

§ 422.101

M+C organizations may directly access (through self-referral) screening mammography and influenza vaccine.

(2) M+C organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine on their M+C plan enrollees.

(i) *Requirements relating to Medicare conditions of participation.* Basic benefits must be furnished through providers meeting the requirements in § 422.204(b)(3).

(j) *Provider networks.* The M+C plans offered by an M+C organization may share a provider network as long as each M+C plan independently meets the access and availability standards described at § 422.112, as determined by CMS.

[65 FR 40319, June 29, 2000, as amended at 67 FR 13288, Mar. 22, 2002]

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.264 (for entitlement that begins or ends during a hospital stay) and § 422.266 (with respect to hospice care), each M+C organization must meet the following requirements:

(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) CMS's national coverage determinations;

(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by operational policy letters or regulations in this part; and

(3) Written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the M+C plan.

[65 FR 40319, June 29, 2000]

42 CFR Ch. IV (10–1–02 Edition)

§ 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.*

(1) Subject to CMS's approval, an M+C organization may require Medicare enrollees of an M+C plan other than an MSA plan to accept and pay for services in addition to Medicare-covered services described in § 422.101 and additional benefits described in § 422.312.

(2) If the M+C organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the M+C plan.

(3) CMS approves mandatory supplemental benefits if the benefits are designed in accordance with CMS's guidelines and requirements as stated in this part and instructions and operational policy letters.

(b) *Optional supplemental benefits.* Except as provided in § 422.104 in the case of MSA plans, each M+C organization may offer (for election by the enrollee and without regard to health status) services that are not included in the basic benefits as described in § 422.100(c) and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits are purchased at the discretion of the enrollee and must be offered to all Medicare beneficiaries enrolled in the M+C plan.

(c) *Payment for supplemental services.* All supplemental benefits are paid for in full, directly by (or on behalf of) the enrollee of the M+C plan.

(d) *Marketing of supplemental benefits.* M+C organizations may offer enrollees a group of services as one optional supplemental benefit, offer services individually, or offer a combination of groups and individual services.

[65 FR 40320, June 29, 2000]

§ 422.103 Benefits under an M+C MSA plan.

(a) *General rule.* An M+C organization offering an M+C MSA plan must make available to an enrollee, or provide reimbursement for, at least the services described under in § 422.101 after the enrollee incurs countable expenses equal to the amount of the plan's annual deductible.

(b) *Countable expenses.* An M+C organization offering an M+C MSA plan