

(b) *Scope.* This part establishes standards for beneficiary eligibility, access, benefits, protections, and low-income subsidies in Part D, as well as establishes standards and sets forth requirements, limitations, procedures and payments for organizations participating in the Voluntary Medicare Prescription Drug Program.

§ 423.4 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial equivalence means a state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with section 1860D-11(c) of the Act and with CMS actuarial guidelines.

Brand name drug means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(c)), including an application referred to in section 505(b)(2) of the Federal Food, Drug and Cosmetic Act (21 USC 355(b)(2)).

Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursement contract under section 1876(h) of the Act.

Eligible fallback entity or fallback entity is defined at § 423.855.

Fallback prescription drug plan is defined at § 423.855.

Formulary means the entire list of Part D drugs covered by a Part D plan.

Full-benefit dual eligible individual has the meaning given the term at § 423.772, except where otherwise provided.

Generic drug means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

Group health plan is defined at § 423.882.

Insurance risk means, for a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitutions, nor does it include elements potentially in

the control of the pharmacy (for example, labor costs or productivity).

MA stands for Medicare Advantage, which refers to the program authorized under Part C of title XVIII of the Act.

MA plan has the meaning given the term in § 422.2 of this chapter.

MA-PD plan means an MA plan that provides qualified prescription drug coverage.

Medicare prescription drug account means the account created within the Federal Supplementary Medical Insurance Trust Fund for purposes of Medicare Part D.

Monthly beneficiary premium means the amount calculated under § 423.286 for Part D plans other than fallback prescription drug plans, and § 423.867(a) for fallback prescription drug plans.

PACE Plan means a plan offered by a PACE organization.

PACE organization is defined in § 460.6 of this chapter.

Part D eligible individual means an individual who meets the requirements at § 423.30(a).

Part D plan (or Medicare Part D plan) means a prescription drug plan, an MA-PD plan, a PACE Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

Part D plan sponsor or Part D sponsor refers to a PDP sponsor, MA organization offering a MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

PDP region means a prescription drug plan region as determined by CMS under § 423.112.

PDP sponsor means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part that apply to entities that offer prescription drug plans. This includes fallback entities.

Prescription drug plan or PDP means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in § 423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K of this part. This includes fallback prescription drug plans.

§ 423.6

Service area (Service area does not include facilities in which individuals are incarcerated.) means for—

(1) A prescription drug plan, an area established in § 423.112(a) within which access standards under § 423.120(a) are met;

(2) An MA-PD plan, an area that meets the definition of MA service area as described in § 422.2 of this chapter, and within which access standards under § 423.120(a) are met;

(3) A fallback prescription drug plan, the service area described in § 423.859(b);

(4) A PACE plan offering qualified prescription drug coverage, the service area described in § 460.22 of this chapter; and

(5) A cost plan offering qualified prescription drug coverage, the service area defined in § 417.1 of this chapter.

Subsidy-eligible individual means a full subsidy eligible individual (as defined at § 423.772) or other subsidy eligible individual (as defined at § 423.772).

Tiered cost-sharing means a process of grouping Part D drugs into different cost sharing levels within a Part D sponsor’s formulary.

§ 423.6 Cost-sharing in beneficiary education and enrollment-related costs.

The requirements of section 1857(e)(2) of the Act and § 422.6 of this chapter with regard to the payment of fees established by CMS for cost sharing of enrollment related costs apply to PDP sponsors under Part D.

Subpart B—Eligibility and Enrollment.

§ 423.30 Eligibility and enrollment.

(a) *General rule.* (1) An individual is eligible for Part D if he or she:

(i) Is entitled to Medicare benefits under Part A or enrolled in Medicare Part B; and

(ii) Lives in the service area of a Part D plan, as defined under § 423.4.

(2) Except as provided in paragraphs (b), (c), and (d) of this section, an individual is eligible to enroll in a PDP if:

(i) The individual is eligible for Part D in accordance with paragraph (a)(1) of this section;

(ii) The individual resides in the PDP’s service area; and

(iii) The individual is not enrolled in another Part D plan.

(3) Retroactive Part A or Part B determinations. Individuals who become entitled to Medicare Part A or enrolled in Medicare Part B for a retroactive effective date are Part D eligible as of the month in which a notice of entitlement Part A or enrollment in Part B is provided.

(b) *Coordination with MA plans.* A Part D eligible individual enrolled in a MA-PD plan must obtain qualified prescription drug coverage through that plan. MA enrollees are not eligible to enroll in a PDP, except as follows:

(1) A Part D eligible individual is eligible to enroll in a PDP if the individual is enrolled in a MA private fee-for-service plan (as defined in section 1859(b)(2) of the Act) that does not provide qualified prescription drug coverage; and

(2) A Part D eligible individual is eligible to enroll in a PDP if the individual is enrolled in a MSA plan (as defined in section 1859(b)(3) of the Act).

(c) *Enrollment in a PACE plan.* A Part D eligible individual enrolled in a PACE plan that offers qualified prescription drug coverage under this Part must obtain such coverage through that plan.

(d) *Enrollment in a cost-based HMO or CMP.* A Part D eligible individual enrolled in a cost-based HMO or CMP (as defined under part 417 of this chapter) that elects to receive qualified prescription drug coverage under such plan is ineligible to enroll in another Part D plan. A Part D eligible individual enrolled in a cost-based HMO or CMP offering qualified prescription drug coverage is eligible to enroll in a PDP if the individual does not elect to receive qualified prescription drug coverage under the cost-based HMO or CMP and otherwise meets the requirements of paragraph (a)(2) of this section.

§ 423.32 Enrollment process.

(a) *General rule.* A Part D eligible individual who wishes to enroll in a PDP may enroll during the enrollment periods specified in § 423.38, by filing the appropriate enrollment form with the