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TO: Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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SUBJECT: Summary of Benefits Guidance for Contract Year 2015

This memorandum provides Medicare Advantage Organizations and Section 1876 Cost Plans (plans) and Prescription Drug Plans (sponsors) with the following information to prepare their Contract Year (CY) 2015 Summary of Benefits (SB): general guidance, permissible changes, submission process, SB hard copy change request module, and SB global hard copy change report.

Based on industry feedback and CMS research, CMS revised the SB model documents effective for the 2015 contract year. The revisions focused largely on making the SB more useful to beneficiaries through use of plain language, limiting the description of benefits to those covered under the plan, removing the comparison of plan benefits against coverage under Original Medicare, and including a free-form text field under each benefit for plan use.

General Guidance

Plans and sponsors should generate their SB via the Health Plan Management System (HPMS) using the following path: *HPMS >Plan Bids> Bid Reports>Contract Year 2015> Summary of Benefits Report.* The language for the Introduction, Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services, and the Covered Medical and Hospital Benefits sections must be identical to the SB report, except as allowed by CMS. Any deviation from the SB report, outside of an approved hard copy change or global hard copy change, will result in the material being non-compliant. Deviations include the insertion of footnotes, inappropriately altering the format, including plan-specific clarifications, or exceeding the character limit in the free-form text fields underneath each benefit.

Additional Information Section (formerly Section III)

Plans or sponsors may choose to use the *Additional Information About [insert 2015 plan name]* section to provide additional information that is not related to the covered services already

included in the SB. This section is optional and should not duplicate information that can be or is provided elsewhere in the SB.

This information may be represented as text, pictures, graphics, or maps as long as they meet accessibility standards. The following are examples of information that ***may*** be included in the Additional Information section:

- Local presence
- Plan and sponsor history
- Mission statement
- Plan governance details
- Information about covered services that are not included in the SB (must be verified with the PBP report)
- For those with partial counties, provide a cross-reference to the Introduction and list the zip codes
- Multi-language insert, as desired

The following information ***should not*** be included in this section:

- Standard or supplemental benefit information already contained within the SB
- State-specific Medicaid information (Dual-eligible Special Needs Plans (D-SNPs))

Plans and sponsors should limit the text in this section to 1300 characters, excluding the multi-language insert, and not exceed one page if plans and sponsors use pictures, graphics or maps. Plans and sponsors translating the SB into other languages may add characters, as necessary, to ensure the translation conveys the same information as the English-language version.

Summary of Medicaid-Covered Benefits Section (formerly Section IV)

Dual Eligible Special Needs Plans (D-SNPs) must provide each prospective enrollee, prior to enrollment, a comparison of benefits and cost-sharing protections available under the SNP and the State Medicaid plan. The purpose is to help beneficiaries determine whether they would receive any value from enrolling in the SNP. Plans are responsible for ensuring the accuracy of Medicaid benefits.

The *Summary of Medicaid-Covered Benefits* template with newly updated instructions is accessible via HPMS using the following path: *HPMS>Plan Bids>Bid Submission>CY 2015>Documentation>SB Template for D-SNPs.*

<u>Permissible Changes</u>

The following guidance outlines permissible changes that do not need CMS approval.

Note: These changes will not be reflected in HPMS or the Medicare Plan Finder.

1. Optional Free-Form Text

If you would like to clarify benefits entered in the PBP that are not comprehensively described in the SB, you may use the optional free-form text area to describe the benefits. To help plans describe their benefits accurately, we added the following text in each of the benefit categories *[Use this optional field to provide additional information about the benefit described directly above. This field may not exceed 300 characters. The information included must be consistent with the data displayed in the PBP reports in HPMS. If no additional explanation is necessary, please delete this placeholder.]*

2. Disclaimer

Plans must add their Federal Contracting Disclaimer to the SB after the *Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services* section.

3. Partial Counties

Zip codes for partial counties can either be listed in the *Additional Information* section or in the introduction.

4. Side-by-Side Comparisons

Plans and sponsors may include several plans in the same document by displaying the benefits in separate columns (e.g., MA vs. MA-PD). Plans and sponsors using this option must:

- Only include similar plan types (e.g., HMO to HMO but not HMO to PFFS or HMO to PPO). Please note: SNPs should remain separate from non-SNP plans but may be grouped together by similar SNP type (e.g., chronic SNPs, D-SNPs, Institutional-SNPs) and plan type (e.g., HMO, PPO).
- Manually combine the information in *Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services* and *Covered Medical and Hospital Benefits* into a chart format.
- Modify introduction as follows:
    a. Accurately reflect the plans that have been added to the *Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services and Covered Medical and Hospital Benefits* sections.
    b. Under *Who can join?,* make it clear which service area applies to which plan.

5. Premium/Cost-Sharing Tables in the Summary of Benefits

Plans and sponsors with identical benefits offered in different regions may combine their SB even if their premiums and/or cost-sharing vary. Plans and sponsors using this option must:

- Include the following statement: *"Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area."*

- Include the "Premium/Cost-Sharing Table" at the end of the SB and before the *Additional Information About [insert 2015 plan name]* section, if it is included.

The table must include only the plan's name, number, service area and premium/cost sharing. Plans and sponsors may include introductory information about the table and how to use it; however, no other plan information may be included with the "Premium /Cost-Sharing Table."

6. Medicare Premium and Deductible Placeholder Sentences

Plans have the option to use the prior year's Medicare premium and deductible amounts instead of waiting for CMS to release the upcoming year's amounts. Plans that apply the Medicare-defined cost-sharing for *Inpatient Hospital Care*, *Mental Health Care and Skilled Nursing Facility* may also use the prior year's Medicare cost-sharing amounts.

With this option, the plan's SB will print both the prior year's Medicare cost sharing amounts and a placeholder for the upcoming year's Medicare cost-sharing amounts. Plans that need to print prior to CMS' release of the Medicare cost-sharing may use the prior year's Medicare cost-sharing amounts and sentences, and delete the upcoming year's placeholder sentences.

Plans that can wait until CMS releases the upcoming year's Medicare cost-sharing should use the upcoming year's placeholders and manually update the SB with Medicare cost sharing when the amounts are released. In addition, these plans must delete the prior year's Medicare cost-sharing amounts and sentences.

Note: HPMS and the Medicare Plan Finder will automatically display the upcoming year's Medicare cost-sharing amounts**.**

7. Formatting Changes

- Plans and sponsors may include a front and back cover page.
- Plans and sponsors may display the SB header on each page or on each section of the SB.
- Plans and sponsors may print the SB in portrait or landscape page format.
- Plans and sponsors may use techniques (e.g., capitalize or bold text) to aid in readability provided such techniques do not steer beneficiaries to, or away from, benefits or interfere with legibility.

Submission Process

Plans and sponsors must submit all sections of the SB as one document under the File & Use process.

SB Hard Copy Change Request Module

SB hard copy changes will only be allowed to correct inaccurate or misleading information; it is not to make changes based on your organization's preference. If errors are a result of a system error from the Plan Benefit Package (PBP) software, contact the HPMS help desk at hpms@cms.hhs.gov to correct the information.

CMS will release the SB hard copy change request module in the Health Plan Management System (HPMS) on June 23, 2014 for plans and sponsors to submit hard copy changes to their SB. The module is accessible via HPMS using the following path: HPMS >Plan Bids>SB Hard Copy Change Request>Contract Year 2015. Please note that CMS will not review hard copy change requests related to the benefits in the SB until bid negotiations are complete. The deadline for hard copy change requests is September 24, 2014. The module will no longer be available after this date.

SB Global Hard Copy Change Report (CMS Approved Changes)

Plans and sponsors are required to make any applicable changes outlined in the global hard copy change report prior to submitting the SB in the HPMS Marketing Module. The report can be downloaded into Excel or PDF files, and is accessible via HPMS using the following path: HPMS >Plan Bids> Bid Reports>Contract Year 2015> SB Hard Copy Change Request Global Report. The report will be available in HPMS on July 21, 2014.

Please direct questions regarding this memo to SummaryofBenefits@cms.hhs.gov.