Supplemental Instructions to the 2006 Summary of Benefits Instructions for Part D Plans—9/1/2005

This note supplements the **Specific Guidance for Summary of Benefits** in the **Marketing Guidelines** and the 2006 Summary of Benefits Instructions for Part D Plans memo issued on August 25, 2005. This memo covers three hard copy changes that impact MA-PDs and/or PDPs. Topics include:

- Summary of Benefits (SB) for plans with identical benefits but different premiums (PDPs only),
- Out-of-Network pharmacy benefits (MA-PDs and PDPs), and
- Cost sharing after the initial out of pocket threshold.

SB for Plans with Identical Benefits but Different Premiums (PDPs Only)

Plans with identical benefits but offered in different regions may combine their SB even if their premiums vary between Plans. If organizations wish to do this then they must do the following:

- In Section 2: Benefit Comparison Matrix, Plans must indicate the premium range for all Plans listed in the SB. In addition, they must include note directing the reader to a "Premium Table" that reads "Please refer to the Premium Table located after this section to find out what the premium is in your area."
- The "Premium Table" should be located after Section 2 and before Section 3. The table must include only the plan's name, number, service area and premium. Plans may include introductory information about the table and how to use it. However, no other Plan information may be included with the "Premium Table"

SB with only Sections 1, 2 and the Premium Table are subject to a 45-day review.

Out-of-Network pharmacy benefits (MA-PDs and PDPs)

The following sentences must precede the OON benefits described in Section 2:

"Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the Plan's service area where there is no network pharmacy."

Plans that require members to pay the differential between prescriptions filled at in- and out-of-network pharmacies must also include the following sentence:

"In addition to paying the co-payments/co-insurances listed below, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions."

Finally, Plans must move the sentence(s) and the applicable OON co-payment amounts to the end of Section 2 in order to separate it from the rest of the Plan's benefits.

Cost sharing after the initial out of pocket threshold. (MA-PD & PDP)

This change is **only** for Medicare Part D Sponsor Applicants who have selected one or more groups of cost sharing for cost sharing after the initial out-of-pocket threshold on a mandatory hard copy change to their 2006 Summary of Benefits.

Currently, CMS requires Part D plans to apply the equivalent of one co-payment to each pharmacy transaction regardless of days supply for beneficiaries with statutorily defined flat co pay amounts, that is, enrollees with spending above the $3,600 out-of-pocket threshold. However, the PBP requires the user to enter a day supply and location when "one or more groups of cost sharing" is selected for "cost sharing after the initial out-of-pocket cost threshold".

However, plans should not include the days-supply or location information in Section 2 of their Summary of Benefits.

As a result, Plans are instructed to do the following:

Replace:
After your yearly out-of-pocket drug costs reach $3,600, you pay:
$[*copay*] for a one-month (30 day) supply of [*Tier (1-10)*] drugs you get at [*in-network preferred pharmacy, in-network non-preferred pharmacy, out of network pharmacy, mail order*].

With:
After your yearly out-of-pocket drug costs reach $3,600, you pay:
- $[*copay*] for [*Tier (1-10)*] drugs.

The above phrases beginning $[co pay] would be repeated - one for each tier (cost sharing group).

CMS will electronically correct the sentence in the Health Plan Management System (HPMS) Summary of Benefits report to reflect the language stated above and the corrected language will also be electronically passed to the Medicare.gov website. However, affected Plans must make this hard copy edit on their SB.