

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(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by operational policy letters or regulations in this part; and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

must count toward the annual deductible at least all amounts that would be paid for the particular service under original Medicare, including amounts that would be paid by the enrollee as deductibles or coinsurance.

(c) *Services after the deductible.* For services received by the enrollee after the annual deductible is satisfied, an M+C organization offering an M+C MSA plan must pay, at a minimum, the lesser of the following amounts:

(1) 100 percent of the expense of the services.

(2) 100 percent of the amounts that would have been paid for the services under original Medicare, including amounts that would be paid by the enrollee as deductibles and coinsurance.

(d) *Annual deductible.* The annual deductible for an M+C MSA plan—

(1) For contract year 1999, may not exceed \$6,000; and

(2) For subsequent contract years may not exceed the deductible for the preceding contract year, increased by the national per capita growth percentage determined under § 422.252(b).

§ 422.104 Special rules on supplemental benefits for M+C MSA plans.

(a) An M+C organization offering an M+C MSA plan may not provide supplemental benefits that cover expenses that count towards the deductible specified in § 422.103(d).

(b) In applying the limitation of paragraph (a) of this section, the following kinds of policies are not considered as covering the deductible:

(1) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) A policy of insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to use or ownership of property, and any other similar liabilities that CMS may specify by regulation.

(3) A policy of insurance that provides coverage for a specified disease or illness or pays a fixed amount per day (or other period) of hospitalization.

§ 422.105 Special rules for point of service option.

(a) *General rule.* A POS benefit is an option that an M+C organization may offer in an M+C coordinated care plan or network M+C MSA plan to provide enrollees with additional choice in obtaining specified health care services. The organization may offer a POS option—

(1) Under a coordinated care plan only as an additional benefit as described in § 422.312;

(2) Under a coordinated care plan only as a mandatory supplemental benefit as described in § 422.102(a); or

(3) Under a coordinated care plan or network MSA plan as an optional supplemental benefit as described in § 422.102(b).

(b) *Approval required.* An M+C organization may not implement a POS benefit until it has been approved by CMS.

(c) *Ensuring availability and continuity of care.* An M+C network plan that includes a POS benefit must continue to provide all benefits and ensure access as required under this subpart.

(d) *Enrollee information and disclosure.* The disclosure requirements specified in § 422.111 apply in addition to the following requirements:

(1) *Written rules.* M+C organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) *Evidence of coverage document.* The M+C organization must provide to beneficiaries enrolling in a plan with a POS benefit an “evidence of coverage” document, or otherwise provide written documentation, that specifies all costs and possible financial risks to the enrollee, including—

(i) Any premiums and cost-sharing for which the enrollee is responsible;

(ii) Annual limits on benefits and on out-of-pocket expenditures;

(iii) Potential financial responsibility for services for which the plan denies payment because they were not covered under the POS benefit, or exceeded the dollar limit for the benefit; and

(iv) The annual maximum out-of-pocket expense an enrollee could incur.