



MEDICARE DRUG AND HEALTH PLAN CONTRACT ADMINISTRATION GROUP (MCAG)

DATE: August 15, 2008

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors and 1876 Cost Plans

FROM: Teresa DeCaro, Acting Director /s/
Medicare Drug and Health Plan Contract Administration Group

SUBJECT: CY 2009 Summary of Benefits Global Hard Copy Changes, Model Transition Letter, and Required Changes to the Standardized EOC Due to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

The following guidance includes information on Global Hard Copy changes permitted in the Summary of Benefits (SB) without prior approval from CMS Central Office. These changes include permissible hard copy changes in the SB, required SB changes due to programming errors in the Plan Benefit Package (PBP/SB) software and MIPPA, and resubmission of SBs due to premium changes. This memo also includes additional language for the Model Transition Letter and required changes to the standardized language in the Evidence of Coverage (EOC).

Global Hard Copy changes may be made without CMS Central Office review and approval (except as noted). Please submit your SB with Global Hard Copy changes to your Regional Office reviewer following the normal marketing material review process. All other Summary of Benefits changes must be submitted to the SB mailbox for Central Office review prior to submitting the SB to the Regional Office under the normal marketing material review process.

Permissible Hard Copy Changes in the SB

Benefit Exclusions to the Out-of-Pocket Limit

The Centers for Medicare and Medicaid Services (CMS) expects all plans to be able to provide beneficiaries with accurate information about their coverage, including out-of-pocket maximum exceptions. Plans will need to make a hard copy change in Section II of the SB under “Premium and Other Important Information” to include benefit exclusions to the out-of-pocket limit.

If your SB contains the sentence “Not all plan services are covered under the out-of-pocket limit. Contact plan for a detailed list of non-covered services” for any of the plans, please delete the sentence “Contact plan for a detailed list of non-covered services” and list your plan’s benefit exclusions to the out-of-pocket limit.

-or-

If your SB contains the sentence "All Medicare services covered under the out-of-pocket limit. Contact plan for a detailed list of non-Medicare services covered" for any of the plans, please delete the sentence "Contact plan for a detailed list of non-Medicare services covered" and list your plan's non-Medicare benefit exclusions to the out-of-pocket limit.

Please note that all MA plans should list benefit exclusions to the out-of-pocket limit for In-Network/Out-of-Network/Combined/General (Non-Network) where applicable.

Side-by-Side Plan Comparisons

Organizations and Sponsors offering more than one plan may describe several plans in the same SB by displaying the benefits for different plans in separate columns within Section II of the benefit comparison matrix. Since the Plan Benefit Package (PBP) will only print Sections I and II of the SB for one plan, organizations will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format. Organizations will also need to modify section I of the introduction section to accurately reflect the plans that have been added to Section II of the SB. The side-by-side comparisons are eligible for a 10-day marketing review if no other non-global changes are made to the standardized SB.

Regional Copay/Premium Tables (SB-29)

When Organizations or Sponsors offer plans with identical benefits in multiple regions, they may create a regional copay or premium table to accompany the SB that lists the copays/premiums for all regions covered. Along with the table, should be an instruction to members explaining how to find the copay and premium information that applies to them. The regional copay/premium table and SB is required to be submitted and reviewed by CMS with an attestation that the information populated in the table is identical to what is approved in the bid.

Private-fee-for-service (PFFS) plans that do not offer Medication Therapy Management (MTM) programs

Private-fee-for-service plans that do not offer MTM may remove the section, "What is a Medication Therapy Management (MTM) program," from the SB.

Pharmacy Terms

Part D sponsors may replace the term "non-preferred pharmacy" with the term "other network pharmacy" in section 29 of the SB.

Customer Service Telephone Numbers in the SB introduction

Organizations that have the same set of customer service telephone numbers for both MA and Part D benefits, can opt to list them together in the SB introduction for both programs.

Premium and Other Important Information - Part B Premium Reduction Sentence

Organizations that have elected to display the prior year's Medicare premium and deductible amounts in the SB may display the following sentence if they offer a Part B premium reduction.

“For 2009 <plan name> will reduce your Medicare Part B premium by up to \$xx”

Special Needs Plans (SNP)

For fully integrated dual eligible SNPs, CMS will allow plans to modify the original Medicare (OM) column & Plan Column in Section II of the SB to reflect additional Fee – For-Service Medicaid coverage information applicable to each benefit category. You may rename the heading of the OM column to “Original Medicare/Fee-For-Service Medicaid” and change the language in section I to reflect the integration of Medicare and Medicaid benefits. Plans may include a Section 4 to the SB to list additional Medicaid benefits not covered by Medicare. Section 4 may be bound with the SB as long as it is distinct from Sections 1, 2 and 3. Plans along with the State are responsible for ensuring the accuracy of Medicaid benefits displayed in the SB. The Regional Office Reviewer is not responsible for review of Medicaid benefits.

Note: As referenced on pg. 41 of the Medicare Marketing Guidelines, any approved hard copy changes will not result in changes to the Medicare Options Compare, nor will they result in changes to the Plan Benefit Package.

Required SB changes due to programming errors in the PBP/SB software

The SB report in HPMS, the Model of Care (MOC) and the Medicare Prescription Drug Plan Finder will display the correct sentences in the following situations. Plans will need to make the corrections below to their local SB.

SB -8 Doctor Office Visits (In-area, Network Urgent Care)

- If you do not offer the in-area, network, urgent care benefit, please delete the sentence “\$0 copay for the cost for each in-area, network urgent care Medicare covered visit*.” from your SB.
- *If you do offer the in-network, urgent care benefit at no cost sharing to the beneficiary, and did not enter “\$0” copay, you must request a PBP resubmission. (Select "Yes" to indicate there is a copay, and enter a copay amount of "0.")*

SB-24 Immunizations (Hepatitis B-Special Needs Plan (SNP) copay sentence)

For Dual Eligible SNPs (non-zero cost sharing) that are indicating only coinsurance for Hepatitis B immunization, the “0% or” does not generate. Please indicate the correct sentence in your SB as shown below:

“\$0 or \$__ (plan filed cost sharing) copay [or 0% or __% (plan filed cost sharing) of the cost] for Hepatitis B vaccine.*”

SB-29 Prescription Drugs

For enhanced alternative (EA) plans indicating gap coverage for some or all formulary drugs, the following sentence incorrectly generates, “You pay the following:”. Please indicate the correct sentence in your SB as shown below:

“You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:”

SB-30 Dental

If you select preventive dental in an out-of-network (OON) group, a sentence does not generate in the SB. Please add the following sentence to your SB as shown below:

“\$__ to \$__ (plan filed cost sharing) copay [or __% to __% of the cost] (plan filed cost sharing) for preventive dental benefits.”

SB-32 Vision

If you do not offer mandatory or optional supplemental benefits but require authorization for your Medicare benefits in 17a and 17b, the sentence “Authorization rules may apply” will not generate. Please add the sentence “Authorization rules may apply” to your SB.

SB Introduction – Cost Plans

For Cost plans, the text in the introduction under "Can I Choose My Doctors" has a reference to a website address (for an Online Provider Directory). Please delete the online reference.

SB Opt Sup-Vision

If a plan offers an optional supplemental vision benefit with a \$0 copay or 0% coinsurance, the PBP software will automatically generate the words “\$0 copay for:” incorrectly below the bulleted list. *Please make the following correction* so that the words “\$0 copay for:” appears above the bulleted list as shown below:

In-Network:

\$0 copay for:

- up to X pair(s) of contacts every X years
- up to X pair(s) of lenses every X years
- up to X frame(s) every X years -up to
- \$XX limit for eye wear every year

Required SB changes due to MIPPA

The SB report in HPMS and MOC will display the correct sentences in the following situations. Plans will need to make the corrections below to their local SB.

SB-33 Physical Exams

- If your SB contains the sentence “When you get Medicare Part B, you can get a one-time physical within the first 6 months of your new Part B coverage,” replace the “6” with “12”.
- In the Original Medicare cost-sharing column, in the sentence “When you get Medicare Part B, you can get a one-time physical within the first 6 months of your new Part B coverage” replace the “6” with “12”.
- In the sentence “[x]% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage” replace the “6” with “12”.

Resubmission of SBs due to Premium Change

Although the Part D Premium amount has not been released, plans have already begun submitting their 2009 Summary of Benefits (SB) document to CMS for review. Typically the premium amount is released in August. For plans that are unable to wait until the release, many are submitting their SBs with the premium they included with their bid. We are reminding plans that if their premium changes as a result of the release of the 2009 Part D Premium information, they are required to submit their SB with the corrected premium amount to CMS for review.

Additional language in Part D Model Transition Letter

We are providing additional language in the 2009 model Transition Letter for members residing in long term care (LTC) facilities. The language is optional. Plans may submit templates including the language for LTC and non-LTC enrollees that are consistent with the attached, or they can use the original model's language. Submitting the transition letter with the additional language does not change its status as a model document.

Required EOC changes due to MIPPA

The following changes should be made to the standardized language in the 2009 ANOC/EOC. Plans that have already printed the affected sections may include the information in an errata sheet mailed with the EOC. Further guidance may be forthcoming on other regulatory changes that will need to be communicated to members through an errata sheet to the EOC.

ANOC/EOC, Physical exams:

Plans should make the following changes to the description of physical exams included as standardized language in the ANOC/EOC:

- Section 10, page 116. Plans that cover only what Original Medicare covers should change the following paragraph in the benefits chart: [***Note to any Plan that covers only what Original Medicare covers:*** include “A one-time physical exam for members within

the first ~~12-6~~ months that they have Medicare Part B. Includes measurement of height, weight, body mass index and blood pressure; ~~end-of-life planning-an electrocardiogram~~; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.”]

- ANOC, page 6-7. Plans should indicate any applicable changes in physical exam coverage in the ANOC benefits chart.

ANOC/EOC, Section 1, page 22, late enrollment penalty for persons eligible for extra help:

All plans should make the following changes to the description of the late enrollment penalty included as standardized language in the EOC:

- However, if you qualify~~ied~~ for extra help ~~in 2006, 2007, or 2008~~, you may not have to pay a penalty.
- You received or are receiving extra help ~~AND you enroll in a Medicare prescription drug plan by December 31, 2008, AND you stay in a Medicare prescription drug plan~~

Please send any questions regarding summary of benefits to Summaryofbenefits@cms.hhs.gov. Other marketing related questions should be directed to the CMS Regional Office.