

(2) The SEP ends on the last day of the eighth consecutive month during which the individual is at no time enrolled in a GHP or an LGHP by reason of current employment status.

(c) *Conditions for use of a SEP.*³ In order to use a SEP, the individual must meet the following conditions:

(1) When first eligible to enroll for premium hospital insurance under § 406.20(b) or (c), the individual was—

(i) Age 65 or over and covered under a GHP by reason of the current employment status of the individual or the individual's spouse;

(ii) Under age 65 and covered under an LGHP by reason of the current employment status of the individual or a member of the individual's family ; or

(iii) Under age 65 and covered under a GHP by reason of the current employment status of the individual or the individual's spouse.

(2) For all the months thereafter, the individual has maintained coverage either under hospital insurance or a GHP or LGHP.

(d) *Special rule: Additional SEPs.* (1) Generally, if an individual fails to enroll during any available SEP, he or she is not entitled to any additional SEPs.

(2) However, if an individual fails to enroll during a SEP, because coverage under the same or a different GHP or LGHP was restored before the end of that particular SEP, that failure to enroll does not preclude additional SEPs.

(e) *Effective date of coverage.* (1) If the individual enrolls in a month during any part of which he or she is covered under a GHP or LGHP on the basis of current employment status, or in the first full month when no longer so covered, coverage begins on the first day of the month of enrollment or, at the individual's option, on the first day of any of the three following months.

(2) If the individual enrolls in any month of the SEP other than the

months specified in paragraph (e)(1) of this section, coverage begins on the first day of the month following the month of enrollment.

[61 FR 40346, Aug. 2, 1996]

§ 406.25 Special enrollment period for volunteers outside the United States.

(a) *General rule.* A SEP, as defined in § 406.24(a)(4) of this subchapter, is provided for an individual that meets the following requirements:

(1) The individual is serving as a volunteer outside of the United States in a program that covers at least a 12-month period.

(2) The individual is in a program that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of Internal Revenue Code of 1986.

(3) The individual can demonstrate that he or she has health insurance that covers medical services that the individual receives outside the United States while serving in the program.

(4) The individual—

(i) At the time he or she first met the requirements of § 406.10 through 406.15 or § 406.20(b), elected not to enroll in premium hospital insurance during the individual's initial enrollment period; or

(ii) Terminated enrollment in premium hospital insurance during a month in which the individual met the requirements of this section for a SEP.

(b) *Duration of SEP.* The SEP is the 6-month period beginning on the first day of the month that includes the date that the individual no longer meets the requirements of paragraph (a) of this section.

(c) *Effective date of coverage.* Coverage under a SEP authorized by this section begins on the first day of the month following the month in which the individual enrolls.

[73 FR 36468, June 27, 2008]

§ 406.26 Enrollment under State buy-in.

(a) *Enrollment of QMBs under a State buy-in agreement—*(1) *Effective date.* Beginning with calendar year 1990, a State may request and be granted a modification of its buy-in agreement to

³Before August 10, 1993, an individual under age 65 could qualify for a SEP only if he or she had LGHP coverage as an "active individual", which the statute defined as "an employee, employer, self-employed individual (such as the employer), individual associated with the employer in a business relationship, or as a member of the family of any of those persons".

include enrollment and payment of Part A premiums for QMBs (as defined in section 1905(p)(1) of the Act) who can become entitled to Medicare Part A only by paying a premium.

(i) Any State that has a buy-in agreement in effect must participate in daily exchanges of enrollment data with CMS.

(ii) [Reserved]

(2) *Amount of premium.* Premiums paid under State buy-in are not subject to increase because of late enrollment or reenrollment.

(3) *Enrollment without discrimination.* A State that has a buy-in agreement in effect must enroll in premium health insurance any applicant who meets the eligibility requirement for the QMB eligibility group, with the State paying the premiums on the individual's behalf.

(b) *Beginning of coverage under buy-in.* The coverage period begins with the latest of the following:

(1) The third month following the month in which the agreement modification covering QMBs is effectuated.

(2) The first month in which the individual is entitled to premium hospital insurance under § 406.20(b) and has QMB status. Under a State buy-in agreement, as defined in § 407.40 of this subchapter, QMB-eligible individuals can enroll in premium hospital insurance at any time of the year, without regard to Medicare enrollment periods.

(3) The date specified in the agreement modification.

(c) *End of coverage under buy-in.* Buy-in coverage ends with the earlier of the following:

(1) *Death.* Coverage ends on the last day of the month in which the QMB dies.

(2) *Loss of QMB status.* If the individual loses eligibility for QMB status, coverage ends on the last day of the month in which CMS receives the State's notice of ineligibility.

(3) *Termination of buy-in agreement.* If the State's buy-in agreement is terminated, coverage ends on the last day of the last month for which the agreement is in effect.

(4) *Entitlement to premium-free Part A.* If the individual becomes entitled to premium-free Part A, buy-in coverage

ends on the last day of entitlement to premium Part A.

(d) *Continuation of coverage: Individual enrollment following termination of buy-in coverage—*(1) *Deemed enrollment.* If coverage under a buy-in agreement ends because the agreement is terminated or the individual loses QMB status, the individual—

(i) Is considered to have enrolled during his or her initial enrollment period; and

(ii) Is entitled to Part A benefits and liable for Part A premiums beginning with the first month for which he or she is no longer covered under the buy-in agreement.

(2) *Voluntary termination.* (i) An individual may voluntarily terminate entitlement acquired under paragraph (d)(1) of this section by filing, with SSA or CMS, a request for disenrollment.

(ii) Voluntary disenrollment is effective as follows:

(A) If the individual files a request within 30 days after the date of CMS's notice that buy-in coverage has ended, the individual's entitlement ends on the last day of the last month for which the State paid the premium.

(B) If the individual files the request more than 30 days but not more than 6 months after buy-in coverage ends, entitlement ends on the last day of the month in which the request is filed.

(C) If the individual files the request later than the 6th month after buy-in coverage ends, entitlement ends at the end of the month after the month in which request is filed.

[56 FR 38080, Aug. 12, 1991, as amended at 85 FR 25632, May 1, 2020; 87 FR 66504, Nov. 3, 2022]

§ 406.27 Special enrollment periods for exceptional conditions.

(a) *General rule.* Beginning January 1, 2023, in accordance with the Secretary's authority in sections 1837(m) and 1838(g) of the Act, the following SEPs, as defined under § 406.24(a)(4), are provided for individuals that missed a Medicare enrollment period, (as specified in § 406.21, § 406.24, or § 406.25), due to exceptional conditions as determined by the Secretary and established under paragraphs (b) through (f) of this