< CarePlus HEALTH PLANS >

<PO Box 14098>
<Lexington, KY 40512-4098>

<Month, Day, Year>

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

Dear <Member First Name>:

Our records show that on <date filled>, you filled a prescription for medicine[s] that <have/has> changes to how <they are/it is> covered in <2016>. [*Insert for Initial Eligibility fills*: Because you're within your first 90 days of coverage for <2016>, <Plan name> is required to provide you with a temporary supply of the following medicine[s]: <list medicine[s] here>.] [*Insert for Emergency Fills and Level of Care Fills*: < <Plan name> has provided you with a temporary supply of the following medicine[s]: <list medicine[s] here>.]

It is important that you understand that this is a temporary supply of [this/these] medicine[s].

Talk with your prescriber

Before you run out of your medicine[s], please talk with your prescriber about your treatment options. Ask if you should:

- Switch to <a> new medicine[s] that is on our formulary, OR
- Request a prior authorization demonstrating that you meet our criteria for coverage, OR
- Request an exception to how we cover <this/these> medicine[s].

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

To learn how to switch to <a> new medicine[s], ask for an exception or prior authorization, or appeal a denial, see the instructions at the end of this letter.

The following is a specific explanation of why your medicine[s] <is/are> not covered or <is/are> limited.

[**Name of Medicine**: <*name of medicine*>
Date Filled: <*date filled*>

Reason for this notification: Not Covered
This medicine isn't covered under your <2016> prescription drug plan. Because you're within your first <must be at least 90 days> days of coverage with <CarePlus> for <2016>, [*Insert for members who do not reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <must be at least 30> day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of <must be at least 30-day> day supply of medicine. Before this <must be at least 30-day> day supply ends, your prescriber will have to change your medicine to an alternative <such as <Insert Alternative Drug>,> or request an exception from us to cover your medicine.] [*Insert for members who reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <at least a 91 day supply and may be up to a 98 day supply> day supply. If your prescription is written for fewer days, we will allow multiple fills until you get a <at least a 91 day supply and may be up to a 98 day supply> day supply (please note that the long-term care pharmacy may provide the medicine in smaller amounts at a time to prevent waste). Before this supply ends, your prescriber will have to change your medicine to an alternative <such as <Insert Alternative Drug>,> or request an exception from us to cover your medicine.]

[**Name of Medicine**: <*name of medicine*>
Date Filled: <*date filled*>

Reason for this notification: Quantity Limit

This medicine is covered under your <2016> prescription drug plan, but we don't cover the full amount prescribed. We will not pay for more than what our quantity limits permit unless you obtain a quantity limit exception from us. In this case, we limit the amount of the medicine that we cover at one time for safety reasons.

Because you're within your first 90 days of coverage with <CarePlus> for <2016>, [*Insert for members who do not reside in a LTC facility:* you can refill your prescription until you get a <*must be at least 30*> day supply. Additional fills won't be covered unless your prescriber requests a quantity limit exception from us to cover this medicine.] [*Insert for members who reside in a LTC facility:* you can refill your prescription until you get a <at least a 91 day supply and may be up to a 98 day supply> day supply (please note that the long-term care pharmacy may provide the medicine in smaller amounts at a time to prevent waste). Additional fills won't be covered unless your prescriber requests a quantity limit exception from us to cover this medicine.]

[**Name of Medicine**: <*name of medicine*>
Date Filled: <*date filled*>

Reason for this notification: Prior Authorization

This medicine needs to be approved in advance to be covered under your <2016> prescription drug plan. For this medicine to be covered, your prescriber must get prior approval from us.

Because you're within your first <must be at least 90 days> days of coverage with <CarePlus> for <2016>, [*Insert for members who do not reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <must be at least 30> day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of <must be at least 30-day> day supply of medicine. Before you use up your supply, you must request a prior authorization from us by showing that you meet certain requirements for us to cover this medicine, or your doctor will have to change your medicine to an alternative <such as

<Insert Alternative Drug>>.] [*Insert for members who reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <at least a 91 day supply and may be up to a 98 day supply> day supply. If your prescription is written for fewer days, we will allow multiple fills until you get a <at least a 91 day supply and may be up to a 98 day supply> day supply (please note that the long-term care pharmacy may provide the medicine in smaller amounts at a time to prevent waste). Before you use up your supply, you must request a prior authorization from us by showing that you meet certain requirements for us to cover this medicine, or your doctor will have to change your medicine to an alternative <such as <Insert Alternative Drug>>.]

[**Name of Medicine**: <*name of medicine*>
Date Filled: <*date filled*>

Reason for this notification: Step Therapy
This medicine is on our formulary. However, it will generally only be covered if you first try other safe and effective generic or lower cost brand name medicines. Sometimes there's more than one medicine that will work to treat a specific health condition. Before a prescription is filled for a medicine that costs more, we will ask that you first try at least one other lower-cost medicine <, specifically <Insert Step 1 drug>>.

Because you're within your first <must be at least 90 days> days of coverage with <CarePlus> for <2016>, [*Insert for members who do not reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <must be at least 30> day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of <must be at least 30-day> day supply of medicine. Before you use up your supply, you will need to try at least one other medicine first or, request an exception to the step therapy requirement in order for us to cover this medicine.] [*Insert for members who reside in a LTC facility:* we've provided you with a[n] <days' supply on filled claim> day supply. The maximum supply allowed is a <at least a 91 day supply and may be up to a 98 day supply> day supply. If your prescription is

written for fewer days, we will allow multiple fills until you get a <at least a 91 day supply and may be up to a 98 day supply> day supply (please note that the long-term care pharmacy may provide the medicine in smaller amounts at a time to prevent waste). Before you use up your supply, you will need to try at least one other medicine first or, request an exception to the step therapy requirement in order for us to cover this medicine.]

***Note**: The following notice is for Emergency Fill and Level of Care Change transitions and is optional. However, we encourage plans to notify beneficiaries of Emergency Fill and Level of Care Change Transitions.*

[**Name of Medicine**: <*name of drug*>
Date Filled: <*date filled*>

Reason for this notification: **Not Covered**
This medicine isn't covered under your <2016> prescription drug plan. We will cover this medicine for <days supply on filled claim – must be at least 31 days> day[s] while you seek to obtain a formulary exception from us. If you are in the process of getting an exception, we'll consider allowing continued coverage until a decision is made.]

[**Name of Medicine**: <*name of drug*>
Date Filled: <*date filled*>

Reason for this notification: **Prior Authorization**
This medicine is on our formulary and needs to be approved in advance to be covered under your <2016> prescription drug plan. For this medicine to be covered, your prescriber must get prior approval from us. We will cover this medicine for <days supply on filled claim –must be at least 31 days> day[s] while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.]

[**Name of Medicine**: *<name of drug>*

Date Filled: *<date filled>*

Reason for this notification: **Step Therapy**

This medicine is on our formulary but will be covered only if you first try other safe and effective generic or lower cost brand name medicines as part of our step therapy program. Sometimes there's more than one medicine that will work to treat a specific health condition. Before a prescription is filled for a medicine that costs more, we will ask you to try at least one other lower-cost medicine first. We will cover this medicine for <days supply on filled claim – must be at least 31 days> day[s] while you seek to obtain coverage by showing us that you meet the step therapy requirement. You can also ask us for an exception to the step therapy requirement if you believe it should not apply to you for medical reasons.]

[**Name of Medicine**: *<name of drug>*

Date Filled: *<date filled>*

Reason for this notification: **Not Covered with Quantity Limit**

This medicine isn't covered under your <2016> prescription drug plan. In addition, we don't cover the full amount prescribed. In this case, we limit the amount of the medicine that we cover at one time for safety reasons. We will cover this medicine for <days supply on filled claim – must be at least 31 days> day[s] while you seek to obtain a formulary and/ or quantity limit exception from us.

How do I change my prescription?

Talk with your prescriber and see if the alternative medicine option(s) will work for you. If there is no alternative medicine that will work for you or your prescriber feels the prescribed medicine is best for you, your prescriber can request an exception from us to cover this medicine.

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

The first step in asking for a coverage determination, including an exception to our coverage rules is for you or your prescriber to contact us at:

<Attn: <CarePlus> Clinical Pharmacy Review Team
11430 NW 20th Street, Suite 300
Miami, FL 33172
Fax: 1-800-310-9071
Phone: 1-866-315-7587 (TTY: 711)>

If you are requesting coverage of a medicine that is not on our formulary, or an exception to a coverage rule, your prescriber will need to send a statement supporting the request. It may be helpful to take this letter with you to the prescriber or send a copy to his or her office. <*Insert for not covered*: If the exception request involves a medicine that is not on our formulary, the prescriber's statement must indicate that the requested medicine is medically necessary for treating your condition because all of the medicines we cover would not work as well as the requested medicine or would have adverse effects for you>. <*Insert for exception*: If the exception request involves a prior authorization, or other coverage rule we have placed on a medicine that in on our formulary, the prescriber's statement must indicate that the coverage rule we have placed on your medicine isn't right for your condition or would have adverse effects for you.>

We will let you know if the request was approved or denied no later than 72 hours for standard requests or 24 hours for expedited requests, once it has been received. For exceptions, the timeframe begins when we obtain your prescriber's statement. Your request will be expedited if we determine or if 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 we deny your request for coverage, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must submit your appeal no more than 60 days after

the date of our denial notice on your coverage determination request. We accept standard appeals in writing and expedited appeals by phone and in writing.

<Attn: Grievance and Appeals Department
11430 NW 20th Street, Suite 300
Miami, FL 33172
Fax: 1-800-956-4288
Phone: 1-800-794-5907 (TTY: 711)>

If you have questions about our coverage determination process, including an exception or if you want more information about when we will cover a temporary supply of a medicine, please contact us at <**1-800-794-5907**>. We are happy to take your calls <Monday-Friday> <7 days a week> from 8:00 a.m. to 8:00 p.m. If you use TTY, call <711>. You can ask us for a coverage determination at any time. You can also visit <<**www.careplushealthplans>.com**>.

Sincerely,

< >

<Teresita Washington, Pharm D>
<Director of Pharmacy>

<CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal.>

<This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. [Benefits, premiums and/or member cost-share] may change on January 1 of each year.> <The formulary may change at any time. You will receive notice when necessary.>

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Discrimination is Against the Law

CarePlus Health Plans, Inc. ("CarePlus") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CarePlus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CarePlus:

- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CarePlus Health Plans, Inc.
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172
Telephone: 1-800-794-5907 (TTY users should call 711)
8 a.m. to 8 p.m., 7 days a week

From February 15th to September 30th, we are open Monday-Friday from 8 a.m. to 8 p.m.

Fax: 1-800-956-4288

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

You can 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; 800-537-7697 (TDD)

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

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Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY:711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY:711).

繁體中文 (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 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY:711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-794-5907 (TTY:711) 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-794-5907 (TTY:711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY:711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-794-5907 (TTY:711).

Diné Bizzad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-794-5907 (TTY:711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).

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