<Street Address>
<City, State ZIP

< >

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

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

Dear <MEMBER NAME>:

We want to tell you that <Plan Name> 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 it's included on the formulary but subject to certain limits, as described in more detail later in this letter. <Plan Name> is required to provide you with a temporary supply of this drugs[s], as follows:

[{*Insert for members who do not reside in an LTC facility:}* In the outpatient setting, we're required to provide a maximum of *<insert supply limit (must be at least a 30-day supply)]>* of medication. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum <*insert supply limit (must be at least a 30-day supply)>* of medication.] [{*Insert for members who reside in a LTC facility:}* For a resident of a long term care facility, we're required to provide a maximum of <*insert supply limit (must be at least a 91-day supply and may be up to 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 <*insert supply limit (must be at least a 91-day supply and may be up to a 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 <Plan Name> and/or the prescriber about:

- changing the drug[s] to another drug[s] that is on our formulary; 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 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 <toll free phone number>. TTY users should call <TTY number>. Live representatives are available from <days/hours of operations when live representatives take calls>. You can ask us 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/are> not covered or <is/are> limited.

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is not on our formulary. [{*Insert where applicable:}* In addition, a prior exception you received for coverage of this drug has recently expired.] We will not continue to pay for this drug after you have received the maximum <*insert number*> days' temporary supply that we are required to cover, unless you obtain <a> <an additional> formulary exception from us.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is not on our formulary. 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 as this drug is dispensed for safety reasons, we will not continue to pay for this drug after you have received the maximum <*insert number*> days' supply that we are required to cover unless you obtain a formulary exception from <Plan Name>.]

[**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 <*insert number*> 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 formulary. 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 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 <*insert number*> 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 formulary. 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 formulary first, or we approve your request for an exception, we will not continue to pay for this drug after you have received the maximum <*insert number*> 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 formulary and is subject to a quantity (QL). We will not continue to provide more than what our QL permits, which is <insert the QL>, unless you obtain an exception from <Plan Name>.
***{Note**: The following choices are for Emergency Fill and Level of Care Change and are optional. However, we encourage plans to notify beneficiaries of Emergency Fill and Level of Care Change temporary supplies.}*

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is not on our formulary. We will cover this drug for <days supply on filled claim – must be at least 31 days> while you seek to obtain a formulary exception from <Plan Name>. 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 formulary and requires prior authorization. We will cover this drug for <days supply on filled claim – must be at least 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 formulary, 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 <days supply on filled claim – must be at least 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 formulary, or is on our formulary, 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 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 [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 coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. <Provide the necessary address, fax number, and phone number>.

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 as 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. *[Insert one:* <You must file a standard request in writing.> or <We accept standard requests by phone and in writing.> We accept expedited requests by phone and in writing. <Provide the necessary address, fax number, and phone number>.

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 <Toll-free Number>, <Days/Hours of Operation>. TTY users should call <TTY number>. Live representatives are available from <days/hours of operations when live representatives take calls.> You can ask us for a coverage determination at any time. You can also visit our website at <insert web address>.

Sincerely,

<Plan Representative>

{Pursuant to §30.5 of the Medicare Marketing Guidelines, this notice must be made available in any language that is the primary language of at least five (5) percent of the plan sponsor's PBP service area.}

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

The formulary and or pharmacy network may change at any time. You will receive notice when necessary.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English,

free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number on your member identification card.

ESPAÑOL (SPANISH): ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en su tarjeta de identificacion de afiliado.

繁體中文 (CHINESE): 請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 www.aetnamedicare.com 或致電您的會員卡上的電話號碼。

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Y0001_5040_8050_NM 09/2016

<CVS Code>

SM-0508-16 (9/16)