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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 2017

This memorandum provides Medicare Advantage Organizations (MAOs), section 1876 Cost Plans, and Prescription Drug Plans with the guidance to prepare their Contract Year (CY) 2017 Summary of Benefits (SB) in accordance with CMS requirements.

For CY 2017, Plans will no longer generate the SB via the Plan Benefit Package (PBP) software in the Health Plan Management System (HPMS). CMS made this change as a result of feedback we received from the industry, current marketing practices (i.e., many organizations currently produce their own "benefit highlights" document to market their products), and consumer testing results.

Plans must now develop their own SB that clearly and accurately communicates benefits and cost-sharing using information from their approved bid and the following guidance. Plans must conduct a thorough review of their SB documents and reprint the document if inaccuracies are identified.

Plans must reflect the benefit and cost-sharing for the following in the new SB document in this order:

- Monthly Plan Premium, including Part C and Part D premium;
- Part B premium Buy-Down, if applicable;
- Deductibles, including plan level and category level deductible;
- Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*;
- Inpatient Hospital coverage;
- Doctor Visits (Primary and Specialists);
- Preventive Care;
- Emergency Care;
- Urgently Needed Services;
- Diagnostic Services/Labs/Imaging;

- Hearing Services;
- Dental Services;
- Vision Services;
- Mental Health Services (including inpatient);
- Skilled Nursing Facility;
- Rehabilitation Services;
- Ambulance;
- Transportation;
- Foot Care *(podiatry services)*;
- Medical Equipment/Supplies;
- Wellness Programs *(e.g., fitness)*; and
- Medicare Part B Drugs.

- Part D Sponsors only must include the following:
    - Information about all four phases of the benefit. At a minimum, Part D Sponsors must include information that cost-sharing may change when entering another phase of the Part D benefit and direct readers to call the plan for more information or access the Evidence of Coverage online.
    - The levels of prescription medication with both the tier number/name (e.g., Tier 1, Tier 2, etc.) and the more general description (e.g., generic, preferred brand, etc.)
    - When discussing the levels of prescription medication, Part D Sponsors must notify beneficiaries that cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, mail-order, Long Term Care (LTC) or home infusion, and 30 or 90 days supply.

Plans must maintain the above order of the cost-sharing data elements when developing their SB so as not to confuse beneficiaries when comparing various plan options. Plans have a choice whether to display drug benefits or health benefits first. However, the monthly premium, deductible and the maximum-out-of pocket cost must remain first. If any of the benefits are not offered, indicate them as "not covered." Plans may remove certain benefits if they are not applicable to a particular plan type. For example, stand-alone Part D Plans may remove all health benefits. Plans may list additional benefits after all the required cost-sharing data elements are provided in the SB.

Other required information in the SB:

- The Plan name and type must be clearly labeled for all Plans represented in the SB document. For example, <Plan name, HMO or PPO>;
- Description of the plan and types (e.g., HMO, HMO-POS, PPO, MSA, PFFS, SNPs);
- Service area and eligibility requirements, including the Medicaid eligibility criteria applicable to Dual Eligible Special Needs Plans (D-SNPs);
- Phone number, including TTY/TDD;
- Days and hours of operation;

- Website address;
- In-network and out-of-network cost-sharing information for applicable plan types;
- Link to the provider/pharmacy directory and formulary;
- Applicable disclaimers as per the Medicare Marketing Guidelines;
- Language stating this is a summary document and that the complete list of services is found in the Evidence of Coverage (EOC), as well as language directing readers how to access and/or order the EOC;
- Language that directs readers how to access and/or order the "Medicare & You" handbook;
- If the SB includes plans with and without Part D prescription drug coverage, the distinction between plans should be clear;
- Make it clear if health services require a physician referral or prior authorization;
- Multi-language insert. This can be part of the SB or included with the SB; and
- Information on optional supplemental benefits, if applicable.

Note: Plans must make the SB available in any language that is the primary language of at least five (5) percent of a Plan's plan benefit package service area.

Medicare Medical Savings Account Plans (MSA)

MSA plans must:

- Insert the amount Medicare will deposit into the beneficiaries MSA account; and
- Include language that the beneficiary will pay nothing once the deductible is met.

D-SNPs

If the D-SNP is open to Medicare-Medicaid enrollees with differing levels of cost sharing, SNPs should insert language to make it clear how cost-sharing and benefits differ depending on the level of *Medicaid* eligibility. D-SNPs must describe the Medicaid benefits, if any, provided by the plan. Fully integrated dual eligible SNPs (FIDE SNPs) and other D-SNPs that provide Medicaid benefits should display integrated benefits in the SB. We encourage FIDE SNPs to work with the state Medicaid agencies with which they contract in developing an SB that displays integrated benefits.

Medicaid-Covered Benefits

Plans may continue to use the SB to provide each prospective enrollee, prior to enrollment, a comprehensive written statement describing cost-sharing protections and benefits available under the D-SNP and the State Medicaid plan. The purpose of this comprehensive written statement is to help beneficiaries determine whether they would receive any additional value from enrolling in the D-SNP. Plans are responsible for ensuring the accuracy of the description of Medicaid benefits. Plans that send the Annual Notice of Change (ANOC) and EOC together also have the option to meet this requirement by including this comprehensive written statement in the EOC and ensuring the SB refers beneficiaries to this information in the EOC. Plans that send the ANOC and EOC separately must include the Medicaid benefits in the SB.

Medicare Premium and Deductible

Plans may 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.

For any benefits for which the plan uses Medicare amounts for member cost-sharing in their approved bid, the plan may insert the prior year's Medicare amounts; Plans must include a note that these amounts may change in 2017, and the plan will provide updated rates as soon as Medicare releases them.

Overall design and layout:

- Plans may present multiple plans in the same document by displaying the benefits in separate columns. Plans 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).
- May make use of colors to enhance the ability to navigate the document.
- May incorporate various icons/graphics to help locate important information, such as how to complete an application online or contact information (i.e., phone number) for customer service help.

Recommendations based on consumer testing:

- Avoid the use of multiple folds and a large chart in the document as it is cumbersome and difficult to use;
- Include definitions and purpose of the document;
- Avoid using document designs that are too large (i.e., dimensions) as it could diminish the usefulness of the SB; and
- Avoid the use of footnotes; if necessary to include footnoted information, visually emphasize (e.g., larger or bold font) the inclusion of superscripts in coverage charts.

HPMS Submission Process

Plans must submit the SB under the File & Use process using code 1099.

Attached is a sample SB document for your reference. Plans have the flexibility to deviate from this example, provided the requirements as outlined in this memo are followed.

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