



Part D Transition Policy

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care (LTC) facility, we will cover up to a 98 day supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Our transition policy applies to:

- Drugs not on the formulary
- Drugs on the formulary but have utilization rules:
 - Prior Authorization (PA)
 - Step Therapy (ST)
 - Quantity Limits (QL)

Our transition process will be applied to:

- New members recently enrolled in prescription drug plans following the annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage
- Individuals who switch from one plan to another after the start of the contract year
- Members residing in LTC facilities



- Current members affected by formulary changes from one (1) contract year to the next
- Members with certain medical conditions who are already stabilized on certain drug treatments

The same transition process described above will apply to the following level of care changes:

- Members discharged from a hospital to a home
- Members who end their skilled nursing facility stay (where payments include all pharmacy charges) and who need to revert to the plan's formulary
- Members who lose hospice status and revert to standard Medicare Part A and Part B benefits
- Members who end a long-term care facility stay and return to the community
- Members who are discharged from psychiatric hospitals with medication treatments that are highly individualized
- Members who are auto-enrolled without making an affirmative selection based on their existing treatment needs

A successful transition process is dependent upon us informing you of your options and ensuring your medical needs are safely being met. We will send you a written notice through the U.S. mail within three (3) business days of dispensing the transition supply. The transition letter will include the reason for the transition supply as well as your right to request an exception and the process for you to follow. Coverage Determination or exception request forms are available upon request to both you and your physician.

For more detailed information about your prescription drug coverage, please review your Evidence of Coverage and other plan materials.

Retail/Home Infusion

We will fill up to a 30-day supply when a member presents a prescription in a retail or home infusion pharmacy setting for:

- A drug not on the formulary
- A drug requiring prior authorization
- A drug that does not follow the step therapy guidelines
- A drug that has quantity limits



Fresenius Health Partners
PPO SNP
Accountable Kidney Care

Long Term Care (LTC)

We will fill up to a 98-day supply for members in a long-term care setting for:

- A drug not on the formulary
- A drug requiring prior authorization
- A drug that does not follow the step therapy guidelines
- A drug that has quantity limits

Cost Sharing

For people with Low Income Subsidy (LIS), the cost for a temporary supply of drugs shall never exceed the maximum copay amount set by CMS. For non-LIS members, the cost will be based on approved formulary tiers. It will be consistent with cost sharing that the plan would charge for non-formulary drugs approved under a coverage exception.

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor.