6323 Seventh Avenue
Brooklyn, NY 11220

<Date>

<MEMBER NAME>
<MEMBER ADDRESS>
<MEMBER CITY, STATE ZIP>

**YOUR DRUG IS NOT ON OUR LIST OF COVERED DRUGS (FORMULARY)
OR IS SUBJECT TO CERTAIN LIMITS**

Dear <Member Name>:

We want to tell you that Elderplan has provided you with a temporary supply of the following prescription: <name of drug>.

This drug is either not included on our list of covered drugs (called our formulary), or it's included on the formulary but subject to certain limits, as described in more detail later in this letter. Elderplan is required to provide you with a temporary supply of this drug. If your prescription is written for fewer than <MonthSupply> days, we'll allow multiple fills to provide up to a maximum <MonthSupply> day supply of medication.

It's important to understand that this is a temporary supply of this drug. Well before you run out of this drug, you should speak to Elderplan and/or the prescriber about:

- changing the drug to another drug that is on our formulary; or
- requesting approval for the drug by demonstrating that you meet our criteria for coverage; or
- requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don't assume that any coverage determination, including any exception, you have requested or appealed has been approved just because you receive more fills of a drug. If we approve coverage, then we'll send you another written notice.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-866-490-2102. TTY users should call 711. Live representatives are available from 7 days a week, 24 hours a day. You can ask us for a coverage determination at any time. **Instructions on how to change your current prescription, how to ask for a coverage determination, (including an exception), and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation(s) of why your drug is not covered or is limited.

NOT IN FORMULARY TF REASON (N) 1A, 1B and 1C:
Name of Drug: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is not on our formulary. We will not continue to pay for this drug after you have received the maximum <MonthSupply> days' temporary supply that we are required to cover unless you obtain a formulary exception from us.

PRIOR AUTHORIZATION TF REASON (P) 2A, 2B and 2C:
Name of Drug: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our formulary, but requires prior authorization. Unless you obtain prior authorization from us by showing us that you meet certain requirements, or we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received the maximum <MonthSupply> days' temporary supply that we are required to cover.

STEP THERAPY TF REASON (S) 3A, 3B and 3C:
Name of Drug: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try other drug(s), specifically <AltDrugsS>, as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our formulary first, or we approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received the maximum <MonthSupply> days' temporary supply that we are required to cover.

QUANTITY LIMIT TF REASON (Q) 4A, 4B and 4C:
Name of Drug: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our formulary and is subject to a quantity limit (QL). We will not continue to provide more than what our QL permits, which is <AltDrugsQ>, unless you obtain an exception from Elderplan.

How do I change my prescription?

If your drug is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug used to treat your medical condition is on our formulary, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if this other drug that we cover is an option for you. You have the right to request an exception from us to cover your drug that was originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

How do I request a coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. Contact us at: CVS/Caremark P.O. Box 52000, MC109, Phoenix, AZ 85072-2000; Phone: 1-866-490-2102; TTY: 711; Fax: 1-855-633-7673; 7 days a week, 24 hours a day.

If you are requesting coverage of a drug that is not on our formulary, or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our formulary, the prescriber's statement must indicate that the requested drug is medically necessary for treating your condition because all of the drugs on our formulary would be less effective than the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our formulary, the prescriber's statement must indicate that the coverage rule wouldn't be appropriate for you given your condition or would have adverse effects for you.

We must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber's statement. Your request will be expedited if we determine, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

What if my request for coverage is denied?

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination request. We accept standard requests by phone and in writing. We accept expedited requests by phone and in writing. Contact us at: CVS/Caremark P.O. Box 52000, MC109, Phoenix, AZ 85072-2000; Phone: 1-866-490-2102; TTY: 711; Fax: 1-855-633-7673; 7 days a week, 24 hours a day.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-866-490-2102, 7 days a week, 24 hours a day. TTY users should call 711. Live representatives are available 7 days a week, 24 hours a day. You can ask us for a coverage determination at any time. You can also visit our website at www.elderplan.org.

Sincerely,

Elderplan

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact Elderplan Member Services at 1-800-353-3765 or, for TTY/TDD users, 711, 7 days a week from 8 AM to 8 PM, or visit www.elderplan.org.

Elderplan, Inc.
Notice of Nondiscrimination – Discrimination is Against the Law

Elderplan/HomeFirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that Elderplan/HomeFirst has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Civil Rights Coordinator
6323 7th Ave
Brooklyn, NY, 11220
Phone: 1-877-326-9978, TTY: 711
Fax: 1-718-759-3643

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-800-353-3765 (TTY: 711).

(Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-353-3765 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-353-3765 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-353-3765 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-353-3765 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-353-3765 (TTY: 711)번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-353-3765 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-353-3765 (TTY: 711).

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-353-3765 (TTY: 711)।

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-353-3765 (TTY: 711).

(Arabic)ملحوظة: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في ASL، فإن خدمات المساعدة اللغوية تتوافر لك مجانا. اتصل برقم 1-800-353-3765 (TTY: 711).

(French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-353-3765 (ATS: 711).

(Urdu)خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-353-3765 (TTY: 711).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-353-3765 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-353-3765 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-353-3765 (TTY: 711).

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