DISCLOSURE OF CREDITABLE COVERAGE TO MEDICARE PART D ELIGIBLE INDIVIDUALS GUIDANCE

I. INTRODUCTION

CMS issued General Creditable Coverage guidance in May 2005 and issued an updated version on May 15, 2006. This guidance supersedes the previous guidance issued in May 2005, May 15, 2006 and on February 15, 2007. The following changes are being made in section III entitled "Policy Guidance":

- Changes to the required data elements in the Model Personalized Disclosure Notice/Statement.

In addition to the May 2005, May 2006 and February 15, 2007 guidance, CMS issued guidance on the Disclosure to CMS requirements along with the Disclosure to CMS form in January 2006 and posted the Disclosure to CMS Form Instructions and Screen Shots on September 25, 2007. The Disclosure to CMS guidance, instructions and on-line form can be found on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

Disclosure of Creditable Coverage Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. (*See* Part D of Title XVIII of the Social Security Act (Act), referred to here as "Part D" of Medicare.) Prescription drug coverage under Medicare became available starting January 1, 2006.

Regulations to implement Medicare prescription drug coverage were published January 28, 2005 (70 Fed. Reg. 4193). This guidance pertains to section 1860D-13 of the Act, and 42 CFR §423.56. Under those provisions, most entities that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the entity's coverage is "creditable prescription drug coverage" (Disclosure Notice). A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Health plans and other entities that must comply with these provisions are listed in 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/creditablecoverage. However, entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement. Thus, for example, an employer or union that provides prescription drug coverage to retirees through a Part D plan is exempt from the disclosure requirement. *See* 42 CFR §423.56(c).

Disclosure of whether prescription drug coverage is creditable provides Medicare beneficiaries with important information relating to their Medicare Part D enrollment. Beneficiaries who are not covered under creditable prescription drug coverage and who choose not to enroll before the end of their initial enrollment period for Part D may pay a higher premium on a permanent basis if they subsequently enroll in a Part D drug plan.

42 CFR §423.56 establishes certain requirements regarding Disclosure Notices, including rules regarding timing and general content requirements. This guidance provides additional information concerning those rules, including the form and manner of providing Disclosure Notices. It also addresses several principles relating to the determination of creditable coverage.

II. OVERVIEW OF REGULATORY REQUIREMENTS

Disclosure to CMS

42 CFR §423.56(e) requires all entities described in 42 CFR §423.56(b) to disclose to CMS whether their prescription drug coverage is creditable or non-creditable. The disclosure must be made to CMS on an annual basis, and upon any change that affects whether the coverage is creditable. CMS posted guidance on the timing, format, and the Disclosure to CMS Form on January 4, 2006 and published the Disclosure to CMS Form Instructions and Screen Shots on September 25, 2007. The Disclosure to CMS guidance, instructions and Disclosure to CMS form can be found on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

Disclosure to Medicare Part D Eligible Individuals

The Disclosure Notice must be provided to all Part D eligible individuals who are covered under, or who apply for, the entity's prescription drug coverage. Neither the statute nor the regulations create any exemption based on whether prescription drug coverage is primary or secondary coverage to Medicare Part D. Thus, for example, the Disclosure Notice requirement applies with respect to Medicare beneficiaries who are active employees, disabled, on COBRA, and are retired, as well as Medicare beneficiaries who are covered as spouses or dependents (including those spouses or dependents that may be disabled or on COBRA) under active employee coverage and retiree coverage.

While the entity that provides the coverage is responsible for providing the notice, nothing in the regulation prevents that entity from arranging to have it provided by a third party.

Part D eligible individuals - An individual is a Part D eligible individual if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B; and

2. The individual resides in the service area of a prescription drug plan (PDP) or of a Medicare Advantage plan that provides prescription drug coverage (MA-PD). (For purposes of the Part D regulations, an individual who is living abroad or is incarcerated is not eligible for Part D because he or she is not considered to "reside" in the service area of a Part D plan.)

NOTE: In general; an individual becomes "entitled to" Medicare Part A when the person actually has Part A coverage, and not simply when the person is first eligible. A person has Part A coverage without being subject to monthly Part A premiums if the person has attained age 65 and has monthly social security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability. An individual who is eligible for social security benefits but has not applied for such benefits becomes entitled to Medicare Part A only upon the filing of an application for Part A benefits.

Information about Medicare Part A and Part B eligibility and enrollment is provided in the CMS publication "Medicare & You" (publication number 10050). This publication is available on line at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf. Medicare beneficiaries should be directed to their local Social Security (or Railroad Retirement) office for questions about when and how to enroll in Medicare.

Enrollment in Part D

The MMA established an Initial Enrollment Period (IEP) for Part D for all Medicare beneficiaries that began on November 15, 2005 and extended through May 15, 2006. After May 15, 2006, the Initial Enrollment Period for Part D is concurrent with the individual's IEP for Part B which is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements for Parts A & B and ends 3 months after the month of first eligibility.

If, by the end of an individual's Initial Enrollment Period for Part D, the individual has not enrolled in a Medicare prescription drug plan and does not have creditable prescription drug coverage for any continuous period of 63 days or longer following the end of the IEP, the individual may have to pay a higher premium charge for late enrollment.

As stated in 42 CFR §423.56(a)(3)(iii), an individual who becomes entitled to Medicare Part A or enrolled in part B for a retroactive effective date has an initial enrollment beginning with the month in which notification of the Medicare determination is received and ending on the last day of the third month following the month in which the notification was received.

Late Enrollment Penalty (Also referred to as "Higher Premium Charge")

42 CFR §423.46 provides for a late enrollment penalty for Part D eligible individuals who enroll in a Part D drug plan after experiencing a lapse in creditable prescription drug coverage for any continuous period of sixty-three (63) days or longer after the end of their initial Part D enrollment period. The higher premium charge is based on the number of months that the individual did not have creditable coverage. The premium that would otherwise apply is increased by at least 1% of the base beneficiary premium (which is set by CMS and published each year) for each month without creditable coverage. This penalty may apply for as long as the individual remains enrolled in Part D. The individual's higher premium charge will be recalculated each year, because the base beneficiary premium changes annually.

Part D eligible individuals who remain covered under a prescription drug plan that is providing creditable prescription drug coverage will not be assessed a late enrollment penalty if they enroll in Medicare prescription drug coverage within the required time frames at a later date. Individuals who involuntarily lose creditable prescription drug coverage will have a sixty (60) day Special Enrollment Period (SEP) to enroll in a Part D plan. However, they may be assessed a late enrollment penalty if they choose to drop coverage, or lose coverage, and do not promptly take advantage of the resulting Special Enrollment Period. If they go without any creditable coverage for a continuous period of 63 days or longer they may be subject to a late enrollment penalty.

Medicare eligible individuals that delay enrolling in Part D coverage may be required to provide proof that they have maintained creditable prescription drug coverage since the end of their initial enrollment period for Part D. Otherwise, the individual may be subject to the late enrollment penalty. Proof of creditable coverage prescription drug coverage can include, but is not limited to: copies of any disclosure notices provided to them by any entity(s) that provided prescription drug coverage.

Generally, Part D eligible individuals, who are covered under a prescription drug plan that is not creditable prescription drug coverage, need to enroll in a Part D plan during their Initial Enrollment Period for Part D if they do not want to be subject to a late enrollment penalty when they enroll in a Medicare drug plan at a later time. There are limited times each year in which beneficiaries can enroll (including the Annual Coordinated Election Period from November 15th to December 31st each year), and if they do not enroll during their initial open enrollment period, they may pay a late enrollment penalty if they choose to join at a later time.

DISCLAIMER: The above information regarding late enrollment penalties under Medicare is intended to give entities general information regarding the provisions contained in the regulation at 42 CFR §423.46 and §423.286 (c)(3) and in 70 Fed. Reg. 13397, 13399 (March 21, 2005).

Creditable Coverage Definition and Determination

As defined in 42 CFR §423.56(a), coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

This determination is identical to the first prong of the actuarial equivalence test (gross test) that is applied in 42 CFR §423.884 when an employer or union applies for the retiree drug subsidy under that section. It does not take into account whether or to what degree the coverage is financed by the individual or entity.

For plans that have multiple benefit options, the regulation requires that entities apply the actuarial value test separately for each benefit option. A benefit option is defined in 42 CFR §§423.882 as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

III. POLICY GUIDANCE

The following are clarifications and other guidance relating to the above requirements:

Attestation

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the entity is an employer or union electing the retiree drug subsidy. *See* 42 CFR §423.884(d).

Benefit Designs for Simplified Determination of Creditable Coverage Status

If an entity is not an employer or union that is applying for the retiree drug subsidy, it can use the simplified determination of creditable coverage status annually to determine whether its prescription drug plan coverage is creditable or not. The plan will be determined to be creditable if the prescription drug plan design meets all four of the standards set forth below. However, the standards listed under 4(a) and 4(b) below may not be used if the entity's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e., medical, dental, etc.). Integrated plans must satisfy the standard in 4(c).

A prescription drug plan is deemed to be creditable if it:

1. Provides coverage for brand and generic prescriptions;
2. Provides reasonable access to retail providers;
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
4. Satisfies at least one of the following:

    a. The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    b. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    c. For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

Integrated Plan - An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

1. a combined plan year deductible for all benefits under the plan,
2. a combined annual benefit maximum for all benefits under the plan, and/or
3. a combined lifetime benefit maximum for all benefits under the plan.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet steps 1, 2, 3 and 4(c) of the simplified method If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet steps 1, 2, 3 and either 4(a) or 4(b).

NOTE: If the entity cannot use the Simplified Determination method stated above to determine the creditable coverage status of the prescription drug plan offered to Medicare eligible individuals, then the entity must make an actuarial determination annually of whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

Content of Creditable/Non-Creditable Coverage Disclosures from Entity to Beneficiaries.

CMS has provided model/sample language that entities can (but are not required to) use when disclosing creditable coverage status to beneficiaries. CMS issued initial Model Disclosure Notices in May 2005 to be used for the period of November 15, 2005 through May 14, 2006. Model Creditable and Non-Creditable

disclosure notice language that entities can use for annual disclosure to new plan enrollees (those with Part D Initial Enrollment Periods on or after May 15, 2006), for use upon request by a Medicare eligible individual, and for use in future plan years have been posted on the CMS website at http://www.cms.hhs.gov/creditablecoverage.

CMS recommends that entities complete the personalized box on of the Model Creditable and Non-Creditable Disclosure Notice if an individual requests a copy of a disclosure notice. Individuals may submit a copy of a personalized disclosure notice as proof of prior creditable coverage when enrolling in a Part D plan. If the entity chooses to not use the Model Disclosure Notices, they can provide a personalized statement of creditable coverage which contains all of the following elements:

- individual's first and last name;
- individual's date of birth or unique member identification number;
- entity name and contact information;
- statement that the entity's plan was determined by the entity to be creditable or non-creditable coverage; and
- The date ranges of creditable coverage.

ENTITIES THAT CHOOSE NOT TO USE THE MODEL/SAMPLE DISCLOSURE NOTICE LANGUAGE MUST PROVIDE DISCLOSURE NOTICES THAT MEET THE FOLLOWING CONTENT STANDARDS:

Content of Coverage Disclosures from Entity to Beneficiaries – Creditable Coverage

If the prescription drug coverage offered by the entity is determined to be Creditable Coverage, a disclosure notice will be considered to meet these requirements if it addresses the following information elements:

1. That the entity has determined that the prescription drug coverage it provides is creditable;
2. The meaning of creditable coverage, i.e., that the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan in the applicable year for which the disclosure notice is being provided is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average; and
3. An explanation of why creditable coverage is important and a caution that even though coverage is creditable, the person could be subject to payment of higher Part D premiums if the person subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.

CMS recommends that the entities also provide the following clarifications in their disclosure statements:

- An explanation of an individual's rights to a notice, i.e., the times when an individual can expect to receive a notice and the times that an individual can request a copy of the notice.

- An explanation of the benefit plan provisions/options that affect Part D eligible individuals (or their dependents) that are related to Part D and their benefit plan. These options may include, for example:
  - that they can retain their existing coverage and choose not to enroll in a Part D plan; or
  - that they can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.
  - if their existing prescription drug coverage is under a Medigap policy, that they cannot have both their existing prescription drug coverage and Part D coverage, and that if they enroll in Part D coverage, they should inform their Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

    Recommended CMS language insert for Medigap insurers:

    If you decide you do not want to enroll in one of the new plans that provide Medicare prescription drug coverage, you can keep your current Medigap policy without changes. However, you cannot have prescription drug benefits from both a Medigap policy with [Name of Entity] and a Medicare prescription drug plan at the same time. So if you enroll in one of the plans that provide Medicare prescription drug coverage and wish to keep your Medigap policy, please let us know as soon as possible. Federal law requires us to remove the prescription drug benefit from your Medigap policy and your premium will be adjusted.

    If you choose to get your Medicare prescription drug coverage through a Medicare Advantage plan, which is a company such as an HMO that contracts with the federal government to provide your Medicare benefits, you may decide it is best for you to cancel your Medigap policy with [Name of Entity]. This is because a Medigap policy can't work with a Medicare Advantage plan.

    In making your decision about what to do, please keep in mind that recent changes in law require us to make certain changes to our Medigap plans. These changes will have an effect on future premiums, especially for policies with drug benefits. Please contact us so we can discuss the likely differences in premiums over time among your different choices.

- Whether the covered individuals and/or their covered dependents will still be eligible to receive all of their current health coverage if they or their dependents enroll in a Medicare prescription drug plan.

Recommended CMS language:

Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will [or will not] still be eligible to receive all of your current health and prescription drug benefits.

- A clarification of the circumstances (if any) under which the individual could re-enroll in his/her prescription drug coverage if they drop their current coverage and enroll in Medicare prescription drug coverage and later drop the Medicare coverage. (For Medigap insurers, a clarification that the individual cannot get his/her prescription drug coverage back under such circumstances).

  Recommended CMS language- Non-Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may (or may not) enroll back into the [Name of Entity] benefit plan during an open enrollment period under the [Name of Entity] benefit plan.

  Recommended CMS language- Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you cannot get back the prescription drug benefits in the [Name of Entity] Medigap policy.

- Information on how to get extra help paying for a Medicare prescription drug plan including the contact information for the Social Security Administration (SSA).

  Recommended CMS language:

  For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Content of Coverage Disclosures from Entity to Beneficiaries – Non-Creditable Coverage

If the prescription drug coverage offered by the entity is determined to be Non-Creditable Coverage, the disclosure notice to the individual a disclosure notice will be considered to meet these requirements if it addresses the following information elements in its Non-Creditable Coverage Disclosure Statement:

1. That the entity has determined that the prescription drug coverage it provides is not creditable;
2. The meaning of creditable coverage, i.e., that the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan in the applicable year is less than what standard Medicare prescription drug coverage would be expected to pay on average;
3. That an individual generally may only enroll in a Part D plan from November 15th through December 31st of each year; and
4. An explanation of why creditable coverage is important and that the individual may be subject to payment of higher Part D premiums if the person fails to enroll in a Part D plan when first eligible.

CMS recommends that the entities also provide the following clarifications in their disclosure statements:

- An explanation of an individual's rights to a notice, i.e., the times when a individual can expect to receive a notice and the times that an individual can request a copy of the notice.

- An explanation of the benefit plan provisions/options that affect Part D eligible individuals (or their dependents) that are related to Part D and their benefit plan. These options may include, for example:
- that they can retain their existing coverage and choose not to enroll in a Part D plan; or
- that they can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.
- if their existing prescription drug coverage is under a Medigap policy, that they cannot have both their existing prescription drug coverage and Part D coverage, and that if they enroll in Part D coverage, they should inform their Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium, as of the date the Part D coverage starts.

Recommended CMS language insert for Medigap insurers:

If you decide you do not want to enroll in one of the new plans that provide Medicare prescription drug coverage, you can keep your current Medigap policy with [Name of Entity] without changes. However, you cannot have prescription drug benefits from both a Medigap policy and a Medicare prescription drug plan at the same time. So if you enroll in one of the plans that provide Medicare prescription drug coverage and wish to keep your Medigap policy, please let us know as soon as possible. Federal law requires us to remove the prescription drug benefit from your Medigap policy and your premium will be adjusted.

If you choose to get your Medicare prescription drug coverage through a Medicare Advantage plan, which is a company such as an HMO that contracts with the federal government to provide your Medicare benefits, you may decide it

is best for you to cancel your Medigap policy with [Name of Entity]. This is because a Medigap policy can't work with a Medicare Advantage plan.

In making your decision about what to do, please keep in mind that recent changes in law require us to make certain changes to our Medigap plans. These changes will have an effect on future premiums, especially for policies with drug benefits. Please contact us so we can discuss the likely differences in premiums over time among your different choices.

- Whether the covered individuals and/or their covered dependents will still be eligible to receive all of their current health coverage if they or their dependents enroll in a Medicare prescription drug plan.

  Recommended CMS language:

  Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will [or will not] still be eligible to receive all of your current health and prescription drug benefits.

- A clarification of the circumstances (if any) under which the individual could re-enroll in his/her prescription drug coverage if they drop their current coverage and enroll in Medicare prescription drug coverage. (For Medigap insurers, a clarification that the individual cannot get his/her prescription drug coverage back under such circumstances).

  Recommended CMS language- Non-Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may (or may not) enroll back into the [Name of Entity] benefit plan during the open enrollment period under the [Name of Entity] benefit plan.

  Recommended CMS language- Medigap Issuers:

  If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you cannot get back the prescription drug benefits in the [Name of Entity] Medigap policy.

- Information on how to get extra help paying for a Medicare prescription drug plan including the contact information for the Social Security Administration (SSA).

  Recommended CMS language:

  For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For

more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Alternative Form and Manner of Coverage Disclosure from Entity to Beneficiaries

This guidance clarifies that entities have flexibility in the form and manner of providing Disclosure Notices to beneficiaries. The notice need not be sent as a separate mailing. The Disclosure Notice may be provided with other plan participant information materials (including enrollment and/or renewal materials). The entity may provide a single disclosure notice to the covered Medicare individual and all his/her Medicare eligible dependent(s) covered under the same plan. However, the entity is required to provide a separate disclosure notice if it is known that any spouse or dependent that is Medicare eligible resides at a different address than from where the participant/policyholder materials were provided.

Plan Sponsors may use the electronic disclosure requirements outlined at 29 CFR §2520.104b-1(c)(1) to meet the creditable coverage disclosure requirements under 42 CFR §423.56(c). These requirements allow the entity sponsoring a group health plan to provide a creditable coverage disclosure notice electronically to plan participants who have the ability to access electronic documents at their regular place of work if they have access to the plan sponsor's electronic information system on a daily basis as part of their work duties. If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

An entity can also provide a Disclosure Notice through electronic means to retirees only if the Medicare eligible individual has indicated to the entity that s/he has adequate access to electronic information. An entity must not take the right to provide materials to an individual via electronic means as a permissible way to deliver documents to all individuals. Before individuals agree to receive their information via electronic means, they must be informed of their right to obtain a paper version, how to withdraw their consent, how to update address information, and be advised of any hardware or software requirements needed to access and retain the creditable coverage disclosure.

If the individual consents to an electronic transfer of the notice, a valid e-mail address must be provided to the entity and the consent from the individual must be submitted electronically to the entity. This ensures the individual's ability to access the information as well as ensures that the system for furnishing these documents results in actual receipt. In addition to having the disclosure notice sent to the individual's email address, the notice (except for personalized notices) must be posted on the entity's website, if applicable, with a link on the entity's home page to the creditable coverage disclosure notice.

If entities choose to incorporate disclosures with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure notice portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page of the provided plan participant information.

Example of reference to creditable or non-creditable coverage requirements:

> ***If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details.***

Timing of Creditable Coverage Disclosure from Entity to Beneficiaries

42 CFR §423.56(f) specifies the times when creditable coverage disclosures must be made to Part D eligible individuals. At a minimum, disclosure must be made at the following times:

1. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) – beginning November 15th through December 31st of each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D, as described under §423.38(a);
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. Upon request by the individual.[1]

If the creditable coverage disclosure notice is provided to all plan participants annually, prior to November 15th of each year, CMS will consider items 1 and 2 to be met.

This guidance clarifies that "prior to" means that the individual must have been provided the Disclosure Notice within the past twelve months.

[1] Unlike some entities such as group health plans, Medigap issuers do not cover individuals until **after** they are enrolled in Medicare. Moreover, as of January 1, 2006, Medigap issuers cannot offer for sale any policies with prescription drug coverage. Therefore, only situations 1, 4 and 5 apply to Medigap issuers.

III CONTACT FOR FURTHER INFORMATION

If you would like further information on creditable coverage, visit the CMS website link related to creditable coverage issues at:
http://www.cms.hhs.gov/creditablecoverage

IV. LINK TO THE MODEL CREDITABLE, NON-CREDITABLE AND PERSONALIZED CREDITABLE COVERAGE DISCLOSURE NOTICES TO BE USED ON OR AFTER JANUARY 1, 2009

- **Model Individual Creditable Coverage Disclosure Notice**
- **Model Individual Creditable Coverage Disclosure Notice – Spanish**
- **Model Individual Non-Creditable Coverage Disclosure Notice**
- **Model Individual Non-Creditable Coverage Disclosure Notice – Spanish**

http://www.cms.hhs.gov/creditablecoverage