

Checklist for Combined ANOC/EOC

Instructions

- The Evidence of Coverage/ Annual Notice of Change Checklist is to be submitted with your Combined ANOC/EOC. Both documents should be zipped and submitted as 1 zip file.
- Complete the checklist and submit it with your Combined ANOC/EOC, which you will transmit via the HPMS MA or PDP Marketing Module.

Requirements

All required and relevant information is included in the Combined ANOC/EOC:

MA, MA-PD EOC	Page #
<input type="checkbox"/> Adheres to language and format of the Evidence of Coverage	<u>N/A</u>
<input type="checkbox"/> Marketing material ID	<u> </u>
<input type="checkbox"/> Materials in 12 point font	<u>N/A</u>
<input type="checkbox"/> Include customer service number and TTY/TDD number and hours of operation	<u> </u>
<input type="checkbox"/> Include plan name and benefit year	<u> </u>
<input type="checkbox"/> Include all required sections of the Evidence of Coverage	<u> </u>
<input type="checkbox"/> Include benefits chart	<u> </u>
<input type="checkbox"/> Include explanation of benefits for Part D plans (if applicable)	<u> </u>
<input type="checkbox"/> Include Part D drugs (If applicable)	<u> </u>
<input type="checkbox"/> Include Medicare Supplement policy for coverage for prescription drugs (if applicable)	<u> </u>
<input type="checkbox"/> Include annual deductible amounts, initial coverage, cost sharing under the initial coverage limit; and cost sharing between the initial coverage limit and annual out-of-pocket threshold. (if applicable)	<u> </u>
<input type="checkbox"/> Include major exclusions and limitations. For example, utilization management programs applied to drugs on the formulary. (if applicable)	<u> </u>
<input type="checkbox"/> Include all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or service. (if applicable)	<u> </u>
<input type="checkbox"/> Include description of assurance policies and procedures, including drug utilization management and medication therapy management programs (if applicable)	<u> </u>
<input type="checkbox"/> Include statement that the Part D plan's contract with CMS is renewed annually (if applicable)	<u> </u>
<input type="checkbox"/> Include definition of Formulary (if applicable)	<u> </u>
<input type="checkbox"/> Include how formulary functions (if applicable)	<u> </u>
<input type="checkbox"/> Include statement that drugs on the formulary may change during the contract year (if applicable)	<u> </u>
<input type="checkbox"/> Include explanation how to obtain an exception to the formulary or tiered cost-sharing Structure (if applicable)	<u> </u>
<input type="checkbox"/> Include how to obtain additional information about the drugs included on the Part D Plan's formulary (if applicable)	<u> </u>
<input type="checkbox"/> Include how to access Part D plan benefits (if applicable)	<u> </u>
<input type="checkbox"/> Include how extra help is available to people with limited incomes (if applicable)	<u> </u>
<input type="checkbox"/> Include description of the right to request, and the procedures for requesting grievance, Coverage determinations (including a description of the exceptions process, and appeals. Also, describe disenrollment rights, responsibilities, and procedures	<u> </u>

- ___ Include explanation of benefits (if applicable) ___
- ___ Include all lock-in requirements ___
- ___ Include plan premium and billing information ___
- ___ Include rules for receipt of primary care, specialty care, hospital care, and other medical services ___
- ___ Include rules for emergency care, urgent care, and post-stabilization care (if applicable) ___
- ___ Include appeal rights ___
- ___ Include rules for referrals for follow-up specialty care (If applicable) ___
- ___ Include when a beneficiary enrolls in a plan, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services (If applicable) ___
- ___ Include what happens when beneficiaries use non-plan or non-preferred providers ___
- ___ Include prior authorization rules (If applicable) ___
- ___ Include prior notification (If applicable) ___
- ___ No spelling errors ___

Part D EOC

- ___ Adheres to language and format of the Evidence of Coverage ___
- ___ Marketing material ID ___
- ___ Materials in 12 point font ___
- ___ Include customer service number and TTY/TDD number and hours of operation ___
- ___ Include plan name and benefit year ___
- ___ Include all required sections of the Evidence of Coverage ___
- ___ Include LIS rider ___
- ___ Include benefits chart ___
- ___ Include description of plan service area ___
- ___ Include description of plan Medigap policy ___
- ___ Include annual deductible amounts, initial coverage, cost sharing under the initial coverage limit; and cost sharing between the initial coverage limit and annual out-of-pocket threshold. ___
- ___ Include major exclusions and limitations. For example, utilization management programs applied to drugs on the formulary.(if applicable) ___
- ___ Include all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or service. (if applicable) ___
- ___ Include description of assurance policies and procedures, including drug utilization management and medication therapy management programs (if applicable) ___
- ___ Include statement that the Part D plan's contract with CMS is renewed annually ___
- ___ Include definition of Formulary ___
- ___ Include how formulary functions ___
- ___ Include statement that drugs on the formulary may change during the contract year ___
- ___ Include explanation how to obtain an exception to the formulary or tiered cost-sharing Structure ___
- ___ Include how to access Part D plan benefits ___
- ___ Include how extra help is available to people with limited incomes ___
- ___ Include description of the right to request, and the procedures for requesting grievance, Coverage determinations (including a description of the exceptions process, and appeals. Also, describe disenrollment rights, responsibilities, and procedures ___
- ___ Include explanation of benefits ___

- ___ Include prior authorization rules _____
- ___ Include prior notification _____
- ___ Include No spelling errors _____

ANOC

- ___ Marketing material ID _____
- ___ Material is member-specific and the member's own name either on the envelope addressed to the member or on the ANOC itself _____
- ___ Include table of different plan offerings, the members plan is clearly identified (If applicable) _____
- ___ Include Medicare Prescription Drug coverage _____
- ___ Include how monthly Premium will change _____
- ___ Include changes taking place on January 1 of the upcoming year. _____
- ___ Include other benefits offered (If applicable) _____
- ___ Include when an enrollee can join/leave the Medicare health plan _____
- ___ Include Medicaid drug coverage (If applicable) _____
- ___ No spelling errors _____

Based on my best knowledge, information, and belief, all information submitted to CMS in these documents is accurate, complete, and truthful. Our organization has performed a second quality review of the materials before submitting them to CMS for review and approval.

(Name & Title of preparer of materials/ Date)

(Name & Title of second Quality Reviewer/Date)

On behalf of

(NAME OF ORGANIZATION)