

§ 417.434

42 CFR Ch. IV (10–1–23 Edition)

a Medicare enrollee of the HMO or CMP:

(1) At least 30, but no earlier than 90, days before the enrollee—

(i) Attains age 65; or

(ii) Reaches his or her 25th month of entitlement to social security disability benefits under title II of the Act or railroad retirement disability benefits under section 7(d) of the Railroad Retirement Act of 1974.

(2) Within 30 days after the enrollee initiates a course of renal dialysis, or on or before the day he or she enters a hospital in anticipation of a kidney transplant.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46570, Sept. 13, 1991; 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 77 FR 22166, Apr. 12, 2012]

§ 417.434 Reenrollment.

If an HMO or CMP requires periodic reenrollment, it must reenroll Medicare enrollees unless there is a basis for disenrollment as set forth in § 417.460.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.436 Rules for enrollees.

(a) *Maintaining rules.* An HMO or CMP must maintain written rules that deal with, but need not be limited to the following:

(1) All benefits provided under the contract, as described in § 417.440.

(2) How and where to obtain services from or through the HMO or CMP.

(3) The restrictions on coverage for services furnished from sources outside a risk HMO or CMP, other than emergency services and urgently needed services (as defined in § 417.401).

(4) The obligation of the HMO or CMP to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services as required by § 417.414(c).

(5) Any services other than the emergency or urgently needed services that the HMO or CMP chooses to provide as permitted by this part, from sources outside the HMO or CMP. A cost HMO or CMP must disclose that the enrollee may receive services through any Medicare providers and suppliers.

(6) Premium information, including the amount (or if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable.

(7) Grievance and appeal procedures.

(8) Disenrollment rights.

(9) The obligation of an enrollee who is leaving the HMO's or CMP's geographic area for more than 90 days to notify the HMO or CMP of the move or extended absence and the HMO's or CMP's policies concerning retention of enrollees who leave the geographic area for more than 90 days, as described in § 417.460(a)(2).

(10) The expiration date of the Medicare contract with CMS and notice that both CMS and the HMO or CMP are authorized by law to terminate or refuse to renew the contract, and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in the HMO or CMP.

(11) Advance directives as specified in paragraph (d) of this section.

(12) Any other matters that CMS may prescribe.

(b) *Availability of rules.* The HMO or CMP must furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter.

(c) *Changes in rules.* If an HMO or CMP changes its rules, it must submit the changes to CMS in accordance with § 417.428(a)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

(d) *Advance directives.* (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in § 489.100 of this chapter, with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to:

(i) Provide written information to those individuals concerning—

(A) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning such