(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 section 1854(f)(1)(A) of the Act;

(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 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 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.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005; 75 FR 19805, Apr. 15, 2010]

§ 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.

Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the MA program apply to the MA plan coverage and benefits provided to enrollees eligible for benefits under an employer, labor organization, trustees of a fund established by one or more employers or labor organizations, or Medicaid contract.

(2) Employer benefits that complement an MA plan, which are not part of the MA plan, are not subject to review or approval by CMS.

(3) Medicaid benefits are not reviewed under this part, but are subject to appropriate CMS review under the Medicaid program. MA plan benefits provided to individuals entitled to Medicaid benefits provided by the MA organization under a contract with the State Medicaid agency are subject to MA rules and requirements.

(b) *Examples.* Permissible employer, labor organization, benefit fund trustee, or Medicaid plan benefits include the following:

(1) Payment of a portion or all of the MA basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the MA plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

(c) *Waiver or modification of contracts with MA organizations.* (1) MA organizations may request, in writing, from CMS, a waiver or modification of those requirements in this part that hinder the design of, the offering of, or the enrollment in, MA plans under contracts between MA organizations and employers, labor organizations, or the trustees of funds established by one or more employers or labor organizations to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations.

(2) Approved waivers or modifications under this paragraph granted to any MA organization may be used by any other similarly situated MA organization in developing its bid.

(d) *Employer sponsored MA plans for plan years beginning on or after January 1, 2006.* (1) CMS may waive or modify any requirement in this part or Part D that hinders the design of, the offering of, or the enrollment in, an employer-sponsored group MA plan (including an MA–PD plan) offered by one or more employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof), or that is offered, sponsored or administered by an entity on behalf of one or more employers or labor organizations, to furnish benefits to the employers' employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations. Any entity seeking to offer, sponsor, or administer such an MA plan described in this paragraph may request, in writing, from CMS, a waiver or modification of requirements in this part that hinder the design of, the offering of, or the enrollment in, such MA plan.

(2) An MA plan described in this paragraph may restrict the enrollment of individuals in that plan to individuals who are beneficiaries and participants in that plan.

(3) Approved waivers or modifications under this paragraph granted to any MA plan may be used by any other similarly situated MA plan in developing its bid.

(4) An employer-sponsored group MA plan means MA coverage offered to retirees who are Medicare eligible individuals under employment-based retiree health coverage, as defined in paragraph (d)(5) of this section, approved by CMS as an MA plan.

(5) Employment-based retiree coverage means coverage of health care costs under a group health plan, as defined in paragraph (d)(6) of this section, based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. The term includes coverage provided by voluntary insurance coverage, or coverage as a result of a statutory or contractual obligation.

(6) Group health plans include plans as defined in section 607(1) of ERISA, (29 U.S.C. 1167(1)). They also include the following plans:

(i) A Federal or State governmental plan, which is a plan providing medical care that is established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision of a State (including a county or local government), or by any agency or instrumentality or any of the foregoing, including a health benefits plan offered under 5 U.S.C. 89 (the Federal Employee Health Benefit Plan (FEHBP)).

(ii) A collectively bargained plan, which is a plan providing medical care that is established or maintained under or by one or more collective bargaining agreements.

(iii) A church plan, which is a plan providing medical care that is established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches that is exempt from tax under section 501 of the Internal Revenue Code of 1986 (26 U.S.C. 501).

(iv) Any of the following plans:

(A) An account-based medical plan such as a Health Reimbursement Arrangement (HRA) as defined in Internal Revenue Service Notice 2002–45, 2002–28 I.R.B. 93.

(B) A health Flexible Spending Arrangement (FSA) as defined in Internal Revenue Code (Code) section 106(c)(2).

(C) A health savings account (HSA) as defined in Code section 223.

(D) An Archer MSA as defined in Code section 220, to the extent they are subject to ERISA as employee welfare benefit plans providing medical care (or would be subject to ERISA but for the exclusion in ERISA section 4(b), 29 U.S.C.1003(b), for governmental plans or church plans).

[65 FR 40320, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4721, Jan. 28, 2005; 76 FR 21562, Apr. 15, 2011]

§ 422.107 Special needs plans and dual-eligibles: Contract with State Medicaid Agency.

(a) *Definition*. For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dual-eligible individuals.

(b) *General rule*. MA organizations seeking to offer a special needs plan serving beneficiaries eligible for both Medicare and Medicaid (dual-eligible) must have a contract with the State Medicaid agency. The MA organization retains responsibility under the contract for providing benefits, or arranging for benefits to be provided, for individuals entitled to receive medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

(c) *Minimum contract requirements*. At a minimum, the contract must document—

(1) The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits.

(2) The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under the Statute at sections 1902(a), 1902(f), 1902(p), and 1905.

(3) The Medicaid benefits covered under the SNP.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(d) *Date of Compliance*. (1) Effective January 1, 2010—

(i) MA organizations offering a new dual-eligible SNP must have a State Medicaid agency contract.

(ii) Existing dual-eligible SNPs that do not have a State Medicaid agency contract—

(A) May continue to operate through the 2012 contract year provided they meet all other statutory and regulatory requirements.

(B) May not expand their service areas during contract years 2010 through 2012.

(2) [Reserved]

[73 FR 54248, Sept. 18, 2008, as amended at 76 FR 21563, Apr. 15, 2011]