CarePlus Part D Pharmacy Manual

2022

CarePlus HEALTH PLANS

H1019_PHAProviderRxManual2022_C
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CarePlus bank identification number (BIN) and processor control number (PCN)

Plan	BIN	PCN
CarePlus MAPD plans	015581	03200008
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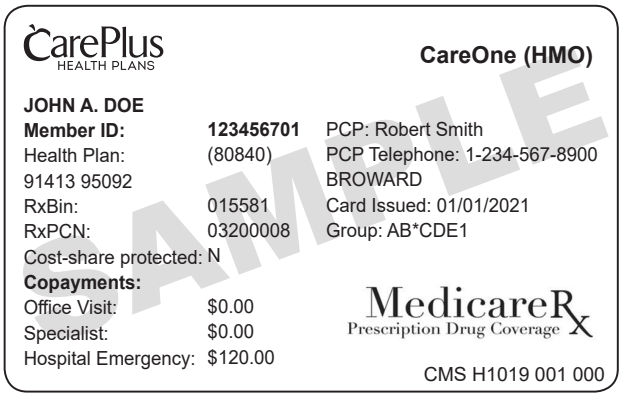
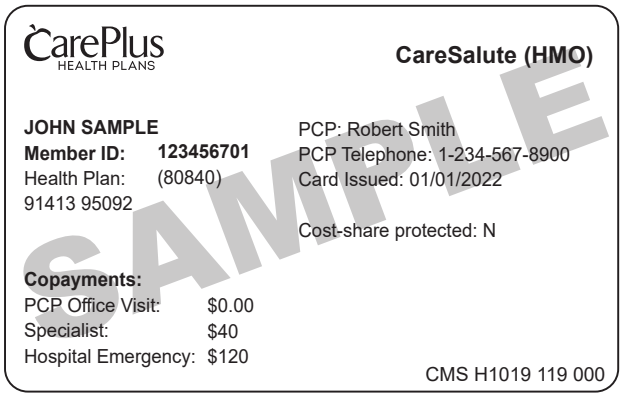
CarePlus membership cards

The following are examples of the ID cards pharmacy employees may see from CarePlus MAPD and MA-only patients:

MAPD Card



MA-only Card



CarePlus Medicare Advantage Plans

CarePlus Medicare Advantage plans include coverage for Medicare Part A and Part B. Most plans include prescription drug coverage (Part D) as well. Plans that include Part D drug coverage are called Medicare Advantage Prescription Drug plans (MAPD).

CarePlus MAPDs have a five-tier formulary with copayments and coinsurance based on drug tier placement in the formulary. Select plans in certain areas provide additional coverage for Tier 1 and Tier 2 medications through the coverage gap. CarePlus is a health maintenance organization (HMO), which requires the use of network providers.

CarePlus offers several types of Medicare Advantage plans with prescription drug coverage:

- **CareOne (HMO)**
- **CareOne PLUS (HMO)**
- **CareFree (HMO)**
- **CareFree PLUS (HMO)**
- **CareExtra (HMO)**
- **CareOne PLATINUM (HMO)**
- **CareOne PLATINUM (HMO-POS)**
- **CareComplete (HMO C-SNP)**
- **CareBreeze (HMO C-SNP)**
- **CareNeeds PLUS (HMO D-SNP)**

Note: CareSalute (HMO) is a new CarePlus Medicare Advantage plan for 2022. It's an MA-only plan, meaning it does not cover prescription drugs.

Dual-eligible special needs plans (D-SNPs)

CarePlus HMO D-SNPs are designed for people with both Medicare and Medicaid coverage. These plans offer Medicare Part A and Part B coverage, as well as Part D (prescription drug coverage) with fixed deductibles, copayments and coinsurance based on drug placement in a five-tier formulary. Members also are eligible for Medicare's "Extra Help" assistance program for prescription medications. Because of this low-income subsidy (LIS), most members will not be responsible for the monthly plan premium or an upfront deductible depending on the level of Extra Help the member receives. Cost-sharing per prescription is the lesser of the CarePlus plan cost-share or the federally established LIS cost-share. LIS amounts range from $0 to $9.85 in 2022. In addition, due to the Extra Help program, these members are not subject to the coverage gap. Cost-sharing for most LIS members who reach the catastrophic coverage stage is $0, except for those at LIS Level 4, who pay no more than $9.85 for covered drugs.

Chronic condition special needs plans (C-SNPs)

CarePlus offers two types of C-SNPs, which are designed for those diagnosed with certain chronic conditions. Individuals with Medicare and diagnosed with cardiovascular disorders, chronic heart failure or diabetes may enroll in CareComplete (HMO C-SNP). Those diagnosed with a chronic lung disorder are eligible to enroll in CareBreeze (HMO C-SNP). These plans offer health programs, individualized care plans and prescription drug coverage designed to serve the specialized needs of people with these conditions. All Tier 1 generic drugs are covered at $0 copay, and both Tier 1 and Tier 2 drugs are covered through the coverage gap. These plans include additional benefits designed to assist members with financial burdens resulting from managing their chronic condition(s). Individuals newly diagnosed with any one of the qualifying conditions may use a special election period (SEP) to join a CarePlus C-SNP plan at any time during the plan year.

CarePlus prescription drug coverage information

All CarePlus MAPDs are subject to a formulary of covered drugs. The list of the plan's covered drugs is included in the CarePlus Prescription Drug Guides available at **www.CarePlusHealthPlans.com/Medicare-Plans/2022-Prescription-Drug-Guides**. Every drug in the plan's Drug Guide is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher the cost for the drug:

Tier 1 - Preferred generic: Generic or brand drugs that are available at the lowest cost-share for the plan

Tier 2 - Generic: Generic or brand drugs that the plan offers at a higher cost to members than Tier 1 preferred generic drugs

Tier 3 - Preferred brand: Generic or brand drugs that the plan offers at a lower cost to members than Tier 4 non-preferred drugs

Tier 4 - Non-preferred drug: Generic or brand drugs that the plan offers at a higher cost to members than Tier 3 preferred brand drugs

Tier 5 - Specialty tier: Some injectables and other high-cost drugs

While certain drugs are not covered, most drugs within each Part D-covered class of medication are available to members. CarePlus will consider a request to cover a non-formulary Part D drug only if at least one of the following criteria is met:

- Alternative drugs in the same category are not included on the plan's formulary.
- The formulary-listed alternative is not as effective in treating the member's condition.
- Additional utilization restrictions would cause adverse medical effects.

The Centers for Medicare & Medicaid Services (CMS) has specifically excluded the following categories of drugs from all Part D benefits:

- Non-prescription drugs or over-the-counter drugs
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Some CarePlus plans offer coverage of some of the prescription drugs listed above that are not normally covered under Medicare prescription drug coverage. The amount a member pays when filling a prescription for these drugs does not count toward qualifying for catastrophic coverage. In addition, if the member is receiving Extra Help from Medicare to pay for prescriptions, the Extra Help will not pay for these drugs. Please refer to the "CarePlus Coverage of Additional Prescription Drugs" table in the 2022 CarePlus Prescription Drug Guides to determine which CarePlus plans have this coverage.

The Drug Guides are listed by service area and plan at **www.CarePlusHealthPlans.com/Medicare-Plans/2022-Prescription-Drug-Guides**. For more information, pharmacists, prescribing physicians or other prescribers may call 1-866-315-7587, Monday through Friday, 8 a.m. to 8 p.m., Eastern time. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day.

CarePlus coverage determination review process

A coverage determination is a decision made by CarePlus, as a Medicare Part D sponsor, with respect to a decision about whether to provide or pay for a drug a member believes he or she is entitled. It may involve a decision regarding whether CarePlus will cover a drug, the portion of the drug cost for which the member may be responsible, quantity limits, step therapy or prior authorization requirements.

To learn more about the CarePlus coverage determination review process, please visit **www.CarePlusHealthPlans.com/Members/Drug-Coverage-Determination**. The member or the member's authorized representative also may contact CarePlus Member Services at 1-800-794-5907 (TTY: 711). From Oct. 1–March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1–Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day. Prescribing physicians or other prescribers may call 1-866-315-7587. The caller should be prepared to answer questions related to the prescribed drug. The prescribing physician or member may fax supporting documentation to 1-800-310-9071.

2022 CarePlus prescription drug plans benefit overview

Within the CarePlus pharmacy benefit, there are four types of formularies, each with its own tiered cost-share differentiation. See the following charts for details on coverage differentiation by plan and service area.

Note: The member's county and plan name are located on the CarePlus member identification card. Please see Page 3 for a sample CarePlus ID card.

Tampa area (Hillsborough, Pasco, Pinellas, Polk counties)										
Plan	**Plan benefit package**	**Formulary**	**Rx deductible**	**Initial coverage limit**	**Tier 1 Pref/ Std**	**Tier 2 Pref/ Std**	**Tier 3 Pref/ Std**	**Tier 4 Pref/ Std**	**Tier 5**	**Gap coverage**
CareNeeds PLUS*	026	Plus 5-1 22525	$480 T2, T3, T4, T5	$4,430	$0/ $10	$4/ $20	$47	$100	25%	None
CareOne PLUS (Polk only)	103-001	Plus 5-2 22526	$0	$4,430	$0/ $10	$0/ $20	$5/ $47	$45/ $100	33%	T1, T2
CareOne PLUS (Hillsborough, Pasco and Pinellas only)	103-002	Plus 5-2 22526	$0	$4,430	$0/ $10	$0/ $20	$5/ $47	$45/ $100	33%	T1, T2
CareFree (Polk only)	104-001	Plus 5-1 22526	$0	$4,430	$0/ $10	$0/ $20	$35/ $47	$60/ $100	33%	T1, T2
CareFree (Hillsborough, Pasco and Pinellas only)	104-002	Plus 5-1 22526	$0	$4,430	$0/ $10	$0/ $20	$35/ $47	$60/ $100	33%	T1, T2
CareComplete	107	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2
CareOne PLATINUM (Hillsborough, Pasco and Pinellas only)	111	Plus 5-2 22526	$0	$4,430	$0/ $10	$0/ $20	$10/ $47	$55/ $100	33%	T1, T2
CareBreeze	116	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2

T1 = Tier 1 drugs T2 = Tier 2 drugs T3 = Tier 3 drugs T4 = Tier 4 drugs T5 = Tier 5 drugs

* These members receive LIS Extra Help, which may reduce or eliminate their prescription drug cost-share.

Miami-Dade County

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareOne PLUS	006	Plus 5-2 22526	$0	$9,500	$0	$0	$0	$25/ $36	33%	T1, T2
CareNeeds PLUS*	023	Plus 5-1 22525	$480 T3, T4, T5	$4,430	$0	$0	$47	$99/ $100	25%	None
CareFree PLUS	076	Plus 5-1 22525	$0	$4,430	$0	$0/ $10	$47	$97/ $100	33%	None
CareExtra	089	Plus 5-2 22526	$480 T1, T2, T3, T4, T5	$4,430	$0	$0	21%/ 24%	24%	25%	T1, T2
CareComplete	105	Plus 5-2 22526	$0	$6,000	$0	$0	$0	$35/ $36	33%	T1, T2
CareBreeze	114	Plus 5-2 22526	$0	$6,000	$0	$0	$0	$35/ $36	33%	T1, T2

Broward County

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareOne	001	Plus 5-2 22526	$0	$4,430	$0/ $5	$0/ $10	$5/ $47	$75/ $100	33%	T1, T2
CareNeeds PLUS*	023	Plus 5-1 22525	$480 T3, T4, T5	$4,430	$0	$0	$47	$99/ $100	25%	None
CareFree	065	Super National 5-1 22521	$100 T4, T5	$4,430	$0	$0/ $12	$47	$97/ $100	31%	None
CareComplete	106	Plus 5-2 22526	$0	$4,430	$0	$0/ $12	$47	$97/ $100	33%	T1, T2
CareBreeze	115	Plus 5-2 22526	$0	$4,430	$0	$0/ $12	$47	$97/ $100	33%	T1, T2

T1 = Tier 1 drugs T2 = Tier 2 drugs T3 = Tier 3 drugs T4 = Tier 4 drugs T5 = Tier 5 drugs

* These members receive LIS Extra Help, which may reduce or eliminate their prescription drug cost-share.

Palm Beach County

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareNeeds PLUS*	023	Plus 5-1 22525	$480 T3, T4, T5	$4,430	$0	$0	$47	$99/ $100	25%	None
CareFree	065	Super National 5-1 22521	$100 T4, T5	$4,430	$0	$0/ $12	$47	$97/ $100	31%	T1, T2
CareOne	102	Plus 5-2 22526	$0	$4,130	$0/ $5	$0/ $10	$15/ $47	$75/ $100	33%	T1, T2
CareComplete	106	Plus 5-2 22526	$0	$4,430	$0	$0/ $12	$47	$97/ $100	33%	T1, T2
CareBreeze	115	Plus 5-2 22526	$0	$4,430	$0	$0/ $12	$47	$97/ $100	33%	T1, T2

Orlando area (Lake, Marion, Orange, Osceola, Seminole, Sumter counties)

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareNeeds PLUS*	026	Plus 5-1 22525	$480 T2, T3, T4, T5	$4,430	$0/ $10	$4/ $20	$47	$100	25%	None
CareOne PLUS (POS)	057	Plus 5-2 22526	$0	$4,430	$0/ $10	$0/ $20	$25/ $47	$85/ $100	33%	T1, T2
CareComplete	107	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2
CareOne PLATINUM	112	Plus 5-2 22526	$0	$4,430	$0	$0	$30	$85/ $100	33%	T1, T2
CareBreeze	116	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2
CareFree	120-001	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2
CareFree	120-002	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$35/ $47	$85/ $100	33%	T1, T2

T1 = Tier 1 drugs T2 = Tier 2 drugs T3 = Tier 3 drugs T4 = Tier 4 drugs T5 = Tier 5 drugs

* These members receive LIS Extra Help, which may reduce or eliminate their prescription drug cost-share.

Space Coast (Brevard, Indian River counties)

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareOne	043	Super National 5-1 22520	$0	$4,430	$0/ $10	$5/ $20	$25/ $47	$75/ $100	33%	None
CareNeeds PLUS*	073	Super National 5-1 22520	$355 T2, T3, T4, T5	$4,430	$0/ $5	$4/ $20	$47	$100	27%	None
CareComplete	108	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$85/ $100	33%	T1, T2
CareOne PLATINUM (POS)	110	Plus 5-2 22526	$0	$4,430	$0/ $10	$10/ $20	$30/ $47	$95/ $100	33%	T1, T2
CareBreeze	117	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$85/ $100	33%	T1, T2

Volusia County

Plan	Plan benefit package	Formulary	Rx deductible	Initial coverage limit	Tier 1 Pref/ Std	Tier 2 Pref/ Std	Tier 3 Pref/ Std	Tier 4 Pref/ Std	Tier 5	Gap coverage
CareNeeds PLUS*	073	Super National 5-1 22520	$355 T2, T3, T4, T5	$4,430	$0/ $5	$4/ $20	$47	$100	27%	None
CareOne PLUS	098	Plus 5-2 22526	$0	$4,430	$0/ $10	$0/ $20	$40/ $47	$80/ $100	33%	T1, T2
CareFree	099	Plus 5-1 22525	$0	$4,430	$0/ $10	$5/ $20	$45/ $47	$85/ $100	33%	None
CareComplete	108	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$85/ $100	33%	T1, T2
CareBreeze	117	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$85/ $100	33%	T1, T2

T1 = Tier 1 drugs T2 = Tier 2 drugs T3 = Tier 3 drugs T4 = Tier 4 drugs T5 = Tier 5 drugs

* These members receive LIS Extra Help, which may reduce or eliminate their prescription drug cost-share.

Duval and Clay counties										
Plan	**Plan benefit package**	**Formulary**	**Rx deductible**	**Initial coverage limit**	**Tier 1 Pref/ Std**	**Tier 2 Pref/ Std**	**Tier 3 Pref/ Std**	**Tier 4 Pref/ Std**	**Tier 5**	**Gap coverage**
CareOne	069	Super National 5-2 22521	$0	$4,430	$0/ $10	$0/ $20	$45/ $47	$95/ $100	33%	T1, T2
CareNeeds PLUS*	073	Super National 5-1 22520	$355 T2, T3, T4, T5	$4,430	$0/ $5	$4/ $20	$47	$100	27%	None
CareFree	094	Super National 5-1 22520	$100 T4, T5	$4,430	$0/ $10	$10/ $20	$45/ $47	$95/ $100	31%	None
CareComplete	109	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$95/ $100	33%	T1, T2
CareOne PLATINUM	113	Plus 5-2 22526	$0	$4,430	$0/ $10	$5/ $20	$47	$95/ $100	33%	T1, T2
CareBreeze	118	Plus 5-2 22526	$0	$4,430	$0/ $10	$15/ $20	$45/ $47	$95/ $100	33%	T1, T2

Insulin Savings Program

The Part D Senior Savings Model, also called the Insulin Savings Program (ISP), provides affordable, predictable copayments on select insulins through the first three drug payment stages (deductible, initial coverage and coverage gap) of the Part D benefit.* To find out which drugs are select insulins, please refer to the Drug Guides available at **www.CarePlusHealthPlans.com/Medicare-Plans/2022-Prescription-Drug-Guides**.

To identify which select insulins participate in the ISP, look for the ISP indicator in the Utilization Management column.

* Excludes all Non-DSNP plans and CareSalute.

T1 = Tier 1 drugs T2 = Tier 2 drugs T3 = Tier 3 drugs T4 = Tier 4 drugs T5 = Tier 5 drugs
* These members receive LIS Extra Help, which may reduce or eliminate their prescription drug cost-share.

Beneficiaries eligible for the low-income subsidy (LIS)

Medicare's low-income subsidy (also known as Extra Help) assists people who have limited income and resources with their prescription drug costs. People who qualify for this program receive assistance paying for premiums, deductibles or cost-shares related to their Medicare drug plan. Some people automatically qualify for this subsidy and do not need to apply. Medicare mails a letter to those individuals.

Sometimes members believe they have qualified for the low-income subsidy and are paying an incorrect cost-share amount for their prescriptions. To address these situations, CarePlus has established a process that allows the members to provide the best available evidence (BAE) of their proper cost-share level. At the pharmacy, members can show proof of Extra Help by providing any of the following:

- A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year
- A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year
- A printout from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year
- A printed screenshot from the state's Medicaid systems showing Medicaid status during a month after June of the previous calendar year
- Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year
- A letter from the Social Security Administration showing that the individual receives Supplemental Security Income
- An "Application Filed by Deemed Eligible" confirming that the beneficiary is "automatically eligible for extra help" (SSA publication HI 03094.605)

Please note: This proof must be confirmed by a pharmacist and must show the individual's eligibility took effect on or before the date the prescription was filled. Once the Extra Help eligibility information is updated at the pharmacy, the member must mail the proof within 30 days to the following address to maintain the correct copayment level:

CarePlus Health Plans
Attn: Member Services Department
11430 NW 20th St., Suite 300
Miami, FL 33172

For assistance with Extra Help concerns, members may call CarePlus Member Services at 1-800-794-5907 (TTY: 711). From Oct. 1–March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1–Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day.

Best available evidence for long-term care residents

Part D sponsors are required to accept any one of the following forms of evidence from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized or—beginning on a date specified by the Secretary, but no earlier than Jan. 1, 2017—is an individual receiving home- and community-based services (HCBS) and qualifies for zero cost-sharing:

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year
3. A printed screenshot from the state's Medicaid system showing the individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year
4. Effective as of a date specified by the Secretary, but no earlier than Jan. 1, 2017, a copy of:
    a. A state-issued Notice of Action, Notice of Determination or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
    b. A state-approved HCBS service plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
    c. A state-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
    d. Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year; or
    e. A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

Pharmacists who have evidence that the cost-share responsibility of a CarePlus member residing in a long-term care facility should be different than that shown on adjudicated claims may call 1-866-315-7587, Monday through Friday from 8 a.m. to 8 p.m., Eastern time, to provide applicable evidence regarding the member's LIS status.

CarePlus questions and answers

Q: If a Medicare beneficiary is in my pharmacy and wants to enroll in a CarePlus plan, what should I do?

A: Ask the individual to call CarePlus at 1-866-247-9436 (TTY: 711). From Oct. 1–March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1–Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day.

Q: What should I do if a Medicare beneficiary says that he or she qualifies for the low-income subsidy but is not receiving it?

A: If a member presents best available evidence (BAE) at the pharmacy, but the system is not calculating the right cost-share amount, please refer to the section of this document titled "Beneficiaries eligible for the low-income subsidy (LIS)" (Page 10).

Members with questions may call CarePlus Member Services at 1-800-794-5907 (TTY: 711). From Oct. 1–March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1–Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day. Medicare beneficiaries who do not have BAE should contact the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m.

Q: What should I do if a CarePlus member wants to know his or her true out-of-pocket (TrOOP) balance?

A: Information regarding the TrOOP balance is not transmitted to the pharmacy. Please refer the member to CarePlus Member Services at 1-800-794-5907 (TTY: 711).

Q: How is the TrOOP balance calculated?

A: Prescription copayments and out-of-pocket costs for Part D-covered drugs paid by the beneficiary count toward the TrOOP balance. Expenditures paid by the plan, another group health plan or another third-party arrangement do not count toward the TrOOP balance. Also, payments for drugs excluded by the Medicare Part D benefit do not count toward the TrOOP balance. This is not a complete list of the items/circumstances used to calculate the TrOOP balance. For a complete listing or questions, prescribing physicians or other prescribers may call 1-866-315-7587.

Q: If I have a CarePlus member who wants to appeal a CarePlus decision regarding his or her prescription claim, to whom do I refer the member?

A: The first level of appeal is a redetermination. Standard redeterminations should be submitted in writing, while expedited redeterminations may be requested verbally or in writing. Both types of redeterminations must be submitted within 60 calendar days from the date of the notice of CarePlus' initial decision. Send requests to:

CarePlus Health Plans
Attn: Grievance & Appeals department
11430 NW 20th St., Suite 300
Miami, FL 33172

or

Attn: Grievance & Appeals Department
Fax: 1-800-956-4288

CarePlus can extend the 60-day time frame for filing a redetermination request if the member has a valid reason for missing the deadline. For a standard redetermination, CarePlus will notify the member in writing of the outcome within seven calendar days after receiving the request. An expedited redetermination can be requested by the member, his or her physician or prescriber, or the member's appointed representative if waiting for a standard decision (seven days) could seriously jeopardize the member's life, health or ability to regain maximum function. However, CarePlus would expedite a redetermination only if the request comes directly from the member's physician or prescriber, or if the member has a supporting statement from his or her physician or prescriber indicating why the redetermination must be processed expeditiously. If the member asks for an expedited redetermination on his/her own, without the prescriber's support, CarePlus will decide if his/her health requires an expedited redetermination. To file an expedited redetermination, the member, member-appointed representative or physician may call CarePlus Member Services at 1-800-794-5907 (TTY: 711). The request also may be faxed to 1-800-956-4288. An expedited redetermination will be decided as expeditiously as the individual's health condition requires, but no later than 72 hours from receipt of the request if CarePlus finds that the redetermination should be handled as an expedited request.

Important CarePlus phone numbers and website information

CarePlus Member Services:
Call 1-800-794-5907 (TTY: 711). From Oct. 1–March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1–Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays and holidays. We will return your call within one business day.

Pharmacist services:

Phone: 1-866-315-7587, Monday through Friday from 8 a.m. to 8 p.m., Eastern time
Fax: 1-800-310-9071

CarePlus website:
www.CarePlusHealthPlans.com

MedicareRx
Prescription Drug Coverage