DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C4-23-07
Baltimore, Maryland 21244-1850

MEDICARE ADVANTAGE GROUP

DATE: September 28, 2007

TO: All Medicare Advantage Plans and Prescription Drug Plans
Select Cost Plans

FROM: Cynthia G. Tudor, Ph.D.
Director, Medicare Drug Benefit Group

David A. Lewis
Director, Medicare Advantage Group

SUBJECT: 2008 Summary of Benefits and Combined Standardized Annual Notice of Change and Evidence of Coverage Updates

Medicare Part B Premium and Deductibles

In an effort to ensure that beneficiaries are able to receive the Summary of Benefits (SB) timely, CMS will permit organizations to include the following language related to the 2008 Medicare Part B premium, Part B deductible and Medicare Part A Inpatient Hospital (IP) and Skilled Nursing Care (SNF) cost sharing amounts. Organizations should include the prior year Medicare cost sharing amounts in the SB under the Section "Premium and Important Information". The following statement must be included in the plan column: "This SB includes the 2007 Medicare cost sharing amounts and will change effective January 1, 2008. Social Security will notify you of the new 2008 Medicare Part B premium, deductible and Part A cost sharing amounts prior to January 1, 2008."

Include the following sentence each place the SB lists the 2007 Medicare cost sharing amounts. This includes both the Original Medicare column and the Plan Column. "This SB includes the 2007 Medicare cost sharing amounts and will change effective January 1, 2008."

You may make this change to the hard copy of the SB without specific or additional approval from CMS Central or Regional Office. Organizations must update their SBs with the correct Medicare cost sharing during the next printing.

Global hard copy changes for Special Needs Plans(SNP) with any Low Income Subsidy (LIS) Members

CMS has provided specific prescription benefit cost sharing guidance for SNPs with LIS members. Please refer to the attachment for permissible global hard copy changes. If the attached guidance does not capture your benefit design, you may submit a hard copy request to the Part D SB mailbox at PartDSummaryofBen@cms.hhs.gov.

Please send: any MA questions to SummaryofBenefits@cms.hhs.gov , Part D questions to PartDSummaryofBen@cms.hhs.gov, or MA-PD questions to both mailboxes.

Submission of Combined Standardized Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

On August 17, CMS released the Final Evidence of Coverage and advised plans electing to use the combined standardized ANOC/EOC to submit the materials separately for Regional Office review. As a result, CMS has developed a new marketing material category code (1023) for the combined ANOC/EOC that may be used by all Medicare Organizations (MA) Organizations, Medicare Advantage Prescription Drug Plans (MA-PD), Medicare Prescription Drug Plans (PDPs), or 1876 Cost Plans.

Organizations that received approval on both pieces must submit the entire combined document in HPMS under category code 1023. Although it is optional for plans to use the combined ANOC/EOC, plans using it must submit their final document prior to distribution, according to the following steps:

- In order to use the combined ANOC/EOC process, plans should first submit their stand-alone ANOC and EOC in HPMS for approval.
- Upon approval, plans may insert their ANOC into their EOC in front of the table of contents.
- Plans should not change the content or organization of the approved stand-alone ANOC and EOC when combining the documents. Modifying the content or organization of either approved stand-alone document will require a 45-day review.
- Plans should then submit the Combined ANOC/EOC in HPMS using the code 1023.
- Plans should not change the 'model language' or 'File & Use' fields on the submission page when submitting the document, unless they have modified the content or organization of the document.
- Since this is a File and Use document, it can not be used until five days after the date of submission.

(**Note**: Plans must have File & Use certification or eligibility prior to submitting the Combined ANOC/EOC.)

Questions regarding submitting the Combined ANOC/EOC model document should be referred to your CMS Regional Office.

Global Hard Copy Changes for SNPs with Any LIS Members

	Institutional SNPs	**Disproportionate SNPs**	**Exclusive Dual SNPs (All Variations)**
Deductible	Depending on your income and institutional status, you pay the following: o A $0 yearly deductible; or o A $56 yearly deductible; or o A <insert plan deductible amount> deductible	Depending on your income and institutional status, you pay the following: o A $0 yearly deductible; or o A $56 yearly deductible; or o A <insert plan deductible amount> deductible	A $0 yearly deductible
Initial Coverage	Depending on your income and institutional status, you pay the following for generic drugs (including brand drugs treated as generic): o A $0 copay; or o A $1.05 copay; or o A $2.25 copay; or o 15% coinsurance; or o <insert plan cost-sharing amount(s) here> Depending on your income and institutional status, you pay the following for all other drugs: o A $0 copay; or o A $3.10 copay; or o A $5.60 copay; or o 15% coinsurance; or o <insert plan cost-sharing amount(s) here>	Depending on your income and institutional status, you pay the following for generic drugs (including brand drugs treated as generic): o A $0 copay; or o A $1.05 copay; or o A $2.25 copay; or o 15% coinsurance; or o <insert plan cost-sharing amount(s) here> Depending on your income and institutional status, you pay the following for all other drugs: o A $0 copay; or o A $3.10 copay; or o A $5.60 copay; or o 15% coinsurance; or o <insert plan cost-sharing amount(s) here>	Depending on your income and institutional status, you pay the following for generic drugs (including brand drugs treated as generic): o A $0 copay; or o A $1.05 copay; or o A $2.25 copay for generic drugs Depending on your income and institutional status, you pay the following for all other drugs: o A $0 copay; or o A $3.10 copay; or o A $5.60 copay
[Coverage	[100% coinsurance] or [<insert plan cost-	[100% coinsurance] or [<insert	

Gap]	sharing amount(s)>] [N/A for LIS beneficiaries.]	plan cost-sharing amount(s)>] [N/A for LIS beneficiaries.]	[N/A for LIS beneficiaries.]
Catastrophic Coverage	Depending on your income and institutional status, you pay the following after your yearly out-of-pocket costs reach $4,050: o A $0 copay for all drugs; or o A $2.25 copay for generic drugs (including brand drugs treated as generic) and a $5.60 copay for all other drugs; or o The greater of either 5% coinsurance or a $2.25 copay for generic drugs (including brand drugs treated as generic) and a $5.60 copay for all other drugs	Depending on your income and institutional status, you pay the following after your yearly out-of-pocket costs reach $4,050: o A $0 copay for all drugs; or o A $2.25 copay for generic drugs (including brand drugs treated as generic) and a $5.60 copay for all other drugs; or o The greater of either 5% coinsurance or a $2.25 copay for generic drugs (including brand drugs treated as generic) and a $5.60 copay for all other drugs	After your yearly out-of-pocket drug costs reach $4,050, you pay a $0 copay