in addition to Medicare-covered services described in §422.101.

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

(3) CMS approves mandatory supplemental benefits if the benefits are designed in accordance with CMS’ guidelines and requirements as stated in this part and other written instructions.

(4) Beginning in 2006, an MA plan may reduce cost sharing below the actuarial value specified in section 1854(e)(4)(A) of the Act only as a mandatory supplemental benefit.

(b) Optional supplemental benefits. Except as provided in §422.104 in the case of MSA plans, each MA 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 MA plan.

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

(d) Marketing of supplemental benefits. MA 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.

§422.104 Special rules on supplemental benefits for MA MSA plans.

(a) An MA organization offering an MA 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 self-referral and point of service option.

(a) Self-referral. When an MA plan member receives an item or service of the plan that is covered upon referral or pre-authorization from a contracted provider of that plan, the member cannot be financially liable for more than the normal in-plan cost sharing, if the member correctly identified himself or herself as a member of that plan to the contracted provider before receiving the covered item or service, unless the contracted provider can show that the enrollee was notified prior to receiving the item or service that the item or service is covered only if further action is taken by the enrollee.

(b) Point of service option. As a general rule, a POS benefit is an option that an MA organization may offer in an HMO plan to provide enrollees with additional choice in obtaining specified health care services. The organization may offer a POS option—

(1) Before January 1, 2006, under a coordinated care plan as an additional benefit as described in §422.102(a); or

(2) Under an HMO plan as a mandatory supplemental benefit as described in §422.102(a); or

(3) Under an HMO plan as an optional supplemental benefit as described in §422.102(b).

(c) Ensuring availability and continuity of care. An MA HMO 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. MA organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) Evidence of coverage document. The MA organization must provide 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.

(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 MA organization that offers a POS benefit through an HMO 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.

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

(a) General rule. If an MA organization contracts with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations that cover enrollees in an MA 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 MA plan, the enrollees must be provided the same benefits as all other enrollees in the MA plan, with the employer, labor organization, fund trustees, or Medicaid benefits supplementing the MA plan benefits.