SHARP HEALTH PLAN

Addendum to the 2020-21 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 information that was included in your 2020-21 Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC). These updates will be effective January 1, 2021.

For your convenience, we have highlighted all updates in blue. If you would like to request a physical copy of the 2020-21 ANOC or EOC, please visit **sharpmedicareadvantage.com**, or contact Customer Care at the contact information below.

If you have questions about these changes please contact Customer Care at 1-855-562-8853 (TTY/TDD: 711). Our office hours are 8 a.m. to 8 p.m., seven days a week from October to March and 8 a.m. to 8 p.m., weekdays from April to September. 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 1.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2020 *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Breast cancer screening (mammograms)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Inpatient mental health care	*Except in an emergency, prior authorization may be required from our plan.*	*Except in an emergency, prior authorization may be required from our plan.* *Except in an emergency, referral may be required from your network provider.*
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Opioid treatment program services	Not covered	$10 copayment per visit for covered opioid treatment services *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Outpatient mental health care		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Outpatient substance abuse services	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Partial hospitalization services	*Prior authorization may be required from our plan*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Physician/Practitioner services, including doctor's office visits		**Primary care physician telehealth services:** $10 copayment for each visit. *Prior authorization may be required from our plan for certain specialist services.* *Referral may be required from your network provider for certain specialist services.*
Podiatry services	*Referral may be required from your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Speech-language pathology services	*Prior authorization may be required from our plan.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

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.~~

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medi-Cal Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2
What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (section 2.2 tells you about Medicare Part A and Medicare Part B)
- —*and* — you live in our geographic service area (section 2.3 below describes our service area)
- — *and* — you are a United States citizen or are lawfully present in the United States
- — *and* — you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- — *and* — you meet the eligibility requirements established by the employer/union group sponsor's employment-based health coverage.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Sharp Direct Advantage

Although Medicare is a Federal program, Sharp Direct Advantage is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside

The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider and Pharmacy Directory,* you can request a copy from Customer Care (phone numbers are printed on the back cover of this booklet). You may ask Customer Care for more information about our network providers, including their qualifications. You can also see the *Provider and Pharmacy Directory* at sharpmedicareadvantage.com/members/forms-authorizations-resources or download it from this website. Both Customer Care and the website can give you the most up-to-date information about changes to our network providers.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a List of Covered Drugs (Formulary). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

If requested, we will provide you a copy of the Drug List. The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed on the Drug List, you should visit our website or contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (sharpmedicareadvantage.com/druglist) or call Customer Care (phone numbers are printed on the back cover of this booklet).

Section 3.4 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 6 *(What you pay for your Part D prescription drugs)* gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

SECTION 8
Rules for oxygen equipment, supplies, and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 0% of each month's rental fee.

After 36 months of monthly payments in our plan, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months, up to a total of 5 years, as long as you have a medical need for oxygen. If your medical need continues past the 5-year period, your supplier is no longer required to provide your oxygen and oxygen equipment, and you may choose to get replacement equipment from any supplier. A new 36-month payment period and 5-year supplier obligation period starts once the old 5-year period ends for your new oxygen and oxygen equipment.

If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in our plan is 0% for each month's rental fee for up to an additional 24 months.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining our plan, join our plan for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in our plan and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

During the COVID-19 pandemic public health emergency, Sharp Health Plan may extend coverage for benefits in addition to those outlined in Chapter 4. For example, your cost for medically necessary testing for COVID-19 is waived during the public health emergency. For more information about benefits related to the public health emergency, please contact Customer Care (phone numbers are printed on the back cover of this booklet).

SECTION 1
Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Care.

Section 1.2 What is the most you will pay for: Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2020 is $1,500. The amounts you pay for copayments, and

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care Covered services include mental health care services that require a hospital stay. A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. No prior hospital stay is required. Copays restart when a new benefit period begins. There is no limit to the number of days covered by the plan for each benefit period. *Except in an emergency, prior authorization may be required from our plan.* *Except in an emergency, referral may be required from your network provider.*	$0 copayment per day.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	**Diagnostic tests & procedures:** $0 copayment **Diagnostic radiology & therapeutic radiology services:** 0% coinsurance **Lab Services:** $0 copayment **X-rays:** $0 copayment **Medical supplies (such as dressing, splint, cast):** 0% coinsurance **Prosthetics & orthotics devices (including leg, arm, back, and neck braces, trusses & artificial legs, arms, and eyes):** 0% coinsurance **Physical therapy, speech therapy & occupational therapy services:** $10 copayment

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen® or Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • We also cover some vaccines under our Part B and Part D prescription drug benefit Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. *Prior authorization may be required from our plan.*	There is no coinsurance, copayment, or deductible for Medicare Part B prescription drugs.

Services that are covered for you	**What you must pay** when you get these services
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	$10 copayment per visit for covered opioid treatment services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	$10 copayment for each authorized individual/ group therapy visit.
Outpatient substance abuse services Individual and Group therapy related to substance abuse. *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	$10 copayment for each authorized individual/ group therapy visit.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	$10 copayment for each visit.

Services that are covered for you	**What you must pay** when you get these services

Physician/Practitioner services, including doctor's office visits
 	
Covered services include:
• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
• Consultation, diagnosis, and treatment by a specialist
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment
• Certain telehealth services, including Primary Care Physician Services:
  ° You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
  ° The provider may offer telehealth services using a phone, computer, tablet or video technology. You should request telehealth services when you schedule your visit and ask what type(s) of technology the provider's office has available
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke.
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ° You're not a new patient **and**
  ° The check-in isn't related to an office visit in the past 7 days **and**
  ° The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.
	Primary care physician visit:
	$10 copayment
	
	Primary care physician telehealth services:
	$10 copayment for each visit.
	
	Specialist visit:
	$10 copayment
	
	Certified ambulatory surgical center:
	$50 copayment
	
	Hospital outpatient department:
	See "Outpatient hospital services" of this Benefit Chart.
	
	Basic hearing & exams:
	See "Hearing services" of this Benefit Chart.
	
	Dental Care:
	See "Dental services" of this Benefit Chart and Section 2.2 of this Chapter.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (Continued) • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ° You're not a new patient **and** ° The evaluation isn't related to an office visit in the past 7 days **and** ° The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by telephone, Internet, or electronic health record **if** you're not a new patient • Second opinion by another network prior to surgery Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) *Prior authorization may be required from our plan for certain specialist services.* *Referral may be required from your network provider for certain specialist services.*	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*	$10 copayment for each visit.

Supplemental Vision exclusions and limitations

Our supplemental vision plan is designed to cover visual needs rather than cosmetic materials. There are some services that will not be covered. The following contract limitations and exclusions apply:

- Services and/or materials not indicated on this schedule as covered plan benefits.
- Non-covered lens enhancements
  - Anti-reflective lenses
  - Progressive lenses
  - Photochromic lenses
  - Scratch-resistant lenses
  - Polycarbonate lenses
  - Plano lenses (lenses with refractive correction of less than ± .50 diopter)
- Two pair of glasses instead of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes is not covered under the supplemental vision plan, but is covered when specifically described in the Medical Benefits Chart in this chapter.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing or cleaning.
- Services associated with corneal refractive therapy or orthokeratology.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

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 allows you to order up to **a 90-day supply.**

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.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

· You used mail order services with this plan in the past, or

· You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling Customer Service (phone numbers are on your member ID card).

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund. If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service (phone numbers are printed on the back cover of this booklet).

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel 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. To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Service (phone numbers are printed on the back cover of this booklet).

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 10- 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.

To opt out of our program that automatically prepares mail order refills, please log on to your Caremark.com account or contact us by calling Customer Service (phone numbers are printed on the back cover of this booklet).

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).

- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**

- The drug you have been taking is **no longer on the plan's Drug List.**
- *or* -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. **You must be in one of the situations described below:**

- **For those members who are new or who were in the plan last year:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the benefit year if you were in the plan last year.** This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long- term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 34-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- **For those members entering a long-term care (LTC) facility from other care settings an have a level of care change:** We will cover one 34-day supply of a particular drug, or less if your prescription is written for fewer days.

To ask for a temporary supply, call Customer Care (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider 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. The sections below tell you more about these options.

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 or both)**
    - 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 **or both**.

- We may not tell you in advance before we make that change—even if you are 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 or both. 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 7
What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information; and the DRUGDEX Information System. If the use is not supported by any of these references, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain

SECTION 3
We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. It includes:

- I**nformation for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since the start of the benefit year**. This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information:** This information will display cumulative percentage increases for each prescription claim.
- **Available lower cost alternative prescriptions:** This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.