

disenrollment is the first day following the last day of the initial grace period.

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1543, Jan. 12, 2009; 75 FR 19816, Apr. 15, 2010; 76 FR 21570, Apr. 15, 2011; 79 FR 29962, May 23, 2014; 80 FR 7962, Feb. 12, 2015]

§ 423.46 Late enrollment penalty.

(a) *General.* A Part D eligible individual must pay the late penalty described under § 423.286(d)(3), except as described at § 423.780(e), if there is a continuous period of 63 days or longer at any time after the end of the individual's initial enrollment period during which the individual meets all of the following conditions:

(1) The individual was eligible to enroll in a Part D plan;

(2) The individual was not covered under any creditable prescription drug coverage; and

(3) The individual was not enrolled in a Part D plan.

(b) *Role of Part D plan in determination of the penalty.* Part D sponsors must obtain information on prior creditable coverage from all enrolled or enrolling beneficiaries and report this information to CMS in a form and manner determined by CMS.

(c) *Reconsideration.* Individuals determined to be subject to a late enrollment penalty may request reconsideration of this determination, consistent with § 423.56(g) of this part. Such review will be conducted by CMS, or an independent review entity contracted by CMS, in accordance with guidance issued by CMS. Decisions made through this review are not subject to appeal, but may be reviewed and revised at the discretion of CMS.

(d) *Record retention.* Part D plan sponsors must retain all information collected concerning a creditable coverage period determination in accordance with the enrollment records retention requirements described in § 423.505(e)(1)(iii).

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 54251, Sept. 18, 2008; 74 FR 1543, Jan. 12, 2009]

§ 423.48 Information about Part D.

Each Part D plan must provide, on an annual basis, and in a format and using standard terminology that CMS may specify in guidance, the information

necessary to enable CMS to provide to current and potential Part D eligible individuals the information they need to make informed decisions among the available choices for Part D coverage.

§ 423.56 Procedures to determine and document creditable status of prescription drug coverage.

(a) *Definition.* Creditable prescription drug coverage means any of the following types of coverage listed in paragraph (b) of this section only if the actuarial value of the coverage equals or exceeds the actuarial value of defined standard prescription drug coverage under Part D in effect at the start of such plan year, not taking into account the value of any discount or coverage provided during the coverage gap, and demonstrated through the use of generally accepted actuarial principles and in accordance with CMS guidelines.

(b) *Types of coverage.* The following coverage is considered creditable if it meets the definition provided in paragraph (a) of this section:

(1) Prescription drug coverage under a PDP or MA-PD plan.

(2) Medicaid coverage under title XIX of the Act or under a waiver under section 1115 of the Act.

(3) Coverage under a group health plan, including the Federal employees health benefits program, and qualified retiree prescription drug plans as defined in section 1860D-22(a)(2) of the Act.

(4) Coverage under State Pharmaceutical

Assistance Programs (SPAP) as defined at § 423.454.

(5) Coverage of prescription drugs for veterans, survivors and dependents under chapter 17 of title 38, U.S.C.

(6) Coverage under a Medicare supplemental policy (Medigap policy) as defined at § 403.205 of this chapter.

(7) Military coverage under chapter 55 of title 10,

U.S.C., including TRICARE.

(8) Individual health insurance coverage (as defined in section 2791(b)(5) of the Public Health Service Act) that includes coverage for outpatient prescription drugs and that does not meet the definition of an excepted benefit

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(as defined in section 2791(c) of the Public Health Service Act).

(9) Coverage provided by the medical care program of the Indian Health Service, Tribe or Tribal organization, or Urban Indian organization (I/T/U).

(10) Coverage provided by a PACE organization.

(11) Coverage provided by a cost-based HMO or CMP under part 417 of this chapter.

(12) Coverage provided through a State High-Risk Pool as defined under 42 CFR 146.113(a)(1)(vii).

(13) Other coverage as the Secretary may determine appropriate.

(c) *General disclosure requirements.* With the exception of PDPs and MA-PD plans under § 423.56(b)(1) and PACE or cost-based HMO or CMP that provide qualified prescription drug coverage under this Part, each entity that offers prescription drug coverage under any of the types described in § 423.56(b), must disclose to all Part D eligible individuals enrolled in or seeking to enroll in the coverage whether the coverage is creditable prescription drug coverage.

(d) *Disclosure of non-creditable coverage.* In the case that the coverage of the type described in § 423.56(b) is not creditable prescription drug, the disclosure described in paragraph (c) of this section to Part D eligible individuals must also include:

(1) The fact that the coverage is not creditable prescription drug coverage, as provided by CMS;

(2) That there are limitations on the periods in a year in which the individual may enroll in Part D plans; and

(3) That the individual may be subject to a late enrollment penalty, as described under § 423.46.

(e) *Disclosure to CMS.* With the exception of PDPs and MA-PD plans under § 423.56(b)(1) and PACE or cost-based HMO or CMP that provide qualified prescription drug coverage under this Part, all other entities listed under paragraph (b) of this section must disclose whether the coverage they provide is creditable prescription drug coverage to CMS in a form and manner described by CMS.

(f) *Notification content and timing requirements.* The disclosure notification to Part-D eligible individuals required

in § 423.56(c) and (d) must be provided in a form and manner prescribed by CMS. Notices must be provided, at minimum, at the following times:

(1) Prior to an individual's initial enrollment period for Part D, as described under § 423.38(a);

(2) Prior to the effective date of enrollment in the prescription drug coverage and upon any change that affects whether the coverage is creditable prescription drug coverage;

(3) Prior to the commencement of the Annual Coordinated Election Period as defined in § 423.38(b); and

(4) Upon request by the individual.

(g) *When an individual is not adequately informed of coverage.* If an individual establishes to CMS that he or she was not adequately informed that his or her prescription drug coverage was not creditable prescription drug coverage, the individual may apply to CMS to have the coverage treated as creditable prescription drug coverage for purposes of applying the late penalty described in § 423.46.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20505, Apr. 15, 2008; 77 FR 22168, Apr. 12, 2012]

Subpart C—Benefits and Beneficiary Protections

§ 423.100 Definitions.

As used in this part, unless otherwise specified—

Actual cost means the negotiated price for a covered Part D drug when the drug is purchased at a network pharmacy, and the usual and customary price when a beneficiary purchases the drug at an out-of-network pharmacy consistent with § 423.124(a).

Affected enrollee means a Part D enrollee who is currently taking a covered Part D drug that is either being removed from a Part D plan's formulary, or whose preferred or tiered cost-sharing status is changing and such drug removal or cost-sharing change affects the Part D enrollee's access to the drug during the current plan year.

Alternative prescription drug coverage means coverage of Part D drugs, other than standard prescription drug coverage that meets the requirements of