

**EVIDENCE OF COVERAGE SUBMISSION CHECKLIST**  
**(Checklist Items based on 2007 PFFS EOC)**

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**Instructions**

“Page #” - Indicate the page number on your EOC in which this information can be found.

- If the particular topic does not apply to your plan (for example, explanation of traveler’s benefits or description of the formulary), write “N/A” in this column.
- If the topic is found throughout the document (e.g., member services phone number) write “multiple” in this column

“If not in EOC, where can this be found?” – If you do not include this information in the EOC, indicate what other publication(s) you put it in, e.g., Member Handbook.

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*MA Name* *Contract No.*

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*Material ID No.* *No. of Pages*

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**Welcome Letter/Cover Letter**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Inform member that EOC is available in alternative formats (e.g., Spanish, large print, audio tape, etc).		

**Section 1 – Telephone/Reference Numbers**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Member Service Department – including TTY and hours of operation		
2.	SHIPs		
3.	QIO		
4.	Medicaid		
5.	Social Security		
6.	Railroad Retirement Board		
7.	Employer (or “Group”) Coverage		

**Section 2 – Getting the care you need, including some rules you must follow**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Explain that member still has Medicare as a member of your plan		
2.	Copy and explanation of use of Member Card		
3.	Explain the need for the member to notify the plan of changes (e.g., address changes)		
4.	Service area listing		
5.	Explain difference between “plan” and “non-plan” providers. For PPOs: this includes explaining the financial impact of using non-plan providers.		
6.	Explain how to get care out of the service area (traveler’s benefits)		
7.	Explain what happens if the doctor leaves the plan		

**Section 3 – Getting care if you have a medical emergency or an urgent need for care**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Definition of a medical emergency and emergency services		
2.	Rules for getting emergency care. Member calls 911 for help or go to nearest emergency room. Explain that you do not need prior authorization for emergency care		
3.	Explain Coverage of post-stabilization services		
4.	Explain what is covered for an emergency. Coverage for renal dialysis when member temporarily out of area		
5.	Definition of urgently needed services		
6.	Rules for getting urgently needed care when in the service area		
7.	Rules for getting urgently needed care when outside of the plan’s service area		

**Section 4 – Benefits Chart**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Define covered services		
2.	Explain conditions that apply in order to get covered services		
3.	List of covered benefits, to include the following as appropriate:		
	Inpatient hospital care		
	Inpatient mental health care		
	Skilled nursing facility care		
	Inpatient services (when the stay is not or is no longer covered)		
	Home health care		
	Hospice care		
	Physician services, including doctor office visits		
	Chiropractic services		
	Podiatry services		
	Outpatient mental health care		
	Outpatient substance abuse services		
	Outpatient surgery		
	Ambulance services		
	Emergency care		
	Urgently needed care		
	Outpatient rehabilitation services		
	DME and related supplies		
	Prosthetic devices and related supplies		
	Diabetes self monitoring, training and supplies		
	Medical nutrition therapy		
	Outpatient diagnostic tests and therapeutic services and supplies		
	Bone mass measurements		
	Colorectal screening		
	Immunizations		
	Mammography screening		
	Pap smears, pelvic exams, and clinical breast exam		
	Prostate cancer screening exams		
	Cardiovascular screening blood tests		
	Physical exams		
	Renal Dialysis (kidney)		
	Drugs that are covered under Original Medicare		
	Plan Prescription Drug that are covered under Original Medicare		
	Dental services		
	Hearing services		
	Vision care		
	Health and wellness education		
4.	How to purchase optional supplemental benefits		
5.	Explain that benefits can only be enhanced mid-year		
6.	Explain what to do if there are problems in getting services that are believed to be covered		
7.	Explain that the formulary (or drugs on a preferred list) may change during the contract year		

**Section 5 – Medical care and services that are not covered**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	List services/care that are not covered (list of exclusions)		

**Section 6 – Prescription Drugs**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Explain formulary		
2.	Explain how to fill prescriptions outside the network		
3.	Explain drugs covered by plan (drug tiers, changes in formulary, exception of the plans formulary, transition policy, drug exclusions)		
4.	Explain Drug Management programs (utilization management, drug utilization review, medical therapy management)		
5.	Explain how enrollment in the Plan effects coverage for drugs covered under Medicare Part A or B		
6.	Explain costs for drugs covered by the Plan (deductible, initial coverage level, coverage gap and catastrophic)		
7.	Explain what extra help is available to qualified enrollees (drug costs for people with limited income and how to apply)		
8.	Explain how out-of-pocket cost is calculated		
9.	Define Explanation of Benefits (explain what information is included)		
10.	Explain how prescription drug coverage works if enrollee goes to a hospital or skilled nursing facility (include payments that apply out of pocket)		

**Section 7 – Hospital care, skilled nursing facility care and other services**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Describe inpatient hospital service coverage, including when the stay is not covered. Also explain that Original Medicare will cover unauthorized care form non-plan providers..		
2.	Describe SNF coverage, including when the stay is not covered. Also explain that Original Medicare will cover unauthorized care form non-plan providers.		
3.	Explain hospital care (what is a benefit period)		
4.	Explain home health agency care		
5.	Describe hospice care for people who are terminally ill		
6.	Describe organ transplants		
7.	Describe clinical trials		
8.	Describe care in religious non-medical health care institutions(RNHCI)		

**Section 8 - What you must pay for your Medicare health plan coverage and for the care you receive**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Summary of the member's financial obligations		
2.	Definition of plan premium		
3.	Explanation of how to pay premium		
4.	Explanation of what happens when premiums are not paid		
5.	Explain that premiums cannot be raised mid-year		
6.	Definitions of copayment, coinsurance, deductible		
7.	Explain cost of services that are not covered		
8.	Explain coordination of benefits - why benefits need to be coordinated, who pays first		
9.	Explain what to do if the member pays for emergency care, or is billed for services		
10.	Explain keeping plan updated on health insurance		
11.	Explain what to do if member has bills providers that they think the plan should pay		

**Section 9 – Your rights and responsibilities as a member of [name of plan]**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Explain a member's rights and protections		
2.	Explain a member's right to be treated with fairness and respect		
3.	Explain a member's right to privacy of medical records and personal health information		
4.	Explain a member's right to see plan providers, get covered services, and get prescription drugs filled within a reasonable period of time		
5.	Explain a member's right to know their treatment choices and participate in decisions about your health care		
6.	Define advance directives		
7.	Explain a member's right to use advance directives- such as living will or power of attorney (how to obtain and what to do with advance directives)		
8.	Explain a member's right to make complaints		
9.	Explain a member's right to get information about their health care coverage and costs		
10.	Explain a member's right to get information about the plans providers		
11.	Explain how to get more information about the member's rights		
12.	Explain what to do if a member feels they have been treated unfairly		
13.	Explain member's responsibilities as a member		

**Section 10 – How to file a grievance**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Define grievance		
2.	Explain the types of problems that would lead to filing a grievance		
4.	Describe how to file a grievance		
5.	Explain how a member should complain about quality of care		
6.	Explain how to file a quality of care complaint with the QIO		

**Section 11 – Information on how to make a complaint about Part C services**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Describe the rules for making a complaint about Part C services		

2.	Explain complaints change a decision about services the plan will cover or will pay		
3.	Explain what to do for complaints if member is being discharged from the hospital too soon		
4.	Complaints if SNF coverage, home health or comprehensive outpatient rehabilitation facility services is ending too soon		
5.	Explain process for asking for an initial decision, explanation of fast decisions, timeframes for process		
6.	Explain step-by-step process for appealing coverage decisions (first level appeals) – how to file, when to file, explanation of fast appeals, timeframes for appeals process		
7.	Explain the <i>Important Message from Medicare</i> – purpose and when received		
8.	Remind member that they cannot appeal an optional supplemental benefit but should instead file a grievance.		
9.	Explain appeals process at Independent Review Organization		
10.	Explain ALJ appeals process		
11.	Explain appeals process at Medicare Appeals Council level		
12.	Explain process when appeal goes to Federal Court		

**Section 12 – What to do if you have complaints about your Part D Prescription Drug Benefits**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Explain what to do if member has complaints		
2.	Explain how to request a coverage determination and an appeal		
3.	Explain process for asking for a standard or fast coverage determination		
4.	Explain how to request an appeal		
3.	Explain appeal levels 1-5		

**Section 13 –Leaving [Name of plan] and your choices for continuing Medicare after you leave**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Define disenrollment		
2.	Explain process for leaving a plan		
3.	Explain process for disenrolling		
4.	Explain how often you can disenroll and choices		
5.	Describe process for joining a PDP, MA, or Other Medicare Health Plan		
6.	Explain process for switching from plan to Original Medicare		
7.	Describe process for joining a PDP, MA, or Other Medicare Health Plan		
8.	Explain Medigap		
9.	Explain what happens if the organization leaves the Medicare program or plan leaves the service area		
10.	Explain conditions that can end membership		
11.	Explain right to make a complaint		

**Section 14 – Legal Notices**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Explain notice about governing law		
2.	Explain notice about non-discrimination		

**Section 15– Definitions**

	<b>Topic/Requirement</b>	<b>Page #</b>	<b>If not in EOC, where can this be found?</b>
1.	Definition of “MA organization”, MA plan and Medicare cost plan		
2.	Definition of Service Area		
3.	Definition of Emergency Services and Emergency medical condition		
4.	Definition of Urgently needed services		
5.	Definition of Lock-in		
6.	Definition of Prior Authorization		
7.	Definition of Organization Determination		
8.	Definition of Credible Coverage		
9.	Definition of Coverage Determination		