

(vi) Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the materials have the concurrence of all MA organizations involved and have received prior approval by CMS. Physicians or providers may distribute health plan brochures (exclusive of application forms) at a health fair or in their offices. Physicians may discuss, in response to an individual patient's inquiry, the various benefits in different health plans.

(vii) Accept plan applications in provider offices or other places where health care is delivered.

(viii) Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to MA plan names in effect on July 31, 2000.

(ix) Engage in any other marketing activity prohibited by CMS in its marketing guidance.

(2) In its marketing, the MA organization must:

(i) Demonstrate to CMS's satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(ii) Establish and maintain a system for confirming that enrolled beneficiaries have in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(f) *Employer group retiree marketing.* MA organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the MA organization, and furnish these materials only to the group members. While the materials must be submitted for approval under paragraph (a) of this section, CMS will not review portions of these materials that relate to employer group benefits.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4719, Jan. 28, 2005]

Subpart C—Benefits and Beneficiary Protections

SOURCE: 63 FR 35077, June 26, 1998, unless otherwise noted.

§ 422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an MA organization offering an MA plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c) of this section (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An MA organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide services covered by the MA plan:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in § 422.113.

(ii) Emergency and urgently needed services as provided in § 422.113.

(iii) Maintenance and post-stabilization care services as provided in § 422.113.

(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(v) Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

(2) An MA plan (and an MA MSA plan, after the annual deductible in § 422.103(d) has been met) offered by an MA organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that MA plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

(c) *Types of benefits.* An MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.

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(1) Basic benefits are all Medicare-covered services, except hospice services.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits are services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

(ii) Optional supplemental benefits are health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

(d) *Availability and structure of plans.* An MA organization offering an MA plan must offer it—

(1) To all Medicare beneficiaries residing in the service area of the MA plan;

(2) At a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.262(c)(2).

(e) *Multiple plans in one service area.* An MA organization may offer more than one MA plan in the same service area subject to the conditions and limitations set forth in this subpart for each MA plan.

(f) *CMS review and approval of MA benefits.* CMS reviews and approves MA benefits using written policy guidelines and requirements in this part and other CMS instructions to ensure that—

(1) Medicare-covered services meet CMS fee-for-service guidelines;

(2) MA organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services; and

(3) Benefit design meets other MA program requirements.

(g) *Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine.* (1) Enrollees of MA organizations may directly access

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(through self-referral) screening mammography and influenza vaccine.

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

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

(i) *Provider networks.* The MA plans offered by an MA organization may share a provider network as long as each MA 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; 70 FR 4719, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.318 (for entitlement that begins or ends during a hospital stay) and § 422.320 (with respect to hospice care), each MA 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 regulations in this part or related instructions; and

(3) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan. If an MA plan covers geographic areas encompassing more than one local coverage policy area, the MA organization offering