



**MEDICARE DRUG AND HEALTH PLAN CONTRACT ADMINISTRATION GROUP (MCAG)**

---

DATE: July 21, 2009

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

FROM: Teresa DeCaro, RN, MS, Acting Director, Medicare Drug and Health Plan  
Contract Administration Group

Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: CY 2010 Summary of Benefits Global Hard Copy Changes

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 and required SB changes due to programming errors in the Plan Benefit Package (PBP/SB) software.

Global hard copy changes may be made without CMS Central Office review and approval. Please submit your SB with global hard copy changes to your Regional Office reviewer following the normal marketing material review process. All other SB change requests 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.

**(1) Permissible Hard Copy Changes in the SB – not reflected in Health Plan Management System (HPMS)**

**Side-by-Side Plan Comparisons**

MA organizations (MAOs) and Part D sponsors offering more than one plan may describe several plans in the same SB as outlined in the marketing guidelines. 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.

**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.

## **(2) Required SB Hard Copy Changes – not reflected in HPMS**

### **Comprehensive Written Statement for Prospective Enrollees (SB Section 4) Special Needs Plans (SNP)**

Dual-Eligible Special Needs Plans (SNPs) must provide each prospective enrollee, prior to enrollment, with a comprehensive written statement that describes the benefits and cost sharing protections that the individual is entitled to under Title XIX – Medicaid. In order for plans to describe their benefits, the section 4 SB template can be downloaded using the following navigation path: Plan Bids>Bid Submission>CY 2010>Documentation>SB Template for DE SNPs. Adding only section 4 to the SB will not trigger a non-model 45-day review process. If a plan does not have a section 3, the Medicaid language does not have to be labeled as section 4, but it must be distinct from sections 1-3 of the SB. Plans should not substitute SB section 3 with section 4.

**Fully Integrated Dual-Eligible SNPs:** For fully integrated dual-eligible SNPs that meet requirements 1- 4, CMS will allow plans to modify section 2 of the SB to reflect integrated benefits applicable to each benefit category.

1. Provides dually eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization (MCO);
2. Has a contract with a state Medicaid agency that includes coverage of specified primary, acute and, long-term care benefits and services, consistent with State policy, under risk-based financing;
3. Coordinates the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
4. Employs policies and procedures approved by CMS and the state to coordinate or integrate member materials, including enrollment, communications, grievance and appeals, and/or quality assurance.

Plans must still include the comprehensive written statement as required by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Plans along with the State are responsible for ensuring the accuracy of the Medicaid benefits displayed in the SB. The Medicare Regional Office reviewer will not be responsible for review of Medicaid benefits.

### **SB Introduction – Prescription Drug Plan (PDP)**

The SB language under the heading “What should I do if I have other insurance in addition to Medicare” has been revised to read as follows:

“If you have a Medigap (Medicare Supplement Insurance) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap policy, your

Medigap Issuer will remove the prescription drug coverage portion from your Medigap policy. This will occur as of the effective date of your Medicare Prescription Drug Plan coverage. Your Issuer will adjust your premium. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join << Plan Name (PDP)>>. Get this information before you decide to enroll in this plan.”

#### SB Introduction – PDP plans

This section needs to be shortened to remove the MA language, as follows:

#### “WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare prescription drug coverage in your area.

As a member of <Plan Name *PBP\_A\_PLAN\_NAME*> you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, <QIO Name> <QIO Telephone Number>.”

#### SB Introduction – MA only plans

The following section was inadvertently omitted from the MA-only plan introduction, and needs to be added to the MA-only SB introduction.

#### “WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send

you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of <Plan Name>, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, <QIO Name> <QIO Telephone Number>.”

#### SB Introduction – MA-PD plans

The SB introduction under the section “what are my protections in this plan?” for MA-PD plans should read as follows:

##### “WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of <Plan Name>, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, <QIO Name> <QIO Telephone Number>.”

As a member of <Plan Name *PBP\_A\_PLAN\_NAME*> you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to

request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, <QIO Name> <QIO Telephone Number>.”

**Note:** The 90 days notice time frame in the above 3 templates was changed to 60 days by a January 12, 2009 final rule.

### SB Introduction - Plan Ratings

All plans should display the following language in the SB introduction, immediately before the contact information in the SB.

#### “PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at [insert plan number] to obtain a copy of the plan ratings for this plan. TTY users call [insert TTY number].

### SB 3 - Inpatient Hospital Care and

### SB 4 - Inpatient Mental Health Care

Section C, out-of-network (OON) Inpatient Hospital and/or Inpatient Mental Health Care:

If a plan selects (a) "No to copayment" or (b) "Yes to copayment" but enters a value of \$0.00, the cost sharing sentences do not generate in the SB.

- Plans should display ‘\$0 copay’ sentences.

### SB 8 - Doctor Office Visits

Whenever a plan has indicated 'Yes' or 'Sometimes, Describe' to a separate office visit (OV) cost sharing in any PBP service category, the SB will generate a sentence displaying the OV cost sharing as entered under PBP B-7A: “Separate Office Visit cost sharing of \$\_\_ to \$\_\_ [or \_\_% to \_\_%] may apply.”

When the OV cost sharing differs from the Primary Care Physician (PCP) cost sharing, the user should enter the OV cost sharing range in the PCP fields. The true PCP cost sharing should be entered in the PBP notes and plans should make a hard copy change to display the PCP cost sharing as entered in the PBP notes.

**Please note:** The above changes **will not** be reflected in HPMS, Medicare Options Compare (MOC) or the Medicare Prescription Drug Plan Finder. Plans will need to make corrections to their local SB.

### **(3) Required SB changes due to programming errors in the PBP/SB software**

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

\*\*denotes SB items included in the Optional Patch (May 15, 2009). These items have already been fixed for those users that have downloaded this patch and local hard copy change is not needed.

#### **SB Introduction**

If the legal entity name is changed in HPMS after the PBP has been downloaded, then the Local SB must be edited to reflect the revised name.

#### **SB Introduction - Phone Numbers: TTY/TDD\*\***

When TTY/TDD local numbers are the same for current and prospective members, but TTY/TDD toll-free numbers differ, only a code appears in the SB Report. (E.g., TTY/TDD number is displayed as "TTY/TDD@PBP\_A\_TTYTDD\_CUR\_LOC\_PHONE".)

- Plans should indicate the correct telephone number in the SB.

#### **SB Introduction - Service Area\*\***

When identical county names exist in two or more different states in the plan's Service Area, one of the counties does not generate in the section: "Where is Plan Available?"

- Plans should display all unique county/state name combinations.

#### **SB Introduction - Cost Plan**

There is a grammatical inconsistency in the section "'Who is Eligible to Join <Plan>?" The word "yours" has been changed to "their" as shown below:

"You can join <plan> if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in <plan> unless they are members of our organization and have been since **their** dialysis began."

### SB Introduction - Chronic and Disabling SNPs\*\*

The list of chronic and disabling conditions in the section “Who is eligible to join <plan name>” is not being displayed in the SB.

- Plans should list the chronic and disabling conditions as specified in the HPMS Summary of Benefits report.

### SB Original Medicare Sentences - Dual Eligible Special Needs Plan

For Dual Eligible Medicaid-Subset \$0 cost share, the \$0 cost share sentences are not generated in the Original Medicare (OM) column.

- Plans should update their OM sentences to display ‘\$0 cost share’ sentences.

### SB 1 - Premium and Other Important Information – Private Fee for Service (PFFS)

For non-network PFFS plans that have a maximum out-of-pocket limit (in Section D of the PBP) that applies only to a subset of the Medicare-covered benefits, the list of items excluded from the limit are not displayed on the SB.

- Plans should display the list of Medicare-covered categories selected in Section D that are excluded from the out-of-pocket limit.

### SB 3 - Inpatient Hospital Original Medicare Sentences - Dual Eligible Special Needs Plans

For Dual Eligible All Dual SNPs, the OM sentence for Inpatient Hospital displays the year 2009, instead of 2010.

- Plans should display the sentence as: ‘These amounts will change for 2010.’

### SB 3 - Inpatient Hospital - Dual Eligible Special Needs Plans

For Dual-Eligible All Dual SNPs, the plan sentence for Inpatient Hospital displays the year 2009, instead of 2010.

- Plans should display the sentence as: ‘In 2010 the amounts for each benefit period...’

### SB 4 - Inpatient Mental Health Care\*\*

For plans that select more than one cost-sharing interval for out- of-network Inpatient Mental Health, the second interval appears before the first.

- Plans should display the correct order.

## SB 6 - Home Health Care- Part B-only Plans\*\*

Incorrect Original Medicare (OM) sentence generated in Home Health Care for Part B-only plans.

- Plans should display '\$0 copay' in the OM column.

## SB 15 - Emergency Care and SB 16 -Urgent Care

For the Emergency Care and Urgently Needed Care sections in the PBP (B4a, B4b), SB report does not display the copay/coinsurance amounts correctly (displays "@AMOUNT").

- Plans should display the correct copay/coinsurance maximum amounts.

## SB 21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Dual Eligible SNPs

For All Duals, Full Duals, and Medicaid Subset (non-zero cost share) Dual-Eligible SNPs, when the maximum and minimum coinsurance amounts are the same, the cost sharing amounts do not generate correctly.

- Plans should display the correct cost sharing amounts as: "0% or xx% of the cost Medicare-covered..."

## SB 26 - Pap Smears and Pelvic Exams - Dual Eligible SNPs

For All duals, Full duals, and Medicaid Subset (non-zero cost share) dual eligible SNPs, if the plan has a 0% coinsurance for Pap Smears, and a minimum and maximum range for Pelvic Exams, then the sentence for Pap Smears appears with an extra '0%' as: "0% or 0% of the cost for Medicare-covered pap smears.\*"

- Plans should remove the first occurrence of '0%'.

For All duals, Full duals, and Medicaid Subset (non-zero cost share) dual eligible SNPs, if the plan has a \$0 co-pay for Pap Smears, and a minimum and maximum range for Pelvic Exams, then the sentence for Pap Smears appears with an extra '\$0' as: "\$0 or \$0 of the cost for Medicare-covered pap smears.\*"

- Plans should remove the first occurrence of '\$0'.

For All duals, Full duals, and Medicaid Subset (non-zero cost share) dual eligible SNPs, if the plan has a copay for Pap Smears, and a \$0 co-pay for Pelvic Exams, then the sentence for Pelvic Exams appears with an extra '\$0' as: "\$0 or \$0 of the cost for Medicare-covered pelvic exams.\*"

- Plans should remove the first occurrence of '\$0'.



### SB 29 - Prescription Drugs

Incorrect wording for the following SB sentence:

“If you request a tier exception in this plan, you will pay <Tier label> cost sharing.”

- Plans should update their SB sentence as follows:  
“If you request a formulary exception for a drug and <plan name> approves the exception, you will pay <tier x> cost-sharing for that drug”

### SB 29 - Prescription Drugs

For MA-ONLY plans, an extra heading ‘General’ appears twice before the “Most drugs not covered” sentence.

- Plans should delete the extra ‘General’ heading.

### SB 29 - Prescription Drugs

The word ‘pharmacy’ is missing from Mail Order gap sentences for one month, three months, other preferred and non-preferred as shown below:

“\$xx copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred mail order

\$xx copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order

\$xx copay for a 15-day supply of all drugs covered in this tier from a preferred mail order

\$xx copay for a one-month (31-day) supply of all drugs covered in this tier from a non-preferred mail order

\$xx copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order

\$xx copay for a 15-day supply of all drugs covered in this tier from a non-preferred mail order”

- Plans should add the word ‘pharmacy’ at the end of each sentence.

### SB 29 - Prescription Drugs

The words ‘in this tier’ are missing from the gap coverage sentences for a non-preferred pharmacy

- Plans should display the missing words ‘in this tier’ in the sentence

### **(4) General reminders regarding Summary of Benefits Hardcopy change requests:**

- Hard copy change requests related to the description of benefits should not be submitted until CMS has approved all bids

- Plans may submit administrative hard copy requests (e.g., changes to local phone or website location) prior to the bid approval
- Hard copy changes are only permitted to correct inaccurate or misleading information or errors generated from the PBP/SB software
- The fact that a hard copy change was approved in a prior year is no guarantee that it will be approved in a subsequent year
- Any approved hard copy changes will not result in changes to the Medicare Options Compare or to the Plan Benefit Package (PBP)
- Plans should validate the data entered in the PBP as well as reference the SB crosswalk to ensure the correct sentences are generated for the specific benefit being described
- Hard copy change requests will not be considered once the PBP is closed for corrections (10/01/2009)

### **How to request a SB hard copy change:**

Plans should send an e-mail to [Summaryofbenefits@cms.hhs.gov](mailto:Summaryofbenefits@cms.hhs.gov). The Subject line in the request must read: “Hard Copy Change Request for ***H/S/R/M*** ***<number>***, ***PBP <number or range>***.” In the body of the e-mail, plans should provide:

- The contract number and PBP #(s) and the regional office reviewer responsible for SB review;
- If the request for change applies to multiple contract numbers and plan IDs, the plan may include all applicable contract numbers and plan IDs in one e-mail;
- The existing standardized Summary of Benefits language;
- An explanation of why the existing standardized language is inaccurate; and
- A modified sentence.

Hard copy change requests must be submitted to the following mail box: [Summaryofbenefits@cms.hhs.gov](mailto:Summaryofbenefits@cms.hhs.gov). Other marketing related questions should be directed to the CMS Regional Office.