ASPIRE HEALTH PLAN

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

[PROCESSED DATE]
[MEMBER NAME]
100 Main street
Madison, ct 06443

Dear [MEMBER NAME]:

We want to tell you that Aspire Health Advantage (HMO) has provided you with a temporary supply of the following prescription: THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER .

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. Aspire Health Advantage is required to provide you with a temporary supply of this drug. If your prescription is written for fewer than [RTL_DSLIMIT] days, we'll allow multiple fills to provide up to a maximum of [RTL_DSLIMIT] 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 Aspire Health Advantage 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 Member Services Department at 888-495-3160 (TTY/TDD users should call 711). Live representatives are available from 24 hours a day, 7 days a week. You can ask us for a coverage determination at any time. You can also visit our website at https://www.aspirehealthplan.org/drug-coverage/.

**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 of why your drug is not covered or is limited.



**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**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 [RTL_DSLIMIT] days' temporary supply that we are required to cover, unless you obtain a formulary exception from us.

**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**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 [RTL_DSLIMIT] days' temporary supply that we are required to cover.

**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**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 [STEP THERAPY DRUGS], 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 [RTL_DSLIMIT] days' temporary supply that we are required to cover.

**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**Reason for Notification:** This drug is on our formulary, but is subject to a quantity limit (QL). We will not continue to provide more than what our quantity limit permits, which is [QUANTITY LIMIT], unless you obtain an exception from Aspire Health Advantage.

**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**Reason for Notification:** This drug is not on our formulary. We will cover this drug for a [RTL_DSLIMIT] day supply while you seek to obtain a formulary exception from Aspire Health Advantage. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.

**Name of Drug:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**Reason for Notification:** This drug is on our formulary, but requires prior authorization (PA). We will cover this drug for up to a [RTL_DSLIMIT] day supply 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:** THIS IS A REALLY LONG DRUG NAME THAT GOES ON THE LETTER
**Date Filled:** 04/11/1979
**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 up to a [RTL_DSLIMIT] day supply 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 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 is used to treat your medical condition 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 coverage determination, including an exception?**

You, your representative, or your prescriber on your behalf may contact us to request a coverage determination, including an exception. Please submit requests via telephone at 888-495-3160, via Fax: (858) 790-7100 or by mail at:
MedImpact Healthcare Systems
10181 Scripps Gateway Court
San Diego, CA 92131.

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 their 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. We accept standard appeal requests by phone and in writing We accept expedited requests by phone and in writing. Please submit all requests via telephone at 888-495-3160, via fax: (858) 790-7100 or by mail at:



MedImpact Healthcare Systems
Attn: Appeals & Grievance
10181 Scripps Gateway Court
San Diego, CA 92131

Sincerely,

Aspire Health Plan

H8764_Part D TL_1123_C

Form Approved
OMB# 0938-1421


## Multi-Language Insert

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-5700-1600 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-5700-1600 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-5700-1600 (TTY:711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-5700-1600 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-5700-1600 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-5700-1600 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-5700-1600 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-5700-1600 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-5700-1600 (TTY:711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-5700-1600 (TTY:711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-5700-1600 (TTY:711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-5700-1600 (TTY:711)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-5700-1600 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-5700-1600 (TTY:711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-5700-1600 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-5700-1600 (TTY:711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-5700-1600 (TTY:711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。