

§ 422.104 Special rules on supplemental benefits for M+C MSA plans.

(a) An M+C organization offering an M+C 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 HCFA 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 point of service option.

(a) A POS benefit is an option that an M+C organization may offer in an M+C coordinated care plan or network M+C MSA plan to provide enrollees with additional choice in obtaining specified health care services from individuals or entities that do not have a contract with the M+C organization to provide service through the M+C coordinated care plan or network M+C MSA plan offering the POS option. The plan may offer a POS option—

(1) Under a coordinated care plan only as an additional benefit as described in § 422.312;

(2) Under a coordinated care plan only as a mandatory supplemental benefit as described in § 422.102(a); or

(3) Under a coordinated care plan or network MSA plan as an optional supplemental benefit as described in § 422.102(b).

(b) *Approval required.* An M+C organization may not implement a POS benefit until it has been approved by HCFA.

(c) *Ensuring availability and continuity of care.* An M+C network 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.* M+C organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) *Evidence of coverage document.* The M+C organization must provide to 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 M+C organization that offers a POS benefit must report data on the POS benefit in the form and manner prescribed by HCFA.

§ 422.106 Special arrangements with employer groups.

An M+C organization may negotiate with an employer group to provide benefits to members of the employer group who are enrolled in an M+C plan offered by the organization. While these negotiated employer group benefits may be designed to complement the benefits available to Medicare beneficiaries enrolled in the M+C plan, they are offered by the employer group independently as the product of private negotiation. Examples of such employer-benefits include the following:

(a) Reductions in the portion of the premium that the M+C organization charges to the beneficiary.