **CarePlusHealthPlans.com/NDN.**

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Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন 1-800-794-5907 (TTY: 711) নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907**（听障专线：**711**）。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907（聽障專線：711）**。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français French: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

Ελληνικά Greek: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-794-5907 (TTY: 711)**.

ગુજરાતી Gujarati: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. 1-800-794-5907 (TTY: 711) પર કૉલ કરો.

עברית Hebrew: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-794-5907 (TTY: 711)**

Hmoob Hmong: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-794-5907 (TTY: 711)**.

This notice is available at **CarePlusHealthPlans.com/MLI**.

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Italiano Italian: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-794-5907 (TTY: 711)**.

日本語 Japanese:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-794-5907 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ Khmer៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ 1-800-794-5907 (TTY: 711)។

한국어 Korean: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **1-800-794-5907 (TTY: 711)**번으로 문의하십시오.

Diné Navajo: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ. Kohjį' hodíilnih **1-800-794-5907 (TTY: 711)**.

Polski Polish: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-794-5907 (TTY: 711)**.

Português Portuguese: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-794-5907 (TTY: 711)**.

ਪੰਜਾਬੀ Punjabi: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। 1-800-794-5907 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Русский Russian: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-794-5907 (TTY: 711)**.

Español Spanish: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-794-5907 (TTY: 711)**.

Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. 1-800-794-5907 (TTY: 711) ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. 1-800-794-5907 (TTY: 711) కి కాల్ చేయండి.

(TTY: 711) 1-800-794-5907 کال۔ ہیں دستیاب کی خدمات فارمیٹ متبادل اور امداد، معاون زبان، مفت :Urdu اردو

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.