**2013 Annual Notice of Change/Evidence of Coverage   
(ANOC/EOC) Standardized Models**

**Instructions for Plans**

The 2013 ANOC/EOC standardized model templates must be used by all Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Medicare Prescription Drug Plans (PDPs), and section 1876 cost plans. Text in this document is standardized and must be used exactly as provided, unless indicated otherwise. CMS will conduct retrospective reviews to ensure clarity and accuracy of the materials.

1. **Permissible Document Alterations**:

ANOC/EOC models are standardized documents that must not be modified except as noted in the instructions and allowed by CMS. Plans will not be permitted a global or ad-hoc process for customizing standard language. Permissible alterations to the document include:

* 1. Plans may make minor edits, (e.g., grammatical or punctuation changes, updates/corrections of phone numbers, correcting references, etc.), as necessary.
  2. The document can be formatted as desired, (e.g., font style, margins), as long as all changes meet CMS Medicare Marketing Guidelines and other CMS guidance.
  3. Plans may recreate the graphics and/or tables in the document in the style and format desired. However, the standardized text must be used and must remain in the order given in the standardized document and the revised graphics and/or tables must meet the CMS Medicare Marketing Guidelines and other CMS guidance.
  4. Plans may add their logo to the ANOC/EOC.
  5. If chapters or sections are omitted or added (when permitted), plans may renumber the remaining chapters and sections as needed.
  6. Where the document indicates “[insert plan name],” plans may choose to insert their MAO name instead or to use “we,” “our,” “us,” “the plan,” “our plan,” or “your plan.” In addition, where the document already uses one of the terms, “we,” “our,” “us,” “the plan,” “our plan,” or “your plan,” plans may choose to substitute one of these terms for the term suggested in the model.
  7. Plans sending the LIS Rider separately may edit the LIS Rider references within the standardized ANOC/EOC text to indicate that the LIS Rider was mailed separately.
  8. The EOC uses the terminology “List of Covered Drugs (Formulary)” throughout the template. Plans may replace this terminology to reflect the actual title of their Formulary that is sent to members.
  9. Throughout the document, plans may replace references to broad organization names (SHIPs, QIOs, SPAPs, etc) with the state-specific name in the areas where the product is being offered. Plans may choose to use the broad organization name throughout the document, but if doing so must refer the beneficiary to Chapter 2 for information on their state program.
  10. Section 1876 cost plans offering Part D as a separate and distinct optional supplemental benefit (that does not include other optional supplemental benefits in a package) may list the Part D premium amount separately within the ANOC/EOC. In other words, before a cost plan can list a distinct Part D premium, members must be able to select the cost plan either with or without only the Part D benefit.
  11. Plans may include the Multi-language Insert as part of the ANOC/EOC model document.

1. **Instructions to Modify/Delete Standardized Language**

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

1. Plans should modify or delete, as necessary, all references under “all Plan Types” not relevant to your plan.
2. Plans using an open access model should modify or delete, as necessary for their plan, all references to PCP, referrals, etc.
3. Plans not offering a Part D benefit package should modify or delete, as necessary for their plan, all references to Part D benefits.
4. HMO-POS plans should modify language related to network providers when necessary to clarify when a POS benefit may furnish coverage.
5. All references to Member Services, Pharmacy Directory, Provider Directory, Membership Identification (ID) card may be changed to the appropriate name the plan uses.
6. All references to TTY should be changed to TDD or TTY/TDD, if necessary, to reflect the communication technology provided by the plan.
7. Plans may include multiple benefit packages within one EOC; however, if doing so, the plans must be clearly differentiated. The EOC can be edited to ensure that members easily understand exactly 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, plans could include all MA-only HMOs, or all MA-PD HMOs, but could not include an MA-only HMO with an MA-PD HMO, or an MA-only HMO with an MA-only or MA-PD PPO. Plans may not include multiple benefit packages within one ANOC; rather, each ANOC must be specific to a beneficiary’s plan (i.e. directing beneficiaries to a premium table is not appropriate).
8. Plans offering Part D benefits that do not include step therapy on any of their formulary drugs should delete all references to step therapy.
9. **HPMS Submission**

All premium and cost-sharing information must be reflected in the ANOC/EOC, plans may not submit a template with brackets. If reproduced in separate sections, all sections must be submitted in one file as one complete document. Plans should submit the ANOC/EOC using the following material submission codes - all codes will be effective July 2012.

1. All plans should submit a combined ANOC/EOC through File & Use Certification using HPMS code 1127.

Note: New PBPs with no ANOC should submit the EOC using code 1110.

1. D-SNPs who choose to send the ANOC for member receipt by September 30th and the EOC by December 31st should submit the ANOC using code 1101 and the EOC using code 1110.
2. For CY 2013, plan sponsors may distribute File & Use ANOC/EOC’s immediately following submission in HPMS; that is, CMS is waiving the 5-day requirement for File & Use as it relates to the ANOC/EOC documents.
3. **Mailing the Documents**

All sections of the standardized ANOC/EOC must be sent in the same envelope. Plans are required to send both the formulary and Multi-Language Insert and have the option to include the LIS Rider, Summary of Benefits (SB), Pharmacy and Provider Directories in this mailing. CMS strongly encourages plans to send the LIS Rider in the same envelope as the EOC. Although the LIS Rider may be mailed separately, it is still required for receipt no later than September 30th. Unless otherwise directed, no additional plan communications may be included. To eliminate potential confusion, plans are prohibited from creating communications that will highlight benefits or information in the ANOC/EOC, including details regarding upcoming 2013 plan activities.

1. MA, MAPD, PDP plans and 1876 Cost Plans offering Part D must send the ANOC/EOC for arrival no later than September 30th.
2. Cost plans not offering Part D must send the ANOC and EOC for member receipt by December 1st.
3. D-SNPs have the option to send the ANOC with an SB, Multi-Language Insert, and plan formulary for receipt no later than September 30th and the state-integrated EOC and LIS rider for receipt by December 31st. D-SNPs that choose to send a combined ANOC/EOC for member receipt by September 30th 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 in the second mailing.
4. 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. Plans doing so do not need to resubmit the stand-alone EOC under a new code.
5. Plans must indicate the actual mail date of their ANOC/EOC’s in HPMS within three (3) days of mailing. Plans that mail in waves should enter the actual date of the last wave.
6. **Employer Sponsored Group Plans**

Entities offering employer sponsored group plans (these include 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 (including any requirements related to the timing of these materials) unless specifically waived or modified. Please note the following important employer group waivers/modifications as they relate to the requirements in these combined ANOC/EOC instructions:

1. 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;
2. CMS has waived any requirements that would otherwise prohibit entities offering employer group plans from modifying required standardized model combined ANOC/EOC language to allow these entities to customize these materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group plan members;
3. With regard to premium amounts that are required to be accurately reflected on these standardized model materials, entities should ensure these materials accurately reflect the actual premium amount the beneficiary pays when the supplemental coverage, if any, and any corresponding employer/union premium subsidization is taken into account. If accurate premium information concerning 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
4. CMS has waived/modified applicable timing requirements in certain circumstances such as where a particular employer/union group plan sponsor has an open enrollment period that differs from Medicare’s open enrollment period. In these situations, the combined ANOC/EOC must be received no later than 15 days before the particular employer/union sponsor’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.