SHARP HEALTH PLAN
make life better.

Addendum to the 2019-20 Sharp Direct Advantage® Annual Notice of Changes and Evidence of Coverage

Sharp Direct Advantage (HMO)
Exclusively for City of San Diego Medicare-eligible retirees & dependents,
sponsored by San Diego Public Employee Benefit Association (SDPEBA)

SHARP HEALTH PLAN

Important updates to the Part D formulary information have been made to the 2019-20 Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC). These updates will be effective January 1, 2020.

For your convenience, we have highlighted all updates in blue. If you would like to request a physical copy of the 2019-20 ANOC or EOC, please visit **sharpmedicareadvantage.com**, or contact Customer Care at the contact information below.

If you have questions about these Part D formulary changes please visit **sharpmedicareadvantage.com/2020pharmacyinfo** or contact Customer Care at 1-855-562-8853 (TTY/TDD: 711). Our office hours are Oct. 1 – March 31, 7 days per week, 8 a.m. to 8 p.m., and April 1– Sept. 30, Monday through Friday, 8 a.m. to 8 p.m. On weekends and holidays, your call will be handled by our voicemail system. A Customer Care representative will return your call the next business day.

Sharp Health Plan is an HMO with a Medicare contract. Enrollment with Sharp Health Plan depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/ co-insurance may change when your plan renews each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-562-8853 (TTY/TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 1-855-562-8853 (TTY/TDD: 711).

SECTION 2
Administrative Changes

We are partnering with a new pharmacy benefit manager (PBM) and mail order supplier in 2020 to help us improve your pharmacy experience. These new partnerships will bring some enhancements for you beginning January 1, 2020:

- A new, dedicated Medicare prescription helpline staffed by pharmacy experts who are available to assist you 24/7.
- An improved digital pharmacy experience that allows you to access medication, prescription and pharmacy network tools and information through our website and Sharp Connect member portal.
- Enhanced digital tools, like a free mobile app that lets you see your personalized pharmacy benefit information, refill or request new mail service prescriptions, track order status, view prescription history and much more.

To learn more, visit sharpmedicareadvantage.com/2020pharmacyinfo.

Changes	**2019 (this year)**	**2020 (next year)**
Pharmacy Benefit Manager (PBM)	MedImpact	CVS Caremark®
Mail Order Pharmacy	Postal Prescription Services® Mail Order	CVS Caremark Mail Service Pharmacy

SECTION 3
Deciding Which Plan to Choose

Section 3.1 If you want to stay in Sharp Direct Advantage Gold Card (HMO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by Dec. 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 3.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Section 1.6 Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is located on our website at sharpmedicareadvantage.com/druglist. You can also get a copy of our Drug List mailed to you by calling Customer Care (phone numbers are printed on the back cover of this booklet).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If we make an exception and cover a drug that is not on our drug list, this coverage will expire at the end of your plan benefit year, unless you were otherwise informed at the time the exception was made. See Chapter 9 of your *Evidence of Coverage* for details on how to request an exception.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2020, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-855-222-3183 Calls to this number are free. Representatives are available 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY / TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 24 hours a day, 7 days a week.
FAX	1-855-633-7673
WRITE	Sharp Health Plan c/o CVS Caremark P.O. Box 52000 MC 109 Phoenix, AZ 85072-2000
WEBSITE	sharpmedicareadvantage.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-855-222-3183 Calls to this number are free. Representatives are available 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY / TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available 24 hours a day, 7 days a week.
FAX	1-855-633-7673
WRITE	Sharp Health Plan c/o CVS Caremark Appeals P.O. Box 52000 MC 109 Phoenix, AZ 85072-2000
WEBSITE	sharpmedicareadvantage.com

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs).*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
WRITE	**For Medical Care:** Sharp Health Plan Attn: Customer Care 8520 Tech Way, Ste. 201 San Diego, CA 92123-1450 **For Medicare Part D Prescription Drugs:** Attn: Medicare Part D Paper Claim - CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066
WEBSITE	sharpmedicareadvantage.com

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Customer Care (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are not available through our plan's mail-order service are marked with an **"NM"** in our Drug List.

Our plan's mail-order service requires you to order **a 90-day supply of the drug.**

To get order forms and information about filling your prescriptions by mail, contact our dedicated Medicare prescription helpline at 1-855-222-3183.

Usually a mail-order pharmacy order will get to you in no more than 10 to 15 days. However, sometimes your mail-order may be delayed. If this happens, your Plan allows for a mail delay override. Please call Customer Care to get an override approval. Once approval is received, we can transfer your prescription to the pharmacy of your choice or have your prescriber phone a prescription for a shorter supply to the pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail order prescriptions. For refills, please contact the mail-order pharmacy 10 to 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please contact our dedicated Medicare prescription helpline at 1-855-222-3183 or log on to your Caremark.com account to provide your preferred contact information.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs that are *not* available through our plan's mail-order service are marked as "**NM**" in our Drug List. Our plan's mail-order service requires you to order a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **Prescriptions for a Medical Emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  When traveling within the U.S. you have access to network pharmacies nationwide. Bring your prescriptions and medication with you and be sure to check the pharmacy directory for your travel plans to locate a network pharmacy while traveling. If you are leaving the country, you may be able to obtain a greater day supply to take with you before leaving the country where there are no network pharmacies available.
- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.
- If you receive a Part D prescription drug, dispensed by an out-of-network institutional-based pharmacy, while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.
- If you have not received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

Out-of-network prescriptions may be limited to a 10-day supply of your drug.

Please note that our plan cannot cover a drug purchased outside the United States and its territories.

In these situations, **please check first with Customer Care** to see if there is a network pharmacy nearby. (Phone numbers for Customer Care are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

Section 3.2 There are six "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Cost-Sharing Tier 1: Preferred Generic Drugs**
  Includes preferred generic drugs
- **Cost-Sharing Tier 2: Generic Drugs**
  Includes generic drugs
- **Cost-Sharing Tier 3: Preferred Brand Name Drugs**
  Includes preferred brand name drugs and non-preferred generic drugs
- **Cost-Sharing Tier 4: Non-Preferred Drugs**
  Includes non-preferred generic and non-preferred brand name drugs
- **Cost-Sharing Tier 5: Specialty Drugs**
  Includes very high-cost brand and generic drugs, which may require special handling and/or close monitoring
- **Cost-Sharing Tier 6: Select Care Drugs**
  Includes select care generic drugs for treating conditions such as diabetes, high blood pressure, and high cholesterol

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 *(What you pay for your Part D prescription drugs).*

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have *two* ways to find out:

1. Visit the plan's website (sharpmedicareadvantage.com/members/forms-authorizations-resources). The Drug List on the website is always the most current.
2. Call Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 (Specialty Drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6
What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each new benefit year. However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug**
(for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.

currently taking the brand name drug.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30 -day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Changes to drugs on the Drug List that will not affect people currently taking the drug:
For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

SECTION 5
During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has six cost-sharing tiers

Every drug on the plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Cost-Sharing Tier 1: Preferred Generic Drugs**
  Includes preferred generic drugs
- **Cost-Sharing Tier 2: Generic Drugs**
  Includes generic drugs
- **Cost-Sharing Tier 3: Preferred Brand Name Drugs**
  Includes preferred brand name drugs and non-preferred generic drugs
- **Cost-Sharing Tier 4: Non-Preferred Drugs**
  Includes non-preferred generic and non-preferred brand name drugs
- **Cost-Sharing Tier 5: Specialty Drugs**
  Includes very high-cost brand and generic drugs, which may require special handling and/or close monitoring
- **Cost-Sharing Tier 6: Select Care Drugs**
  Includes select care generic drugs for treating conditions such as diabetes, high blood pressure, and high cholesterol

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Mail your request for payment together with any bills or receipts to us at this address:

For Medicare Part D Prescription Drugs:

Attn: Medicare Part D Paper Claim - CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

Medical Care:

Sharp Health Plan
Attn: Claims Research
8520 Tech Way, Ste. 200
San Diego, CA 92123

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.

You must submit your claim to us within *one year* of the date you received the service, item, or drug for medical claims and within three years for prescription drug claims.

Contact Customer Care if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3
We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
  - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
  - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Drugs).
- **If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.**

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.