Medicare Part D Transition Policy

Transition Policy for New and Current Enrollees of our Medicare Part D Prescription Drug Plan

PURPOSE:

Simply Healthcare Plans, Inc. must maintain an appropriate transition process in accordance with federal regulations and CMS requirements for new and existing Medicare Part D beneficiaries to provide a safe accommodation of enrollee's medical needs with the plan's formulary.

DEFINITIONS:

Emergency Fill: After the initial new enrollee transition period, LTC facility residents who are ordered non-formulary, PA, ST drugs, must receive their medications as ordered without delay. Therefore, Simply Healthcare Plans will cover an emergency supply of these drugs for LTC facility residents as part of their transition process. These emergency supplies of non-formulary Part D drugs – including Part D drugs that are on a Simply Healthcare Plans’s formulary but require prior authorization or step therapy under a Simply Healthcare Plans’s utilization management rules – must be for at least 31 days of medication, unless the prescription is written by a prescriber for less than 31 days.

Formulary Changes Across Contract Years: Includes drugs that will become Non-Formulary (no longer covered on the formulary), or drugs that remain on the formulary but have new PA or ST restriction added from one contract year to another.

Level of Care Change: When an enrollee is changing from one treatment setting to another. Examples include, but are not limited to: (1) beneficiaries who enter LTC facilities from hospitals; (2) beneficiaries who are discharged from a hospital to a home; (3) beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; (4) beneficiaries who give up hospice status to revert to standard Medicare Part A and B benefits; (5) beneficiaries who end an LTC facility stay and return to the community; and (6) beneficiaries who are discharged from psychiatric hospitals with drug regimens that are highly individualized.

Non-formulary Drug: Part D drugs that are not on the Simply Healthcare Plans’s formulary and that are on the Simply Healthcare Plans’s formulary, but require prior authorization (PA), or step therapy (ST) under a plan’s utilization management rules.

Transition Process: (1) the transition of new enrollees into prescription drug plans following the annual coordinated election period; (2) the transition of newly eligible Medicare beneficiaries from other coverage; (3) the transition of individuals who switch from one plan to another after the start of the contract year; (4) Enrollees residing in LTC facilities (including Level of Care Changes and Emergency Fills) and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next.
POLICY:

1. Transition Process in the Retail, Home Infusion, Mail-Order or I/T/U:

The Simply Healthcare Plans must have and implement an appropriate transition process in accordance with CMS requirements for beneficiaries to obtain at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days, for non-formulary Part D drugs he or she was taking prior to enrollment (including Part D drugs that are on a plan’s formulary but require prior authorization or step therapy under a plan’s utilization management rules) anytime during the first 90 days of the beneficiary’s enrollment in a plan, beginning on the enrollee’s effective date of coverage.

This Transition process applies specifically to:

- New enrollees into the plan on January 1 following the previous year’s annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage in the previous year in another PDP
- Individuals who switch from one PDP to another after January 1
- In some cases, current enrollees affected by formulary changes from one contract year to the next.

Enrollees must be allowed to refill a transition supply of a non-formulary Part D drug if the prescription is dispensed for less than the written amount due to a plan edit (quantity limits).

Simply Healthcare Plans has systems capabilities that allow them to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity.

Simply Healthcare Plans will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, the Simply Healthcare Plans will ensure that cost-sharing for a temporary supply of drugs provided under its transition process is based on one of its approved cost-sharing tiers (if the Simply Healthcare Plans has a tiered benefit design) and is consistent with cost-sharing the Simply Healthcare Plans would charge for non-formulary drugs approved under a coverage exception.

Simply Healthcare Plans will ensure that it will apply all transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

Simply Healthcare Plans will extend its transition policy across contract years should a enrollee enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.
Please note the definition of “Non-formulary Drug” as outlined in the Definitions section above and that the definition of “Transition Process” includes “formulary drugs that remain on formulary but a new prior authorization or step therapy restriction is added from one contract year to another.”

Note: Since certain enrollees may join a plan at any time during the year, this policy must not incorrectly limit this transition to the first 90 days of the contract year.

2. **One Time Fills**

The Simply Healthcare Plans must have and implement an appropriate transition process in accordance with CMS requirements for beneficiaries to obtain one 30-day fill.

Simply Healthcare Plans will make arrangements to continue providing requested drugs on a case-by-case basis if an individual’s exception request or appeal has not been processed by the end of the minimum transition period, and until such time that a transition has been made (either through a switch to an appropriate formulary alternative, or a decision on an exception request). Until that transition is made, continuation of drug coverage is required, other than for drugs not covered under Part D.

**Formulary Changes Across Contract Years:**

Simply Healthcare Plans will implement a transition process for current enrollees consistent with the transition process required for new enrollees. In order to prevent coverage gaps, Simply Healthcare Plans will provide a temporary supply of the requested prescription drug (where not medically contraindicated) and provide enrollees with notice that they must either switch to a drug on the Simply Healthcare Plans’s formulary or get an exception to continue taking the requested drug.

**Level of Care Changes:**

Per CMS, Simply Healthcare Plans should consider how to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.

Also, Simply Healthcare Plans must have systems capabilities that allow them to provide a one time, temporary supply of non-formulary Part D drugs (including Part D drugs that are subject to prior authorization or step therapy) in order to accommodate the immediate needs of an enrollee, as well as to allow theSimply Healthcare Plans and/or the enrollee sufficient time to work out with the prescriber an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons. This policy means that an enrollee eligible for a transition supply of a drug must leave the pharmacy with a filled prescription.

3. **Transition Process for Residents of Long-Term Care Facilities:** Simply Healthcare Plans must have and implement an appropriate transition process in accordance with CMS requirements for beneficiaries to obtain a 31-day fill (unless the enrollee presents with a prescription written for less than 31 days, with multiple refills as necessary, up to a 93 day supply during the first 90 days of a beneficiary's enrollment in
a plan, beginning on the enrollee's effective date of coverage for non-formulary Part D drugs in a long-term care (LTC) setting.

Enrollees being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

Enrollees must be allowed to refill a transition supply of a non-formulary Part D drug if the prescription is dispensed for less than the written amount due to a plan edit (quantity limits).

Per CMS, Simply Healthcare Plans should consider how to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.

4. **Emergency Fill in LTC setting outside of transition period while exception request pending:** Since LTC residents must receive their medication without delay, Simply Healthcare Plans must cover an Emergency Supply of a Non-Formulary Part D Drug (or a drug that has PA or ST), even if the enrollee is outside his or her initial 90-day transition period, while an exception or prior authorization is requested.

The Simply Healthcare Plans must provide up to 31 days (unless the prescription is written for less than 31 days) of a non-formulary Part D drug to a enrollee in a LTC setting at any time outside of the enrollee’s 90-day transition period while an exception or prior authorization request is being processed.

This policy applies to both current enrollees in a LTC setting requiring an emergency fill and those entering a LTC setting from other care settings.

5. **Enrollees who remain in same plan they were enrolled in for the prior year and are on a drug as a result of an exception that was granted in the prior year:** Simply Healthcare Plans will provide the enrollee with a temporary supply of the requested prescription drug at the beginning of the current plan year and provide the enrollee with notice that they must either switch to a therapeutically appropriate drug on the plan’s formulary or get an exception to continue taking the requested drug.

6. **Notice Requirement for Temporary Transition Fills:** If the Simply Healthcare Plans provides a temporary fill for a non-formulary Part D drug under its transition process, it must provide the enrollee with appropriate written notice regarding the transition process within three (3) business days of the temporary fill.

Simply Healthcare Plans will send written notice via U.S. first class mail to enrollee within three business days of adjudication of a temporary fill. The notice must include (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the plan Simply Healthcare Plans and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the enrollee's right to request a formulary exception; and (4) a description of the procedures for requesting a formulary exception. Simply Healthcare Plans will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to CMS for marketing review subject to a 45-day review.
Simply Healthcare Plans will make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on plan web sites.

7. **Communication of Transition Claims and Transition Process:** Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, Simply Healthcare Plans will promptly implement either: (1) appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim (see the 5.1 Editorial Document), or (2) alternative approaches that achieve the goals intended in the messaging guidance.

Simply Healthcare Plans must make general information about their transition process available for beneficiaries in a similar manner to information provided on formularies and benefit designs. CMS will make plan transition process information available to enrollees via a required link from Medicare Prescription Drug Plan Finder to Simply Healthcare Plans web site and include in pre- and post-enrollment marketing materials as directed by CMS.

8. **Reporting:** Transition Process: Simply Healthcare Plans must provide reports to CMS regarding data related to the transition process as requested.

9. **Training:** Simply Healthcare Plans will provide training annually and as necessary to all staff, subcontractors and other relevant personnel on this policies and procedures.

10. **Policy Updates:** Simply Healthcare Plans will monitor CMS guidance for updates or revisions to current policy as needed.

11. **Monitoring:** Simply Healthcare Plans will monitor and audit operations and compliance on a regular basis.

**PROCEDURES:**

1. **General Procedures:**

Simply Healthcare Plans will provide a temporary supply fill anytime during the first 90 days of an enrollee’s enrollment in a plan (NOT just the first 90 days of the contract year). Simply Healthcare Plans’s adjudication system is very flexible and can be programmed to allow the CMS minimum of one 30-day fill for retail and 31 day supply for LTC of non-formulary Part D drugs and formulary Part D drugs requiring prior authorization or step therapy during the 90 day transition process.

I. The first 90 days of the enrollee’s enrollment, also referred to as the new enrollee transition period, include the following situations:
- New enrollees into the plan on January 1 following the previous year’s annual coordinated election period;
- Newly eligible Medicare beneficiaries from other coverage in the previous year in another Medicare Part D plan;
- Individuals who switch from one Medicare Part D plan to another plan after January 1, including enrollees with an effective enrollment date of either November 1 or December 1 who will have transition periods extend into the following contract year in order to satisfy the required 90 day transition period;
- Beneficiaries who are with the plan, then leave, then come back will be treated as new enrollees based on their new effective date of when they returned to the plan;
- Beneficiaries who change contracts or PBPs and undergo a formulary change as a result within the same contract qualify for a new enrollee transition period;
- Enrollees residing in LTC facilities (reference Section 4.- #3, pgs. 12-15, of this P&P);
- Current enrollees affected by formulary changes between one contract year to the next (See Section 4 - #2B, pgs. 7-10, of this P&P for Formulary Changes Across Contract Years);

II. All utilization management and non-formulary edits (not including B vs. D PAs, edits to reject non-part D drugs, quantity limits for safety reasons, and early refill edits) are overridden during the transition period to allow the multiple fills up to the overall transition day supply limit. Therefore, multiple refills of a transition supply may be obtained up to the maximum allowable days supply of a transition supply.

III. This temporary transition supply will accommodate the immediate needs of an enrollee and allow the enrollee sufficient time to meet with their prescriber to discuss an appropriate switch to a therapeutically equivalent medication or to submit and receive a decision on a coverage determination and exception request to maintain coverage of an existing drug based on medical necessity reasons.

IV. For LIS enrollees, the cost share amount for the transition supply will not exceed the statutory maximum copay amounts. For Non-LIS enrollees, the cost share for the temporary transition supply will be based on one of the approved cost sharing tiers and will be consistent with the co-pay that would typically be charged for an approved non-formulary medication exception. In addition, the copay that would be charged for a PA or ST drug would be consistent with the copay for the CMS approved formulary tier for that product.

V. Since we are unable to determine if an initial transition supply is a brand-new prescription for therapy initiation, or an ongoing prescription to continue therapy, all claims will be treated as brand new prescriptions eligible for a transition supply.

VI. Enrollees who receive a transition supply of a PA or ST drugs in the Six Classes of Clinical Concern will be automatically be grandfathered to continue taking that medication throughout their benefit. They will not be considered “new starts” and will not need to go through the coverage determination and exception process in order to continue on their medication. These members will not be sent a transition letter, since they will be able to continue on their therapy without interruption.
VII. All edits will be resolved at the point of service adjudication. No “hard edits” are utilized in order to manage transition supplies. Since the utilization management edits (except B vs. D PA), are overridden to allow the transition fill during first 90 days of the enrollment, there is no need for the Retail, home infusion, safety-net, or I/T/U pharmacists to enter an override. These claims will pay without any additional input from the submitting pharmacist and therefore the enrollee will never leave the pharmacy without a transition supply.

VIII. The P&T Committee reviews this transition policy at least annually to ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs non-formulary drugs or formulary drugs that require prior authorization or step therapy and which may have risks associated with a change in the prescribed regimen. Simply Healthcare Plans is currently contracted with an outside vendor to provide P&T Committee services, and therefore this vendor conducts this review.

IX. The procedures for addressing medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination is addressed in the Coverage Determinations and Exception Requests P&P.

2. Eligibility for Transition Period
   I. All Medicare beneficiaries are identified in the claims processing system (by enrollment date) so the appropriate transition period can be determined.
   
   RxClaim, the claim adjudication system, will examine the member’s enrollment data determine if the member is a new enrollee, if there is a gap in coverage, or if there is a change in Contract and/or PBP. If the system detects any of these elements, the member is eligible for a 90 day transition period. This 90 day transition period may also cross contract years.
   
   During the transition period, the system allows a transitional fill for all products identified as transition eligible.
   
   When a transition supply claim is paid through RxClaim, pharmacies will be notified via an electronic message informing them that the fill was part of a transition supply. If the claim encounters a valid transitional reject, a message is returned to the pharmacy to indicate the reason for the rejection.
   
   Once the transition period has ended, RxClaim will reject those claims for which the products are non-formulary or exceed plan limitations.

3. One-time Fills at End of Transition Period
   1. Prior to the end of the 90-day transition period, the prescribing physician must either:
      a. Prescribe an alternative formulary medication OR
      b. Complete the coverage determination and exception form and return it to Simply Healthcare Plans via fax or mail OR
      c. Submit a statement of medical necessity in lieu of the coverage determination and exception form to Simply Healthcare Plans via fax or mail
   2. The Simply Healthcare Plans Pharmacy Department will review the prior authorization exception request and make a coverage determination.
3. If the physician does not request an exception for the transition drug, the automated override for the transition drug will expire after the original timeframe (the initial 90-day transition period).

4. If the enrollee, enrollee’s representative, or physician, has submitted a coverage determination and exception request and the decision is still pending at the end of the 90-day transition period, a one-time override will be entered to allow continuation of therapy while the exception request is being processed.

4. One time fills for formulary changes across contract years

1. Simply Healthcare Plans implements a combination of both CMS options for effectuating transitions for enrollees whose drugs are no longer on the formulary, or have had a PA or ST added to them effective January 1 of the next contract year. Simply Healthcare Plans provides a transition process for current enrollees consistent with the transition process required for new enrollees; AND notifies and encourages current enrollees to transition to a therapeutically appropriate formulary alternate.

2. Simply Healthcare Plans encourages enrollees and/or their providers to proactively seek non-formulary exceptions (and other exceptions for drugs that have had utilization management added) prior to the beginning of the next contract year.

3. We support notifying enrollees of formulary changes across contract years using various methods, and the Simply Healthcare Plans client chooses one or more of these methods to provide ample opportunity for members to proactively seek a non-formulary exception:
   - Annual ANOC
   - EOBs in November and/or December
   - Online notification tables
   - Direct enrollee mailings

4. When such exceptions have been approved, the enrollee will be able to continue on that medication through the end of that contract year.

5. If the enrollee, an appointed representative or the prescribing physician has not requested an exception prior to the end of the contract year, the enrollee, an appointed representative or the prescribing physician must still request a coverage determination exception review as expeditiously as possible.

6. If the enrollee has not successfully transitioned to a formulary alternative by Jan.1, we will provide a transition supply beginning Jan. 1, consistent with the process for new enrollee transitions, by programming the negative formulary changes across contract years (drugs that have utilization management added or have become non-formulary) to allow the additional transitional fill for current beneficiaries who utilized the drug during the past 120 days.

7. Formulary Changes Across Contract Years can be identified easily by the Pharmacy Department, Clinical Call Center, and by point-of-sale pharmacists based on unique custom electronic messaging on the rejected claim. The message includes text such as “New 2012 PA – call xxx-xxx-xxxx”

5. One-time Fills for Unplanned Transitions from Hospital, SNF or Hospice.

For a member leaving a hospital, skilled nursing home or hospice setting (where prescriptions are covered under Medicare Part A or Part B), the discharge list of prescription orders may contain
medications that are either non-formulary or subject to utilization management edits. Please refer to the Level of Care Change definition on Page 1 to review additional examples of Level of Care changes.

The RxClaim Level of Care change automated programming identifies if the member has a change in Patient residence code or a change in pharmacy NPI based on the most recent claim with a different fill date. If a Level of Care Change is identified, RxCLAIM can be configured to automatically override the following edits at the plan’s discretion to allow the claim to pay:

- Refill too soon
- Duplicate Prescription
- Duplicate Therapy
- Non-Formulary
- Prior Authorization (excluding BvsD prior authorizations)
- Step Therapy

If the member didn’t have a change identified by a change in Patient residence code or pharmacy NPI, in order to ensure that enrollees do not have a gap in therapy, the pharmacist should call the Simply Healthcare Plans Pharmacy Department team to notify them of the Level of Care Change in order to have an authorization placed in RxClaim to allow the claim to pay.

This authorization will address the following edits resulting in a paid claim as determined by the plan. For example, the client may not wish to override Duplicate Prescription or Duplicate Therapy for level of care changes:

- Refill too soon
- Duplicate Prescription
- Duplicate Therapy
- Non-Formulary
- Prior Authorization (excluding BvsD prior authorizations)
- Step Therapy

These authorizations will be entered as one-time authorizations. However, if the member has subsequent Level of Care Changes, additional one-time authorizations will be entered to ensure there are no gaps in therapy.

6. New Enrollee Transitions for LTC Enrollees:

For LTC beneficiary, the Simply Healthcare Plans new enrollee transition process in RxClaim is programmed to automatically allow a 31-day transition supply, unless the prescription is written for less than 31 days, with multiple refills as necessary, to allow up to a 93 day supply of transition medication during the first 90 days of the beneficiary’s enrollment in a plan. LTC enrollees are identified based on the patient residence code submitted on the claim. This process follows the same process as defined in section 1, except that the total day supply of the transition fill allowed is a total of 93 days.

7. LTC Member Level of Care Changes.
Enrollees admitted to and being discharged from a LTC setting (Level of Care Changes) are NOT subject to "refill too soon" edits. This is to enable these enrollees to fill prescriptions for formulary medications that cannot be taken with them from or into such settings.

In addition, please reference Section 3. Definitions, pg. 1, of this P&P for Level of Care Change definition and additional examples.

The RxClaim Level of Care change automated programming identifies if the member has a change in Patient residence code based on the most recent claim with a different fill date. If a Level of Care Change is identified, RxClaim will automatically override the following edits to allow the claim to pay:

- Refill too soon
- Duplicate Prescription
- Duplicate Therapy
- Non-Formulary
- Prior Authorization (excluding BvsD prior authorizations)
- Step Therapy

If the member didn’t have a change identified by a change in Patient residence code, in order to ensure that enrollees do not have a gap in therapy, the pharmacist should call the Simply Healthcare Plans Pharmacy Department team to notify them of the Level of Care Change in order to have an authorization placed in RxClaim to allow the claim to pay.

This authorization will address the following edits resulting in a paid claim:

- Refill too soon
- Duplicate Prescription
- Duplicate Therapy
- Non-Formulary
- Prior Authorization (excluding BvsD prior authorizations)
- Step Therapy

These authorizations will be entered as one-time authorizations. However, if the member has subsequent Level of Care Changes, additional one-time authorizations will be entered to ensure there are no gaps in therapy.

At least quarterly, the Simply Healthcare Plans pharmacy network will be reminded, via fax blast from the Provider Relations department, of the clarification codes to submit for these situations.

8. LTC pharmacists must implement the filling of a transition drug supply at the point of sale, including overriding step therapy and prior authorization system edits if necessary. Since the utilization management edits (not including B vs. D PAs, edits to reject non-part D drugs, quantity limits for safety reasons, and early refill edits), are overridden to allow the transition fill during first 90 days of the enrollment, which also applies to Residents of LTC facilities, LTC pharmacists to enter an override. These claims will pay without any additional input from the submitting pharmacist and therefore the enrollee
will never be without a transition supply. If the first 90 days have passed, then the automated level of care change identification and override process will apply.

**9.** In order to ensure that enrollees do not have gaps in therapy, the claim adjudication system is programmed to identify level of care changes based on change in patient residence code on the claim. If a change is detected, then the utilization management/non-formulary rejection will be automatically overridden, the transition supply will pay, and a message will be communicated back to the pharmacy on the paid claim that it was a transition supply.

**10.** If for any reason a level of care change is not automatically identified and a claim rejects, the pharmacist should call the Pharmacy Department for an authorization to be entered.

**11.** The Pharmacy Department Professional will enter a one-time override for the claim to pay. If the rejection is related to a Clinical reason (such as NF, PA, ST) the Clinical Call Center will also be notified to being the coverage determination and exception process with the prescriber.

**12.** Simply Healthcare Plans complies with the requirement that enrollees in a LTC setting must be able to obtain an emergency 31-day supply at any time after the end of the 90-day transition period while exception requests are being processed to ensure there is no coverage gap while proceeding through the exceptions process.

**13.** In order to ensure that enrollees do not have a gap in therapy, the pharmacist should call the Simply Healthcare Plans Pharmacy Department team to notify them of the Emergency Fill in order to have an authorization placed in RxClaim to allow the claim to pay.

This authorization will address the following edits resulting in a paid claim:

- Refill too soon
- Duplicate Prescription
- Duplicate Therapy
- Non-Formulary
- Prior Authorization (excluding BvsD prior authorizations)
- Step Therapy

These authorizations will be entered as one-time authorizations. However, if the member has subsequent Emergency Fills, additional one-time authorizations will be entered to ensure there are no gaps in therapy.

**14.** Simply Healthcare Plans will provide enrollees with appropriate written transition letter notification regarding their transition supply for any of the reasons indicated in the CMS model transition notice. This notice will include an explanation of the temporary nature of the transition supply along with instructions for working with Simply Healthcare Plans and the enrollee’s prescriber to determine an
appropriate therapeutic formulary alternative. Additionally, the letter template will provide an explanation on the enrollee’s right to request a formulary exception with the procedures on how to pursue that option. One transition letter is generated per drug, so if one drug has exceeded both Prior Authorization and Quantity Limit restrictions, one letter will include both reasons. If a member receives multiple transition fills of different drugs on the same day, a letter will be generated for each drug.

15. Simply Healthcare Plans uses mail delivery as the method of prescriber notification. Fax delivery is available when a fax number is supplied, which Simply Healthcare Plans receives via contract with a 3rd party vendor. Mailed notices use the address on file, which is also received via contract with a 3rd party vendor.