

(2) If a supplemental benefit plan premium includes charges for both non-covered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium that is for deductibles and coinsurance must be computed separately and must be disclosed to the beneficiary during the enrollment process and before he or she elects coverage options.

(3) The sum of the amounts an HMO or CMP charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.

(e) *Coverage of Part A services for Part B-only Medicare enrollees.* If an HMO or CMP furnishes coverage of Medicare Part A services to a Medicare enrollee entitled to Part B only, the HMO's or CMP's premium (or other payment method) for these services may not exceed the ACR for these services. In addition, if a risk HMO or CMP furnishes these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the HMO or CMP who are entitled to benefits under both Parts A and B, the HMO's or CMP's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollee of the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

**§ 417.454 Charges to Medicare enrollees.**

(a) *Limits on charges.* The HMO or CMP must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) *Limit on charges for inpatient hospital care.* If a Medicare enrollee who is an inpatient of a hospital requests im-

mediate QIO review (as provided in § 417.605) of any determination by the hospital furnishing services or the HMO or CMP that the inpatient hospital services will no longer be covered, the HMO or CMP may not charge the enrollee for any inpatient care costs incurred before noon of the first working day after the QIO issues its review decision.

(c) *Reporting requirements.* A risk HMO or CMP must report, within 90 days after the end of the contract period, all premiums, enrollment fees, and other charges collected from its Medicare enrollees during that period.

(d) *Limit on charges for specified preventive services.* An HMO may not charge deductibles, copayments, or coinsurance for in-network Medicare-covered preventive services (as defined in § 410.152(1)).

(e) *Services for which cost sharing may not exceed cost sharing under original Medicare.* On an annual basis, CMS will evaluate whether there are service categories for which HMOs' cost sharing may not exceed that required under original Medicare and specify in regulation which services are subject to that cost sharing limit. The following services are subject to this limit on cost sharing:

(1) Chemotherapy administration services to include chemotherapy drugs and radiation therapy integral to the treatment regimen.

(2) Renal dialysis services as defined at section 1881(b)(14)(B) of the Act.

(3) Skilled nursing care defined as services provided during a covered stay in a skilled nursing facility during the period for which cost sharing would apply under Original Medicare.

(4) A COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995; 76 FR 21561, Apr. 15, 2011; 85 FR 71197, Nov. 6, 2020; 88 FR 22328, Apr. 12, 2023]

**§ 417.456 Refunds to Medicare enrollees.**

(a) *Definitions.* As used in this section—

*Amounts incorrectly collected* means amounts collected that are in excess of