DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

TO: Medicare Part D Sponsor Applicants

FROM: Bob Donnelly, Director, Medicare Drug Benefit Group /s/
Patricia Smith, Director, Medicare Advantage Group /s/

RE: Instructions for the 2006 Summary of Benefits (for PDP and MA-PDs only)

DATE: August 24, 2005

This memo supplements the Specific Guidance for Summary of Benefits (SB) provided in the Medicare Marketing Guidelines. It provides information on the following three topics:

- One SB for multiple plans,
- Global, mandatory hard copy changes, and
- Information allowed in Section 3.

Some instructions apply to PDPs only and some apply to both PDPs and MA-PDs. Next to each subheading there is a notation to indicate which plans the instructions apply to.

One SB for Multiple Plans

As indicated in the Medicare Marketing Guidelines, Part D Plans that wish to combine multiple SB into one may do so only if either the benefits **or** the service area is identical. Plans may not combine SB if their plans have differing benefits **and** are in differing regions.

Different benefits but offered within the same region (For PDPs only)

- For Section 1 Beneficiary Information::
    - Organizations may adapt each variable field of <PDP Plan Name> appropriately. Organizations may either list all the plans the SB is describing, they may substitute the PDP's legal entity's name, or they may use a general Plan name that applies to all PDP plans described in the SB. (For example, if "Acme" is the family name for all standard plans for an organization, <PDP Plan Name> could be populated with "Acme Plan" instead of stating "Acme, an ABC Plan of X State and Acme, an ABC Plan of Y State.")

    - Organizations must include the following statement under "Where is <PDP Plan Name> Available?": "There is more than one plan listed in this Summary of Benefits. If you are enrolled in one and wish to switch to another, you may do so only during certain times of the year. Please call Customer Service for more information."
- For Section 2: Benefit Comparison Matrix: the Organization must display the benefits of each plan they are displaying in separate columns. Since the PBP will only print sections 1 and 2 of the SB report for one plan, the organization will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format. This change will not require a hard-copy change request.

Identical benefits (including premiums) but offered in different regions (for PDPs only)

- For Section 1: Beneficiary Information:
    - Organizations may adapt each variable field of <PDP Plan Name> appropriately. Organizations may either list all the plans the SB is describing, they may substitute the PDP's legal entity's name, or they may use a Plan's "family" name that applies to all PDP plans described in the SB. (For example, if "Acme" is the family name for all standard plans for an organization, <PDP Plan Name> could be populated with "Acme Plan" instead of stating "Acme, a ABC Plan of X State and Acme, a ABC Plan of Y State.")
    - Organizations must include the following statement under "Where is <PDP Plan Name> Available?": "If you move out of the state where you live into a state listed above, you must call Customer Service in order to update your information. If you do not, you may be disenrolled from <PDP Plan Name>. If you move into a state not listed above, please call Customer Service to find out if <PDP Plan Name has a plan in your new state."
- For Section 2: Benefits Comparison Matrix: the Organization may display the benefits of all their plans within one column since all the benefits are the same.

Global, Mandatory Hard-Copy Changes

Section 1: Beneficiary Information (For PDPs only)

As stated in the **Specific Guidance for Summary of Benefits** section of the **Medicare Marketing Guidelines**, PDPs must not use the "Section 1: Beneficiary Information" that is auto generated by HPMS. Plans must use the "Introduction to the Summary of Benefits for <PDP Plan Name>" that is attached to this memo. Plans that do not make this switch or make modifications to the "Introduction" will receive a disapproval on their SB. Plans do not have to request a hard-copy change request to make this switch.

Section 2: Benefit Comparison Matrix-Premium Information (For PDPs and MA-PDs)

With the release of the Part D premium information, organizations are now able to define their plans' Part D premiums in the Summary of Benefits (SB). Please note that plans should NOT be entering their Part D premium amount in the Plan Benefit Package (PBP) to generate the SB sentences. Instead organizations must manually change their hard copy SB premium sentence(s) to mirror the premium sentence(s) listed in the HPMS SB Section II Category 1 - Premium and Other Important Information. Users can access their HPMS SB reports by going to HPMS > Plan Bids > Reports > Summary of Benefits Report. This hard-copy change will not need to be submitted for approval.

Section 2: Benefit Comparison Matrix-Catastrophic Coverage co-payments/co-insurance (For PDPs and MA-PDs)

As many Part D Plans have noticed there is an error in the SB software and the auto generated sentence in section 2 when describing the catastrophic coverage co-payments/co-insurance does not follow language in the regulation. The following instructions are for Plans offering the Defined Standard Benefit and describing the Medicare Defined Cost Shares Applicable Beyond the Annual Out-Of-Pocket Threshold:

Replace:
"After your yearly out-of-pocket drug costs reach $3600, you pay the greater of:

- $2 for generic or preferred brand drug and $5 for all other drugs, or
- 5% coinsurance.

With:
"After your yearly out-of-pocket drug costs reach $3600, you pay the greater of:

- $2 for generic or preferred brand drug that is a multi-source drug and $5 for all other drugs, or
- 5% coinsurance.

Plans must use the above language unless this language incorrectly describes their benefit. This change does not require a hard-copy change request. Plans that have already made the above request can consider their request approved and must use the language provided above.

Information allowed in Section 3 (For PDPs and MA-PDs)

As stated in the **Specific Guidance for Summary of Benefits** section of the **Medicare Marketing Guidelines**, Part D Plans may use Section 3 describe special features of a program or to provide additional information about benefits described within Sections 1 and 2. All information provided in Section 3 must be verifiable by the PBP report in HPMS.

Attachment

Introduction to the Summary of Benefits for <PDP Plan Name> January 1, 2006-December 31, 2006

Thank you for your interest in <PDP Plan Name>. Our plan is offered by <PDP legal name>, a Medicare Prescription Drug Plan that contracts with Medicare. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation or exclusion. To get a complete list of our benefits, please call <PDP Plan Name> and ask for the Evidence of Coverage.

You have choices in your Medicare Prescription Drug Coverage.

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like <PDP Plan Name>. Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

How can I compare my options?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by <PDP Plan Name> to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

Where is <PDP Plan Name> Available?

The service area for this plan includes: <list individual states>. You must live in one of these states to join this plan.

[Organizations that have the same benefit package in multiple service areas must include the following statements: If you move out of the state where you live into a state listed above, you must call Customer Service in order to update your information. If you do not, you may be disenrolled from <PDP Plan Name>. If you move into a state not listed above, please call Customer Service to find out if <PDP Plan Name> has a plan in your new state.]

[Organizations listing more than one plan (and both plans cover the same service area) in this SB must include the following sentence: There is more than one plan listed in this Summary of Benefits. If you are enrolled in one and wish to switch to another, you may do so only during certain times of the year. Please call Customer Service for more information.

Who is eligible to join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area. Eligible individuals may only enroll in one Medicare Prescription Drug Plan at a time and may not be enrolled in a Medicare Advantage Plan (HMO, PPO), unless they are a member of Medicare Private-Fee-For-Services plan that does not offer Medicare prescription drug coverage or are enrolled in an 1876 Cost Plan. You may join a Medicare Prescription Drug Plan during certain times of the year.

Where can I get my prescriptions?

<PDP Plan Name> has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. <PDP Plan Name> may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases,. [Insert the following sentence if the plan has preferred pharmacies: <PDP Plan Name> has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. A non-preferred pharmacy is still a network pharmacy, but you may have to pay more for your prescriptions.]

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or call Customer Service for an up-to-date list.

Do you cover Medicare Part B or Part D Drugs?

We do not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biologicals and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

Does my plan have a prescription drug formulary?

<PDP Plan Name> uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified, in writing before the change is made.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a service that your plan may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. If you have questions concerning our MTM Program please contact our Customer Service number listed at the end of this section.

What should I do if I have other insurance in addition to Medicare?

If you have a Medigap (Medicare Supplement) 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 supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Under certain circumstances, you can also buy a different Medigap policy without prescription drug coverage sold by your Medigap Issuer. Your Medigap Issuer cannot charge you more, based on any past or present health problems. 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 <PDP Plan Name>. Get this information before you decide to enroll in this plan.

How can I get help with drug plan costs?

Medicare beneficiaries with low or limited income and resources may qualify for additional assistance. If you qualify, your Medicare prescription drug plan costs, the amount of your premium and your drug costs at the pharmacy will be less. Once you have enrolled in <PDP Plan Name>, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800-Medicare to see if you might qualify.

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 90 days before your coverage will end. The letter will explain your options for Medicare prescription drug coverage in your area.

If <PDP Plan Name> ever denies coverage for your prescription drugs, we will explain our decision to you. You always have the right to appeal and ask us to review the claim that was denied. In addition, if your physician prescribes a drug that is not on our formulary, is not a preferred drug or is subject to additional utilization rules, you may ask us to make a coverage exception.

Please call <PDP Plan Name> for more information about this plan.
Customer Service Hours: <xx am-xx pm, Monday-Friday>
Current members should call <number>
TTY/TDD <number>
Prospective Members should call <number>
TTY/TDD <number>
For more information about Medicare, call 1-800-Medicare (1-800-633-4227).
TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or visit www.medicare.gov.

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