2015 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) Standardized Models

Instructions

The 2015 ANOC/EOC standardized model templates must be used by all Medicare Advantage Organizations (MAOs), Medicare Prescription Drug Plans (PDPs), and section 1876 Cost Plans. ANOC/EOC models are standardized documents and must be used exactly as provided, unless otherwise indicated. The Centers for Medicare & Medicaid Services (CMS) will conduct retrospective reviews to ensure clarity and accuracy of the materials.

1. **Permissible Document Alterations**:

MAOs, PDPs, and Cost Plans will not be permitted a global or ad-hoc process for customizing standard language.

i. Minor edits (e.g., grammatical or punctuation changes, updating/correcting phone numbers, correcting references) as necessary.

ii. Formatting (e.g., font style, margins) that meets CMS Medicare Marketing Guidelines and other CMS guidance.

iii. Recreating graphics and/or tables for style and format that meets CMS Medicare Marketing Guidelines and other CMS guidance. However, the standardized text must be used in the same order as the standardized document.

iv. Adding plan logo.

v. Renumbering chapters and sections if chapters or sections are omitted or added (when permitted).

vi. Inserting MAO name or "we," "our," "us," "the plan," "our plan," or "your plan" where the document indicates "[insert plan name]." In addition, "we," "our," "us," "the plan," "our plan," or "your plan" may be used interchangeably even when one is already used in the model.

vii. Indicating when the Low-Income Subsidy (LIS) Rider was mailed separately in the LIS Rider references.

viii. For Dual Eligible Special Needs Plans (D-SNPs), indicating when the EOC will be mailed separately in the appropriate references within the ANOC.

ix. Replacing "List of Covered Drugs (Formulary)" with the actual title of the plan Formulary.

x. Replacing references to broad organization names (e.g., State Health Insurance Assistance Program (SHIPs), Quality Improvement Organizations (QIOs), State Pharmaceutical Assistance Programs (SPAPs)) with the state-specific name in the product service areas. If the broad organization name is used throughout the document, the document must refer the beneficiary to Chapter 2 for information on his/her state program.

xi. Section 1876 Cost Plans offering Part D as a separate and distinct optional supplemental benefit may list the Part D premium amount separately within the ANOC/EOC.

xii. Including the Multi-language Insert as part of the model document.

2. Instructions to Modify/Delete Standardized Language

When populating the templates, instructions to plans should be deleted.

i. Modify or delete, as necessary, all references under "all Plan Types" not relevant to your plan.

ii. If your organization uses an open access model, modify or delete, as necessary, all references to primary care providers (PCP), referrals, etc.

iii. If your organization does not offer a Part D benefit package, modify or delete, as necessary, all references to Part D benefits.

iv. Health Maintenance Organization Point of Service (HMO-POS) plans should modify language related to network providers, as necessary, to clarify when a POS benefit may furnish coverage.

v. References to Member Services, the Pharmacy Directory, the Provider Directory, and the Membership Identification (ID) card may be changed to the term used by the organization, sponsor or cost plan.

vi. All references to TTY should be changed to TDD or TTY/TDD, if necessary, to reflect the plan's communication technology.

vii. Multiple benefit packages may be included within one EOC, but must be clearly differentiated to ensure that members easily understand the information for the plan in which they are enrolled. All benefit packages included in one document must be the same plan type and all either offer, or not offer, Part D coverage. For example,

- All MA-only HMOs, or all MA-PD HMOs could be included in one EOC.
- An MA-only HMO could not be included with an MA-PD HMO, and an MA-only HMO could not be included with an MA-only or MA-PD PPO.
- Multiple benefit packages may not be included within one ANOC; rather, each ANOC must be specific to a beneficiary's plan (e.g., directing beneficiaries to a premium table is not appropriate).

viii. MAOs, PDPs, or Cost Plans offering Part D benefits that do not include step therapy on any of their formulary drugs should delete all references to step therapy.

3. HPMS Submission

All premium and cost-sharing information must be reflected in the ANOC/EOC; you may not submit a template with brackets. If reproduced in separate sections, all sections must be submitted in one file as one complete document. You should submit the ANOC/EOC using the following material submission codes:

i. All MAOs, PDPs, and Cost Plans including new Plan Benefit Packages (PBPs) should submit a combined ANOC/EOC through File & Use Certification using HPMS code 1127.

ii. D-SNPs who choose to send the ANOC for member receipt by September 30, and the EOC by December 31, should submit the ANOC using code 1101 and the EOC using code 1110.

iii. The ANOC/EOC documents must be submitted as File & Use, but there is no 5-day requirement; ANOC/EOCs may be distributed immediately following submission in HPMS.

4. Mailing the Documents

All sections of the standardized ANOC/EOC must be sent in the same envelope. MAOs, PDPs, and Cost Plans are required to send both the formulary and Multi-Language Insert, but also have the option of including the LIS Rider, Summary of Benefits (SB), Pharmacy, and Provider Directories in this mailing. CMS strongly encourages MAOs, PDPs, and Cost Plans to send the LIS Rider in the same envelope as the EOC. Although the LIS Rider may be mailed separately, it must be received no later than September 30. Unless otherwise directed, no additional plan communications may be included in this mailing. In order to avoid potential confusion, MAOs, PDPs, and Cost Plans are prohibited from creating communications that will highlight benefits or information in the ANOC/EOC, including details regarding upcoming 2015 plan activities.

i. **MAOs, PDPs, and Cost Plans offering Part D** must send the ANOC/EOC for member receipt no later than September 30.

ii. **Cost Plans not offering Part D** must send the ANOC/EOC for member receipt by December 1.

iii. **D-SNPs** have the option of sending the ANOC with an SB, Multi-Language Insert, and plan formulary for receipt no later than September 30, and the state-integrated EOC and LIS Rider for receipt by December 31. D-SNPs that choose to send a combined ANOC/EOC for member receipt by September 30 are not required to send an SB to current members. D-SNPs that choose to mail the ANOC and EOC at different times are required to send the Multi-Language Insert in the first mailing, and have the option to include it in the second mailing.

iv. **MAOs, PDPs, and Cost Plans sending stand-alone EOCs** to new enrollees with effective dates of January 1 and later may edit the document to remove all references

to the ANOC (even if not bracketed), and send the EOC portion only. Those doing so do not need to resubmit the stand-alone EOC under a new code.

v. **MAOs, PDPs, and Cost Plans** must indicate the actual mail date of their ANOC/EOCs in Health Plan Management System (HPMS) within 15 days of mailing. Those that mail in waves should enter the actual date of the each wave.

5. Employer-Sponsored Group Plans

Entities offering employer-sponsored group plans (including employer/union-only group waiver plans (EGWPs) or individual plans sponsored by employer/union groups) are subject to all applicable Medicare dissemination and disclosure requirements. This includes any requirements related to the timing of these materials, unless specifically waived or modified. Please note the following employer group waivers/modifications as they relate to the requirements in these combined ANOC/EOC instructions:

i. Current CMS guidance does not require entities to submit employer group plan dissemination materials for prior review and approval, although this material must be made available to CMS upon request;

ii. CMS has waived any requirements that would otherwise prevent these entities from changing the required ANOC/EOC language to allow them to customize these materials to more clearly describe the benefits available to employer/union group plan members;

iii. Entities should ensure these materials accurately reflect the actual premium amount the beneficiary pays, including any supplemental coverage and any corresponding employer/union premium subsidization. If the amount the beneficiary actually pays is not available, the entity may use the standardized model language in lieu of providing actual premium amounts (e.g., "contact your employer group plan benefit administrator"); and

iv. CMS has waived/modified applicable timing requirements in certain circumstances, such as when an employer/union group plan has a different open enrollment period from Medicare. In these situations, the combined ANOC/EOC must be received no later than 15 days before the employer/union group plan's open enrollment period begins.

Refer to the Medicare Managed Care Manual (Chapter 9) and the Prescription Drug Benefit Manual (Chapter 12) for more detailed information concerning employer group plans and applicable CMS waivers/modifications.