

need, age, or medical condition, and not based on current or former employment status.

(vi) Does not engage in midyear plan or noncalendar year plan enrollment changes on behalf of a substantial number of its members when authorized to do so on the beneficiary's behalf.

(2) *Use of a single card.* A card that is issued under § 423.120(c) for use under a Part D plan may also be used in connection with coverage of benefits provided under a SPAP and, in such a case, may contain an emblem or symbol indicating such connection.

(3) *Construction.* Nothing in this subpart requires a SPAP to coordinate with, or provide financial assistance to enrollees in, any Part D plan.

(f) *Coordination with other prescription drug coverage—(1) Definition of other prescription drug coverage.* Entities that provide other prescription drug coverage include any of the following:

(i) *Medicaid programs.* A State plan under title XIX of the Act, including such a plan operating under a waiver under section 1115 of the Act, if it meets the requirements of paragraph (e)(1)(ii) of this section.

(ii) Group health plans.

(iii) *FEHBP.* The Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code.

(iv) *Military coverage (including TRICARE).* Coverage under chapter 55 of title 10, United States Code.

(v) *Indian Health Service.* Coverage under Chapter 18 of title 28 of the United States Code.

(vi) *Federally qualified health centers.* Federally qualified health centers as defined under section 1861(aa)(4) of the Act.

(vii) *Rural health clinics.* Rural health clinics as defined under section 1861(aa)(2) of the Act.

(viii) Other Part D plans.

(ix) *Other prescription drug coverage.* Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Part D drugs on behalf of Part D eligible individuals as CMS may specify.

(2) *Treatment under out-of-pocket rule.*

(i) For purposes of determining whether a Part D plan enrollee has satisfied the out-of-pocket threshold provided

under § 423.104(d)(5)(iii), a Part D plan must do all of the following:

(A) Include the enrollee's incurred costs (as defined in § 423.100).

(B) Report, accept and apply benefit accumulator data in a timeframe and manner determined by CMS.

(C) Exclude expenditures for covered Part D drugs made by insurance or otherwise, a group health plan, or other third party payment arrangements, including expenditures by plans offering other prescription drug coverage.

(ii) A Part D enrollee must disclose all these expenditures to a Part D plan in accordance with requirements under § 423.32(b)(ii).

(3) *Imposition of fees.* A Part D sponsor may not impose fees on SPAPs and entities offering other prescription drug coverage that are unrelated to the cost of the coordination of benefits.

(4) *Authority to recover expenditures due to incorrect information on true out-of-pocket costs.* In the event that a Part D plan learns that it has made an erroneous payment due to inaccurate or incomplete information on the satisfaction of the out-of-pocket threshold under § 423.104(d)(5)(iii), that plan is authorized to recover such costs directly from the Part D enrollee on whose behalf the costs were incurred. A Part D enrollee must reimburse the Part D plan for payment made for these costs.

(5) *Plan-to-plan liability.* In the process of coordinating benefits between Part D plans when a Part D plan from which a beneficiary has transferred has incorrectly made payment for covered prescription drug costs incurred after the effective date of the Part D enrollee's enrollment in the new Part D plan of record, the new Part D plan of record must make the reconciling payments based on amounts reported to it by CMS without regard to the Part D plan's own formulary or drug utilization review edits.

(6) *Use of other reconciliation processes.* In the process of coordinating benefits between the correct Part D plan of record and another entity providing prescription drug coverage when that entity has incorrectly paid as primary payer for a covered Part D drug on behalf of a Part D enrollee, the correct Part D plan of record must achieve timely reconciliation through working