30.1 – Definition of Supplemental Benefit

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A supplemental benefit is an item or service not covered by original Medicare, that is primarily health related and for which the MA plan must incur a non-zero direct medical cost. These criteria are defined below.

(1) A supplemental benefit may not be a Medicare Part A or Part B covered service;

(2) The item or service must be primarily health related; that is, the primary purpose of the item or service is to prevent, cure or diminish an illness or injury. If the primary purpose of the item or service is comfort, cosmetic or daily maintenance, then it is not eligible as a supplemental benefit. The primary purpose of an item or service is determined by national typical usages of most people using the item or service, or by community patterns of care; and

(3) The MA plan must incur a non-zero direct medical cost in providing the benefit. If the MA plan only incurs an administrative cost, this requirement is not met.

An item or service that meets the above three conditions may be proposed as a supplemental benefit in an *MA* plan's bid and submitted plan benefit package. The final determination of benefit status is made by CMS during the annual benefit package review.

Mid-year benefit enhancements are not allowed for non-employer plans. For more information regarding requirements specific to employer group plans, please refer to *chapter* 9 of the *MMCM*, "Employer/Union Sponsored Group Health Plans."

MA plans are allowed to cover some benefits over more than one contract year. Such benefits, referred to as "multi-year" benefits, are supplemental benefits that are provided to an *MA* plan's Medicare enrollees over a period exceeding one contract year. For example, it is permissible for an *MA* plan to cover one new pair of eyeglasses every two years. While some benefits may be appropriately offered over multiple years, CMS encourages *MA* plans to limit offerings to one contract year where possible.

Supplemental benefits need *not* be provided through Medicare providers *nor at Medicare certified facilities. Please note, however, MA plans may not make payment to providers who have opted out or been excluded from Medicare through §§422.220 and 422.204(b)(4)/422.752(a)(8)*.