6323 Seventh Avenue
Brooklyn, NY 11220

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

<DATE>

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

Dear <PARTICIPANT NAME>:

We want to tell you that Elderplan FIDA Total Care (Medicare-Medicaid Plan) has provided you with a temporary supply of the following prescription(s): <list medication(s) here>.

This drug(s) is either not included on our List of Covered Drugs (called our formulary, or also the Drug List for short) or included on the Drug List, but subject to certain limits, as described in more detail later in this letter. Our Plan is required to provide you with a temporary supply of this drug(s) as follows:

[*Insert for Participants who do not reside in an LTC facility:* In the outpatient setting, we're required to provide up to 90 days of medication. If your prescription is written for fewer than 90 days, we'll allow multiple fills to provide up to 90 days of medication.]

[*Insert for Participants who reside in an LTC facility:* For a resident of a long-term care facility, we're required to provide a maximum of *a 98-day supply, depending on the dispensing increment* of medication. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum *98-day supply* of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste).]

It's important to understand that this is a temporary supply of this drug(s). Well before you run out of this drug(s), you should speak to our Plan, the prescriber, and/or your Interdisciplinary Team (IDT) about:

- changing the drug(s) to another drug(s) that is on our Drug List; or
- requesting approval for the drug(s) 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 our Plan or your IDT approves 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 our Plan Participant Services or your Care Manager at 1-855-462-3167. TTY users should call 711. Live representatives are available from 7 days a week, 8:00 A.M. to 8:00 P.M. You can ask for a coverage determination at any time. **Instructions on how to change your current prescription(s), 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 of why your drug(s) is not covered or is limited.

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is not on our Drug List. We will not continue to pay for this drug after you have received up to [XX] days' temporary supply that we are required to cover unless you obtain a Drug List exception from our Plan or your IDT.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is not on our Drug List. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called a quantity limit and we impose such limits for safety reasons. In addition to imposing quantity limits for safety reasons as this drug is dispensed, we will not continue to pay for this drug after you have received up to [XX] days' supply that we are required to cover unless you obtain a Drug List exception from our Plan or your IDT.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List, but requires prior authorization. Unless you obtain prior authorization from our Plan or your IDT by showing us that you meet certain requirements or unless 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 up to [XX] days' temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List. However, we will generally only pay for this drug if you first try other drug(s), specifically <insert step drug(s)>, 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 Drug List first or unless we or your IDT approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received up to [XX] days' temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List. However, we will generally only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our Drug List first or unless we or your IDT approve your request for an exception, we will not continue to pay for this drug after you have received up to [XX] days' temporary supply that we are required to cover.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List and is subject to a quantity limit (QL). We will not continue to provide more than what our QL permits, which is <insert the QL>, unless you obtain an exception from our Plan or your IDT.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is not on our Drug List. We will cover this drug for 31 days while you seek to obtain a Drug List exception from our Plan or your IDT. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List and requires prior authorization. We will cover this drug for 31 days while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.]

[**Name of Drug**: <name of drug>
Date Filled: <date filled>
Reason for Notification: This drug is on our Drug List but will generally be covered only if you first try certain other drugs as part of our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for 31 days while you seek to obtain coverage by showing us that you meet the step therapy criteria. 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.]

How do I change my prescription?

If your drug(s) is not on our Drug List, or is on our Drug List, but we have placed a limit on it, then you can ask us what other drug(s) used to treat your medical condition is on our Drug List, 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(s) that we cover is an option for you. You have the right to request an exception from us to cover your drug(s) 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. Elderplan FIDA Total Care's Pharmacy Benefit Manager (PBM) is CVS/Caremark. CVS/Caremark's address is P.O. Box 52000, MC109, Phoenix, AZ 85072-2000. CVS/Caremark's fax number is 1-855-633-7673. CVS/Caremark's phone number is 1-866-443-0935, 7 days a week, 24 hours a day. TTY/TDD users should call 711. Your Care Manager can help you with this.

If you are requesting coverage of a drug that is not on our Drug List 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 Drug List, the prescriber's statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our Drug List 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 Drug List, 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.

Our Plan or your IDT must notify you of its 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 our Plan or your IDT determines, 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 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. Elderplan FIDA Total Care's Pharmacy Benefit Manager (PBM) is CVS/Caremark. CVS/Caremark's address is P.O. Box 52000, MC109, Phoenix, AZ 85072-2000. CVS/Caremark's fax number is 1-855-633-7673. CVS/Caremark's phone number is 1-866-443-0935, 7 days a week, 24 hours a day. TTY/TDD users should call 711. . Instructions for filing an appeal are in Chapter 9 of your Participant Handbook or can be provided to you by your Care Manager, Participant Services, or by the FIDA Participant Ombudsman.

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, please contact Participant Services at our Plan, at 1-855-462-3167 or TTY/TDD 711. Live representatives are available from 7 days a week, 8:00 A.M. to 8:00 P.M. You can ask us for a coverage determination at any time. You can also visit our website at www.elderplanfida.org.

Sincerely,

Elderplan FIDA Total Care (Medicare-Medicaid Plan)

Elderplan FIDA Total Care (Medicare-Medicaid Plan) is a managed care plan that contracts with both Medicare and New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by our Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

ATTENTION: If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-855-462-3167 (TTY: 711).

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-462-3167 (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 1-855-462-3167 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-462-3167 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-462-3167 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-462-3167 (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 1-855-462-3167 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-462-3167 (TTY: 711).

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-462-3167 (TTY: 711)।

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-462-3167 (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 1-855-462-3167 (TTY: 711).

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-462-3167 (ATS: 711).

(Urdu)خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-462-3167 (TTY: 711).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-462-3167 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-462-3167 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-462-3167 (TTY: 711).