Model Notice of Inquiry

<Date>

<Enrollee Name> Enrollee ID Number: *<insert number>*
<Street Address>
<City, State Zip Code>

Dear *<insert enrollee name>*:

This letter is in response to your inquiry on *<insert date>*. You asked if *<insert name of drug>* is covered for you.

< Under section 1860D-2(e)(1) of the Social Security Act (the Act), certain drugs are not covered Part D drugs or are not covered Part D drugs when used to treat certain medical conditions.> **or** *<Under section 1860D-2(e)(2) of the Social Security Act (the Act), certain drugs are excluded from Medicare coverage or are excluded from coverage when used to treat certain medical conditions.>* **o**r *<Under section 1860D-43 of the Social Security Act (the Act), certain drugs are excluded from Medicare coverage if the manufacturer did not sign an agreement to participate in the Medicare Coverage Gap Discount Program.>*

<Insert name of drug> is one of the drugs that is *<not a covered Part D drug>* **or** *<excluded from Medicare coverage>* by law, and we do not offer the drug as a supplemental benefit.

[*If a drug is not a covered Part D drug or is excluded from coverage because of the indication, insert language explaining why the drug isn't covered and the indication(s) that the drug would be covered for.]*

You should work with your physician or other prescriber to determine if a drug on our list of covered drugs (our formulary) is medically appropriate for treating your condition.

[If the drug is excluded from coverage, insert the following language: <If you receive Medicaid, you may be able to obtain coverage for this drug under the Medicaid program. Check with your state Medicaid office.>]

If, after reading this letter, you think we made a mistake and *<insert name of drug>* is *<a covered Part D drug under section 1860D-2(e)(1) of the Act>* **or** *<not excluded under section 1860D-2(e)(2) of the Act>* **or** *<not excluded under section 1860D-43 of the Act>* or is covered by the plan as a supplemental benefit, you or your physician or other prescriber have the right to contact us and request a coverage determination. Contact us at the number below or refer to your evidence of coverage to find out how to ask us for a coverage determination.

If you have any questions, please contact Customer Services at *<toll-free number> <days and hours of operation>*. TTY/TDD users should call *<toll-free TTY number>*.

Thank you,

<Plan sponsor name>