



**CENTRAL HEALTH
MEDICARE PLAN HMO**

Central Health Plan of California
1540 Bridgegate Drive
Diamond Bar, CA 91765

MedicareRx
Prescription Drug Coverage

<DATE>

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

Dear <MEMBER NAME>:

This letter is to inform you that <Plan Name> has provided you with a [Insert one <temporary> <limited>] supply, of the following prescription[s]: **<PRODUCT DESCRIPTION>**.

<This/These> drug[s] <is/are> either not included on our list of covered drugs (called our formulary) or included on the formulary, but subject to certain limits, as described in more detail further below. Our records indicate that you are a [Insert one or both <new enrollee of,> or <current enrollee>] affected by formulary changes implemented this year by <Plan Name> and that you are within your first 90 days of coverage for this plan year. [Insert for members who do not reside in an LTC facility: Therefore, in the outpatient setting, <Plan Name> is required to provide at least a 30-day supply unless the prescription is written for less and does not provide for refills]. [Insert for members who reside in a LTC facility: For a resident of a long term care facility, <Plan Name> is required to provide at least a 91 day supply and may be up to a 98 day supply, consistent with the dispensing increment, with refills provided, if needed (unless the prescription is written for less).]

It is important that you understand that this is a [Insert one or both <temporary> or <limited>] supply of this drug. Before this supply ends, you should speak to <Plan Name> and/or your physician regarding whether you should change the drug[s] you are currently taking, or request an exception from <Plan Name> to continue coverage of <this/these> drug[s].

If you need assistance in requesting an exception, or for more information about our transition policy, please call Customer Service at 1-866-314-2427. TTY users should call 1-888-205-7671. We are happy to take your calls from 24 hours a day, seven days a week. Instructions on how to apply for an exception or how to change your current prescription[s] are discussed at the end of the letter.

The following is an explanation of why your drug is not covered or is limited under <Plan Name>.
Name of Drug: <name of drug>
Date Filled: <date filled>