CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11509	**Date: July 28, 2022**
	Change Request 12798

SUBJECT: Cessation of Use of MyMedicare.gov Web Address

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to direct all contractors to cease use of the MyMedicare.gov web address, and to instead use Medicare.gov. Contractors will need to replace this verbiage anywhere in any of their materials that MyMedicare.gov appears, including correspondence, websites, the Medicare Summary Notice (MSN), etc.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/10.3.5/ Medicare Preventive Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11509	Date: July 28, 2022	Change Request: 12798

SUBJECT: Cessation of Use of MyMedicare.gov Web Address

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is no longer using the "MyMedicare.gov" web address. All Medicare Administrative Contractors (MACs) will need to replace all instances of the "MyMedicare.gov" web address with "Medicare.gov." Any Medicare Summary Notice (MSN) messages will be addressed separately from this CR.

B. Policy: There are no policy implications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12798.1	All contractors shall no longer direct beneficiaries to MyMedicare.gov.	X	X	X	X					RRB-SMAC
12798.1.1	Contractors shall ensure that the MyMedicare.gov web address is no longer used in any correspondence, documents, or on any websites, etc., including on the Medicare Summary Notice (MSN).	X	X	X	X					RRB-SMAC
12798.1.1.1	The contractor shall work with the print centers to update the form flash, on page 2 of the MSN, under the "Medicare Preventive Services" section, to replace the last bullet point with the following bullet point: • Create an account on Medicare.gov. THe Spanish language version should be replaced with: • Crear una cuenta en Medicare.gov.		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12798.1.1.2	Contractors shall work with their print vendors to test print all MSN types, including English and Spanish.	X	X	X						RRB-SMAC
12798.2	All contractors shall now direct Medicare beneficiaries to Medicare.gov to log into, or create, their secure Medicare account. In all instances where MyMedicare.gov is currently used, it shall be replaced with Medicare.gov.	X	X	X	X					RRB-SMAC
12798.3	Contractors shall note the revised language in Chapter 21, Section 10.3.5 F, of the Internet Only Claims Processing Manual.	X	X	X						RRB-SMAC
12798.4	Contractors shall not make changes to any MSN messages that feature "MyMedicare.gov." Those messages will be addressed separately from this CR. CMS will issue instructions for those messages at a later date.	X	X	X	X					CMS, RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Ardissone, 410-786-7410 or Cynthia.Ardissone@cms.hhs.gov , John Parry, 410-786-7845 or John.Parry@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 21 - Medicare Summary Notices

Table of Contents
(Rev. 10180, 06-12-20)
(Rev.11509; 01-01-23)

10.3.5 - Specifications for Section 2: Making the Most of Your Medicare (Page 2)

(Rev. 3210, Issued: 03-03-15, Effective: 04-16-15. Implementation: 04-16-15)

A. Section Title

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 5″), 7 points from the baseline of the Headers for Other Pages subsection. It is full-page or 540 points in width and 24 points in height.

figure 10.3.5.A

FORMATTING

[GR 2.1] black rule
[TH 2] section name

DYNAMIC RULES
N/A - this section is static.

CONTENT
Making the Most of Your Medicare

B. How to Check This Notice

Global Specifications
POSITION

This subsection contains information of varying size per MSN type. It does not vary in overall width or length per type.

The content area begins (0″, 0.94″), 28 points from the baseline of the Section Title subsection. It is one-column or 259 points in width and varies in height depending on the MSN type. Content is static per type.

Indent 8 points from the top, left, and right, and 12 points at bottom to begin content area.

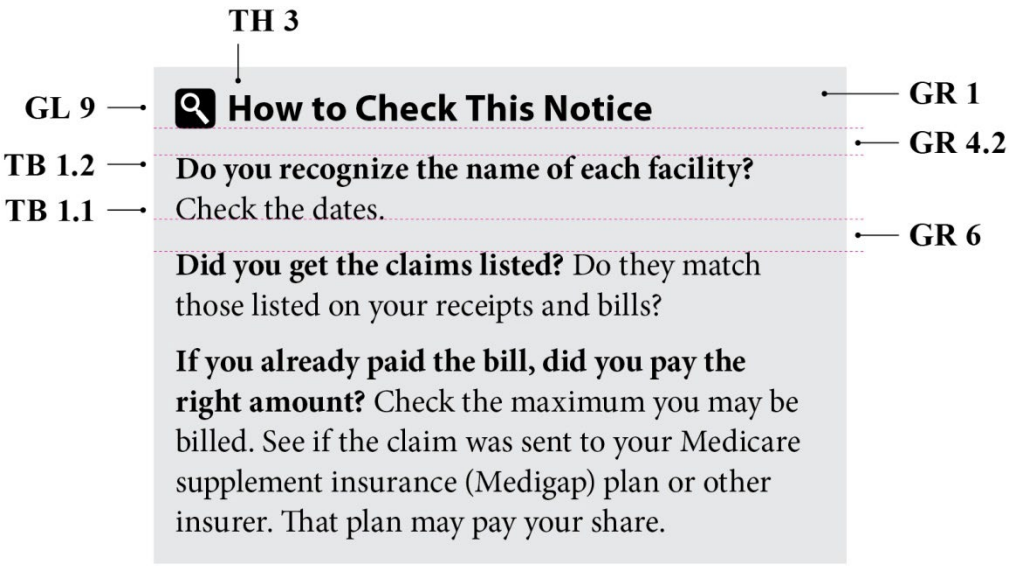

figure 10.3.5.B

FORMATTING

[GL 9] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph
[GR 6] space between paragraph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph
[GR 6] space between paragraph
[TB 1.2] first sentence of each paragraph [TB 1.1] remaining text in each paragraph

DYNAMIC RULES

The body-text content varies depending on which member of the extended family the MSN belongs to - see the content specifications below.

PART A INPATIENT AND 'B OF A', *SPECIFICATIONS*

CONTENT

How to Check This Notice

Do you recognize the name of each facility? Check the dates.
Did you get the claims listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

HOSPICE AND HOME HEALTH SPECIFICATIONS

CONTENT

How to Check This Notice
Do you recognize the name of each doctor or provider? Check the dates. Did you have a visit or service that day?
Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Check This Notice
Do you recognize the name of each doctor or provider? Check the dates. Did you have an appointment that day?
Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Check this Notice
Do you recognize the name of each supplier? Check the dates. Did you make a purchase that day?
Did you get the items/services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

C. How to Report Fraud

Global Specifications

POSITION

This subsection is fixed in width and varies in length depending on content, however the position is dynamic.

The content area begins 19 points from the baseline of the How to Check This Notice subsection. It is one-column or 259 points in width.

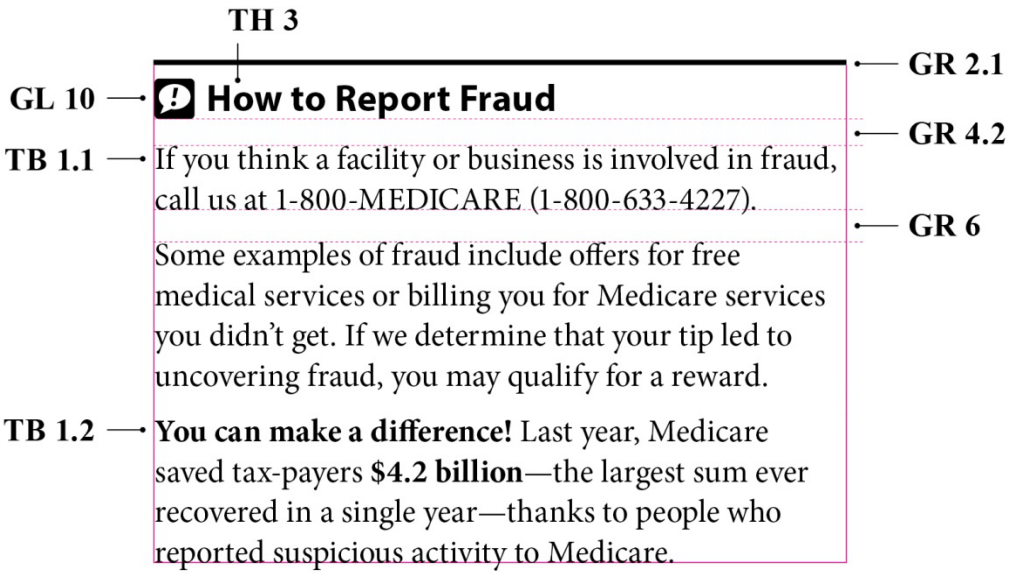

figure 10.3.5.C

FORMATTING

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[GR 4.2] space after glyph
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence highlight [TB 1.1] body text

DYNAMIC RULES

Body-text content in the first paragraph varies depending on which member of the extended family the MSN belongs to - see the content specifications below.
The third and final paragraph of this section contains a fraud-specific message from CMS. The message must be a maximum 185 characters long (inclusive of spaces). The current fraud-specific message can be found on the CMS website:
http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html?redirect=/MSN/02_MSNMessages.asp

PART A INPATIENT AND 'B OF A', *SPECIFICATIONS*

CONTENT

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).
Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.
{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

PART B (ASSIGNED AND UNASSIGNED), HOSPICE, AND HOME HEALTH SPECIFICATIONS

CONTENT

How to Report Fraud
If you think a provider or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Report Fraud

If you think a supplier or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633- 4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

{CMS fraud message of 185 characters (four lines of text) The first sentence may be bold, while the remaining text is roman, with occasional bits, such as **monetary figures or important words**, highlighted in bold.}

D. How to Get Help with Your Questions

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

This subsection begins 19 points below the How to Report Fraud subsection. It is one-column or 259 points in width and 142 points in height.

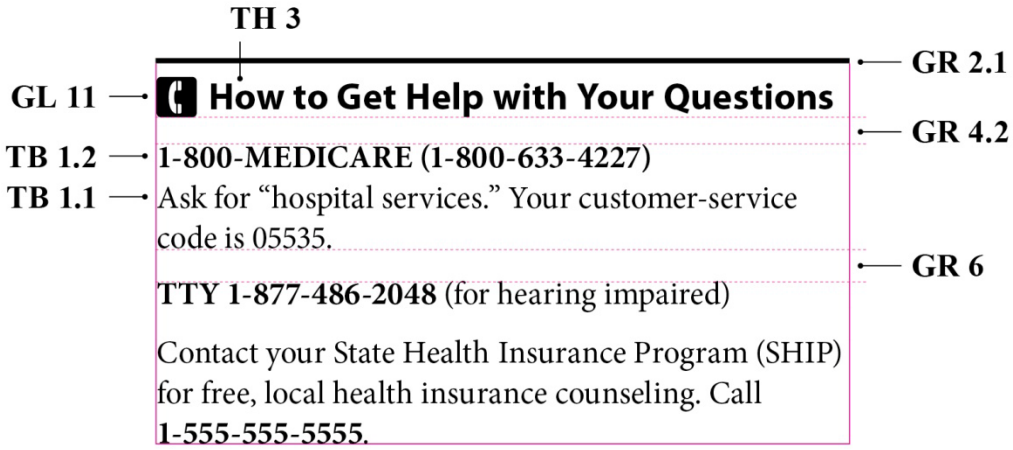

figure 10.3.5.D

FORMATTING

[GR 2.1] black rule
[GL 11] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.2] phone number
[TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] TTY phone number [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.1] body text [TB 1.2] SHIP phone number highlight

DYNAMIC RULES

This subsection contains three pieces of dynamic content: language in the first paragraph that's variable by extended-family member; a MAC ID number; and the SHIP phone number.

Body-text content in the first paragraph varies depending on which member of the extended family the MSN belongs to - see the content specifications below.

The first paragraph also contains the printing MAC's ID number, in order to assist in tracking and routing beneficiary calls to the Medicare call center. This ID number is referred to on the notice as a "customer-service code."

The final paragraph should contain the primary phone number for the State Health Insurance Office, corresponding to the state listed in the notice mailing address in Section 1. The phone numbers for the SHIP offices can be found on the CMS website: http://www.medicare.gov/contacts/organization-search-criteria.aspx.

NOTE*: If the mailing address is that of the legal representative and the beneficiary's address indicates that the beneficiary lives outside of the 50 U.S. states and U.S. territories, then the final paragraph should be suppressed.*

PART A INPATIENT, HOSPICE, HOME HEALTH, AND 'B OF A', *SPECIFICATIONS*

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "hospital services" Your customer-service code is {5-DIGIT A/B MAC (A) ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE}.

Or, if the MSN mailing address is outside the 50 states:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "hospital services." Your customer-service code is {5-DIGIT A/B MAC (A) ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "doctors services." Your customer-service code is {5-DIGIT A/B MAC (B) ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE}.

Or, if the MSN mailing address is outside the 50 states:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "doctors services." Your customer-service code is {5-DIGIT A/B MAC (B) ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "medical supplies." Your customer-service code is {5-DIGIT DME MAC ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call {10-DIGIT PHONE NUMBER FOR SHIP IN RECIPIENT'S STATE OF RESIDENCE}.

Or, if the beneficiary's pricing state is outside the 50 U.S. states and U.S. territories:

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)

Ask for "medical supplies." Your customer-service code is {5-DIGIT DME MAC ID CODE}.

TTY 1-877-486-2048 (for hearing impaired)

E. Your Benefit Periods

This subsection is only for Part A Inpatient MSNs. It can also be included in combined Part A Inpatient and 'B of A' MSNs. It should be suppressed for Hospice, Home Health, Part B (assigned and unassigned), and DME (assigned and unassigned).

The Your Benefit Periods subsection may contain up to three dynamically generated content units, providing beneficiary-specific information related to inpatient hospital benefit days, inpatient lifetime reserve days, inpatient mental health care in a psychiatric hospital limit, and skilled nursing facility (SNF) benefit days.

Language variations exist to describe whether a beneficiary has used all their benefit days for a given type of claim period, or if benefit days remain.

See Exhibit 2.3 for examples of different scenarios regarding benefit periods.

POSITION

This subsection begins (3.9″, 0.94″). This should top align with the How to Check This Notice subsection on the left column. It is one-column or 259 points in width with a variable height, dependent on dynamic content.

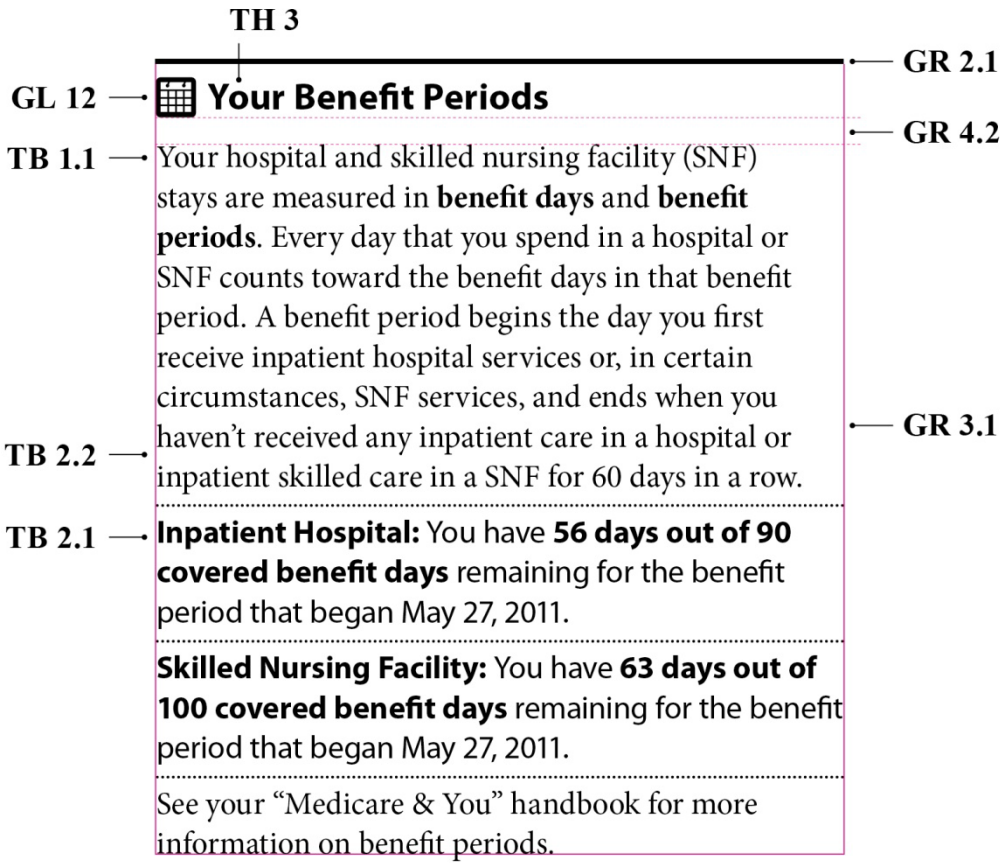

figure 10.3.5.E

FORMATTING

[GR 2.1] black rule
[GL 12] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.1] body text of intro paragraph [TB 1.2] text in bold
[GR 3.1] dotted rule
[TB 2.2] headers for benefit period types [TB 1.1] beneficiary-specific dynamic data within benefit-period info
[GR 3.1] dotted rule
[TB 2.2] headers for benefit period types [TB 1.1] beneficiary-specific dynamic data within benefit-period info
[GR 3.1] dotted rule
[TB 1.2] final paragraph

INPATIENT HOSPITAL DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- If a claim on the notice is for an inpatient hospital stay, and

- The benefit period associated with the claim was still active on the notice date of the MSN - because fewer than 60 days had passed between the last claimed date of stay in the benefit period and the notice date - then this subsection should list how many covered benefit days remain in the benefit period; or

- The benefit period associated with the claim is closed - because more than 60 days had passed since the last claimed date of stay and the notice date - then this subsection should indicate that the benefit period has ended.

- There is no benefit period associated with the claim because it was rejected, therefore no benefit days were used.

The possible dynamic statements for inpatient hospital days are as follows:

You have **{#} out of 90 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

or

You have used all of your 90 covered benefit days for the benefit period that began {Month DD, YYYY}.

or

The benefit periods for all claims on this notice have ended.

or

You didn't have an active benefit period.

LIFETIME RESERVE DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- If a claim on the notice is for an inpatient hospital stay and all inpatient hospital benefit days for the benefit period have been exhausted, and all or a portion of the claimed days have been paid using inpatient lifetime reserve days, and

- The beneficiary still has some number of inpatient lifetime reserve days available, then this subsection should list the remaining inpatient lifetime reserve days the beneficiary had on the date of the notice; or

- The beneficiary had exhausted all of their inpatient lifetime reserve days, then this subsection should indicate that all inpatient lifetime reserve days have been used.

- The beneficiary did not use any inpatient lifetime reserve days because the claim was rejected.

The possible dynamic statements for inpatient lifetime reserve benefit days are as follows:

You have **{#} out of 60 lifetime reserve days** remaining.

or

You have used all of your 60 lifetime reserve days.

or

You didn't have an active benefit period.

INPATIENT MENTAL HEALTH DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- If a claim on the notice is for an inpatient mental health care in a psychiatric hospital stay, and

- The beneficiary still has some number of lifetime mental health care days available, then this subsection should list the remaining lifetime mental health care days the beneficiary had on the date of the notice; or

- The beneficiary had exhausted all of their lifetime mental health care days, then this subsection should indicate that all lifetime mental health care days have been used.

- The beneficiary did not use any mental health care days because the claim was rejected.

The possible dynamic statements for inpatient lifetime reserve benefit days are as follows:

You have **{#} out of 190 mental health care days** remaining.

or

You have used all of your 190 mental health care reserve days.

or

You didn’t have an active benefit period.

SKILLED NURSING FACILITY DAYS

Content in the beneficiary-specific portion of this subsection is subject to the following variations:

- If a claim on the notice is for a skilled nursing facility (SNF) stay, and
- The benefit period associated with the claim was still active on the notice date of the MSN - because fewer than 60 days had passed between the last claimed date of stay in the benefit period and the notice date - then this subsection should list how many covered benefit days remain in the benefit period; or
- The benefit period associated with the claim is closed - because more than 60 days had passed since the last claimed date of stay and the notice date - then this subsection should indicate that the SNF benefit period has ended.
- There is no benefit period associated with the claim because it was rejected, therefore no benefit days were used.

The possible dynamic statements for skilled nursing facility hospital days are as follows:

You have **{#} out of 100 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.

or

You have used all of your 100 covered benefit days for the benefit period that began {Month DD, YYYY}.

or

The benefit periods for all claims on this notice have ended.

or

You didn’t have an active benefit period.

DYNAMIC RULES

In an open inpatient hospital or skilled nursing facility benefit period, the number of remaining covered/reserve days should reflect the number of days that remained on the notice date. If the beneficiary had no remaining benefit days on that date, but the period

was still open, then the second inpatient/SNF statement above should be used, indicating that all benefit days have been used for the period beginning on the stated date.

Only one active benefit period related to the claims listed on the statement should be printed. If there are any additional claims that pertain to another benefit period, suppress the status.

If claims on the notice use any combination of inpatient hospital days, inpatient lifetime reserve days, inpatient mental health care days or skilled nursing facility (SNF) days, then all of the applicable statements, as described above, should be included in this subsection.

If claims did not use lifetime reserve days or inpatient mental health care days, suppress this section and list skilled nursing facility benefit period immediately after inpatient hospital.

CONTENT

Static content, and sample dynamic content, is as follows:

> **Your Benefit Periods**
>
> Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.
>
> **Inpatient Hospital:** You have {**#} out of 90 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.
>
> **Inpatient Lifetime Reserve:** You have **{#} out of 60 lifetime reserve days** remaining.
>
> **Inpatient Mental Health:** You have **{#} out of 190 mental health care days** remaining.
>
> **Skilled Nursing Facility:** You have {**#} out of 100 covered benefit days** remaining for the benefit period that began {Month DD, YYYY}.
>
> See your "Medicare & You" handbook for more information on benefit periods.

F. Medicare Preventive Services

This subsection is only for Part B assigned and unassigned MSNs. It should be suppressed on all other types including Part A Inpatient, Hospice, Home Health, 'B of A', and DME. For Part A Inpatient claims, this subsection should be replaced by the Your Benefit Periods subsection, described above.

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

It begins (3.9″, 0.94″). This should top align with the How to Check This Notice subsection on the left column. It is one-column or 259 points in width and 139 points in height.

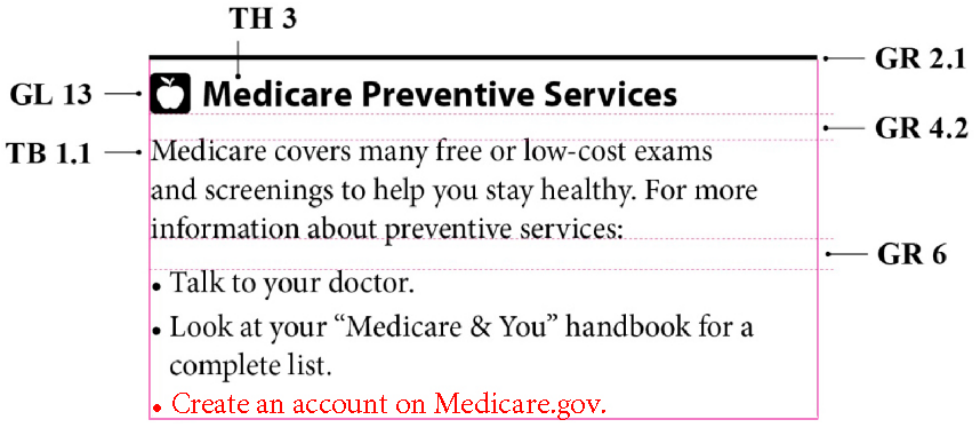

figure 10.3.5.F

FORMATTING

[GR 2.1] black rule
[GL 14] glyph [TH 3] subsection header, center vertically to glyph
[GR 4.2] space after glyph
[TB 1.1] body text of intro paragraph
[GR 6] space between paragraph
[TB 1.1] body text of bulleted paragraph

DYNAMIC RULES

This section should be printed only on Part B assigned and unassigned notices. The content of the section is completely static.
CONTENT

Medicare Preventive Services
Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:

- Talk to your doctor.
- Look at your "Medicare & You" handbook for a complete list.
- *Create an account on Medicare.gov.*

G. Your Messages from Medicare

POSITION

The position of this subsection varies depending on the extended family member: On Part A Inpatient and combined MSNs, it follows the Your Benefit Periods subsection, positioned 19 points from the baseline. On Part B assigned and unassigned MSNs, it follows the Medicare Preventive Services subsection, with 19 points of space from the baseline. On Hospice, Home Health (A) and (B), 'B of A', and DME MSNs, it has a fixed start location at (3.9″, 0.94″), and is top aligned with the How to Check This Notice subsection.

In all cases, it is one-column or 259 points in width with variable height from the dynamic content, depending on the length of the CMS messages.

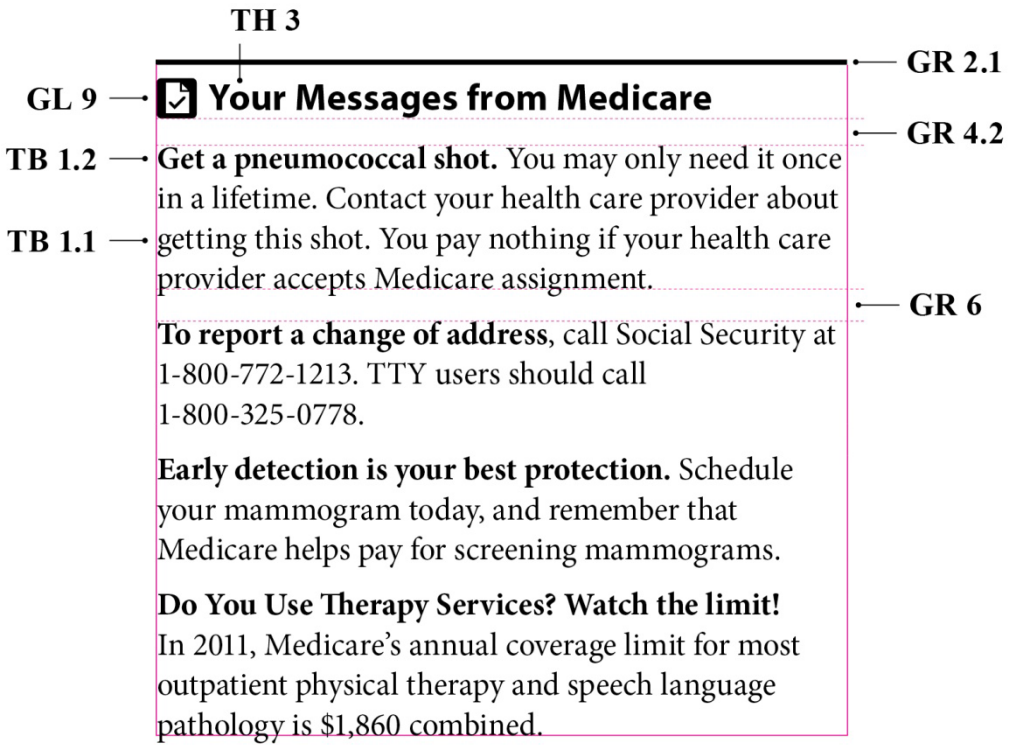

figure 10.3.5.G

FORMATTING

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[GR 4.2] space after glyph
[TB 1.2] first sentence [TB 1.1] body text

[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text
[GR 6] space between paragraph
[TB 1.2] first sentence [TB 1.1] body text

DYNAMIC RULES

This subsection can accommodate up to four messages from CMS. First and second messages must be no longer than 200 characters (inclusive of spaces) and third and fourth messages must be no longer than 250 characters (inclusive of spaces).

Current messages for this subsection, previously known as General Information Messages from Medicare, can be found on the CMS website: http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html.
The first sentence, or the phrase up to the punctuation**,** will be bolded depending on the message. Specific detail on where to bold will be provided by the CR of the variable messages.