

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.

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(e) *Prompt payment.* Health benefits payable under the POS benefit are subject to the prompt payment requirements in § 422.520.

(f) *POS-related data.* An M+C organization that offers a POS benefit through an M+C plan must report enrollee utilization data at the plan level by both plan contracting providers (in-network) and by non-contracting providers (out-of-network) including enrollee use of the POS benefit, in the form and manner prescribed by CMS.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000]

§ 422.106 Coordination of benefits with employer group health plans and Medicaid.

(a) *General rule.* If an M+C organization contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP or Medicaid benefits supplementing the M+C plan benefits. Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the M+C program apply to the M+C plan coverage provided to enrollees eligible for benefits under an EGHP or Medicaid contract.

(2) Employer benefits that complement an M+C plan, and the marketing materials associated with the benefits, are not subject to review or approval by CMS. M+C plan benefits provided to members of the EGHP, and the associated marketing materials, are subject to CMS review and approval.

(3) Medicaid benefits are not reviewed under this part, but are subject to appropriate CMS review under the Medicaid program. M+C plan benefits provided to individuals entitled to Medicaid benefits provided by the M+C organization under a contract with the State Medicaid agency are subject to M+C rules and requirements.

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(b) *Examples.* Employer/Medicaid benefits, permissible EGHP or Medicaid plan benefits include the following:

(1) Payment of a portion or all of the M+C basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the M+C plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

[65 FR 40320, June 29, 2000]

§ 422.108 Medicare secondary payer (MSP) procedures.

(a) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the M+C organization.* The M+C organization must, for each M+C plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Collecting from other entities.* The M+C organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the