2018 Transition Policy

CarePlus wants to be sure that you, as a new or existing member, safely transition into the 2018 plan year. In 2018, you may not be able to receive your current drug therapy if the drug:

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

Cost-sharing for Drugs Provided through the Transition Policy
If you're eligible for the low-income subsidy (LIS) in 2018, 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.

One-Time Transition Supply at a Retail or Mail-Order Pharmacy
Beginning Jan. 1, 2018, 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. 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 have your 30 day supply, you'll receive a letter that explains the temporary nature of the transition medication supply. After you receive the letter, talk to your doctor 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 member presents a prescription written for less) and additional refills for up to a total of 98 day supply 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, 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 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' 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 doctor 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 to ask your prescribing doctor to contact us. Your doctor must submit a statement supporting your request. The doctor'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 doctor'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 physician'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 physician's statement is received. Your request will be expedited if we determine, or your doctor 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 doctor 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 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, call Member Services at 1-800-794-5907; from 8 a.m. to 8 p.m., 7 days a week. From February 15th to September 30th, we are open Monday – Friday from 8 a.m. to 8 p.m. TTY users should call 711.

Prior authorization and exception request forms are available to you and your prescribing physician on CarePlus' 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' website, **www.careplushealthplans.com**, in the same area where the Part D Formulary is displayed.

CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal.

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 member cost-share] may change on January 1 of each year.

The formulary may change at any time. You will receive notice when necessary.

Discrimination is Against the Law
CarePlus Health Plans, Inc. ("CarePlus") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CarePlus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CarePlus:
- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
  − Qualified sign language interpreters

- Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CarePlus Health Plans, Inc.
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172

Telephone: 1-800-794-5907 (TTY users should call 711)
8 a.m. to 8 p.m., 7 days a week
From February 15th to September 30th, we are open Monday-Friday from 8 a.m. to 8 p.m.
Fax: 1-800-956-4288

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

You can also file a civil rights 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, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019; 800-537-7697 (TDD)

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

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY:711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY:711).

繁體中文 (Chinese): 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 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY:711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-794-5907 (TTY:711) 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-794-5907 (TTY:711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY:711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-794-5907 (TTY:711).

Diné Bizzad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-794-5907 (TTY:711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).