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.

(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 and associated cost sharing. CMS reviews and approves MA benefits and associated cost sharing using written policy guidelines and requirements in this part and other CMS instructions to ensure all of the following:

(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.

(4) Except as provided in paragraph (f)(5), MA local plans (as defined in §422.2) must have an out-of-pocket maximum for Medicare Parts A and B services that is no greater than the annual limit set by CMS.

(5) With respect to a local PPO plan, the limit specified under paragraph (f)(4) applies only to use of network providers. Such local PPO plans must include a total catastrophic limit on beneficiary out-of-pocket expenditures for both in-network and out-of-network Parts A and B services that is—

(i) Consistent with the requirements applicable to MA regional plans at §422.101(d)(3) of this part; and

(ii) Not greater than the annual limit set by CMS.

(6) Cost sharing for Medicare Part A and B services specified by CMS does not exceed levels annually determined by CMS to be discriminatory for such services.

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