DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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

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SUBJECT: Contract Year 2013 Summary of Benefits Guidance

This memorandum provides Medicare Advantage Organizations, Prescription Drug Plan Sponsors and 1876 Cost Plans with the following information to prepare their Contract Year (CY) 2013 Summary of Benefits (SB): the SB hard copy change request module, the SB global hard copy change report, general guidance, permissible changes and submission process.

SB Hard Copy Change Request Module

The Centers for Medicare and Medicaid Services (CMS) will release the SB hard copy change request module in the Health Plan Management System (HPMS) on June 22, 2012 for plan sponsors to submit hard copy changes to their SB Sections I and II. Please note that CMS will not review hard copy change requests related to SB Section II until bid negotiations have been completed.

As a reminder, the purpose of SB hard copy changes is to correct inaccurate or misleading information or errors generated from the Plan Benefit Package (PBP) software; it is not to make changes based on an organization's preference. When SB hard copy changes are necessary to clarify benefits entered in the PBP that do not generate an SB sentence, plan sponsors should further describe the benefits in SB Section III.

SB Global Hard Copy Change Report (CMS Approved Changes)

The SB global hard copy change report will be available in HPMS on July 23, 2012. Plan sponsors are required to make any applicable changes outlined in the 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 navigation path: HPMS home page>Plan Bid> Bid Reports>Contract Year 2013> SB Hard Copy Change Request Global Report.

General Guidance

Plan sponsors should generate their SB via HPMS using the following navigation path: HPMS home page>Plan Bid> Bid Reports>Contract Year 2013> Summary of Benefits Report. The language for Sections I and II 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, or including plan specific clarifications.

Fully-integrated dual eligible SNPs (FIDE SNPs) may display integrated benefits applicable to each benefit category in Section II of the SB. If this option is adopted, the standardized sentences may only be modified to make the description of the integration accurate.

Section III is used by plan sponsors to describe special features of a program or to provide additional information about benefits described within Sections I and II. Section III is optional and is not standardized with regard to format or content. It may contain text, graphics, pictures or maps. This section may not exceed six pages (six single-sided pages or three double-sided pages). Plan sponsors translating the SB may add pages, as necessary, to ensure the translation conveys the same information as the English language version.

If the organization chooses to further describe its covered benefits, it must reference the information in the relevant section of the benefit comparison matrix using the following sentence: "See page < > for additional information about (Enter benefit category exactly as it appears in the left column.)." All information included in Section III must be verified with the data entered in the PBP report in HPMS.

SB Section IV (Comprehensive Written Statement – Medicaid Benefits)

Plan sponsors offering Dual Eligible Special Needs Plans (D-SNPs) must provide each prospective enrollee, prior to enrollment, with 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 receive any value from enrolling in the SNP. Plan sponsors are responsible for ensuring the accuracy of Medicaid benefits.

Section IV is accessible in HPMS using the following navigation path: Plan Bids>Bid Submission>CY 2013>Documentation>SB Template for D-SNPS.

If a plan does not have SB Section III, they should not label SB Section IV as SB Section III. The Medicaid Section must be distinct and may be labeled as "Medicaid Benefits."

D-SNPs that cover all duals have the option to include the following disclaimer:
"The services listed below are available only to those SNP members eligible under Medicaid for medical services."

FIDE SNPs that choose to integrate benefits in Section II must include the following disclaimer: "Many of the services that are covered by Medicaid are also covered by Medicare through your Medicare Advantage SNP. These services are not listed below. Only the services that may continue when Medicare coverage ends, or which are not covered by Medicare, are shown."

Note : FIDE SNPs that choose to integrate benefits in Section II are still required to include a Section IV in their SB.

Permissible Changes

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. Partial Counties -SB Section I (Introduction)

SBs that have an asterisk (*) in Section I to indicate partial counties may list the zip codes in Section I or provide a cross-reference and list the zip codes in Section III.

2. 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.

3. Side-by-Side Comparisons

Plan sponsors may describe several plans in the same document by displaying the benefits for different plans in separate columns within the benefit comparison matrix, (e.g., MA vs. MA-PD). Plan sponsors using this option must:

- Only include similar plan types when describing several plans, (e.g., HMO to HMO but not HMO to PFFS or HMO to PPO).
- Create a side-by-side comparison matrix for two (or more) plans by manually combining the information in Section II into a chart format.
- Modify Section I (introduction) to accurately reflect the plans that have been added to Section II.
- Include the following statement in Section I: "Where is <the plan name> available?": "There is more than one plan listed in this Summary of Benefits."
- Include the following statement in Section I, for plans with identical benefits within one contract (e.g., one contract S/H/R number): "Where is <plan name> available?": "If you move out of the state or county where you currently live to a state listed above, you must call Customer Service to update your information. If you don't, you may be disenrolled from <plan name>. If you move to a state not listed above, please call Customer Service to find out if <plan org> has a plan in your new state or county."

4. Use of Premium Tables in the Summary of Benefits

Plan Sponsors with identical benefits offered in different regions may combine their SB even if their premiums vary between plans. Plan sponsors using this option must:

- Indicate the premium range for all plans listed in the SB in Section II. In addition, plans must include a note directing the reader to a "Premium Table" that reads "Please refer to the Premium Table after this section to find out the premium in your area."

- Include the "Premium Table" after Section II and before Section III. 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."

Regional Copay/Premium Table: Plan sponsors with identical benefits in multiple regions may create a regional copay or premium table to accompany the SB that lists the copays/premiums for all regions covered. Along with the table, there should be an instruction to members explaining how to find the co-pay and premium information that applies to them.

5. Medicare Premium and Deductible Place Holder Sentences in SB Section II

Plan sponsors 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. MAOs that apply the Medicare-defined cost sharing for Inpatient Hospital Acute, Inpatient Hospital Psychiatric and Skilled Nursing Facility may also use the prior year's Medicare cost sharing amounts.

With this option, the SB will print both the prior year's Medicare cost sharing amounts and a place holder sentence for the upcoming year's Medicare cost sharing amounts. Plan sponsors that need to go to production 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.

Plan sponsors that can wait until CMS releases the upcoming year's Medicare cost sharing should use the upcoming year's placeholder sentences and manually update the SB with Medicare cost sharing when the amounts are released. In addition, these plan sponsors should delete the prior year's Medicare cost sharing amounts and sentences.

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

6. Formatting Changes

- Plan sponsors may include a front and back cover page.
- Plan sponsors may display the SB header on each page or on each section of the SB.
- Plan sponsors may print the SB in portrait or landscape page format.
  Plan 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

Plan sponsors must submit all sections of the SB as one document under the file & use process.

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