## Errata Sheet to the

## <Plan Name>

## < Year>

## <Annual Notice of Change and Evidence of Coverage>

*Instructions: plans should only use this errata sheet to correct ANOCs and/or EOCs that were distributed to beneficiaries. Plans that have a correction affecting more than one location in an ANOC and/or EOC should only use one row to describe the change. Plans addressing an error in the EOC, but not the ANOC (and vice versa), may remove references to these documents as appropriate. Plans may also make minor grammatical adjustments to accommodate changes in references (e.g., make a word singular/plural).*

*[Insert date]*

*[Plans may add a greeting (e.g., Dear Member, Dear Mrs. [insert name]).]*

**This is important information on changes in your <insert plan name> coverage.**

We previously sent you the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents which provide information about your coverage as a member of our plan. This notice is to let you know there are errors in your ANOC/EOC document<s>. Below you will find information describing and correcting the errors. Please keep this information for your reference.

**Changes to your ANOC/EOC**

|  |  |  |  |
| --- | --- | --- | --- |
| **Where you can find the error in your [Current Year] ANOC/EOC** | Original Information | Corrected Information | What does this mean for you? |
| [Insert ANOC, EOC, page number, Section, and Title of Section] | [insert original (incorrect) information] | [insert corrected information] | [insert information further describing the corrected information in plain language so that readers understand the impact to them] |
| **Below are examples** | **Below are examples** | **Below are examples** |  |
| On page 2, under “Section 3. Medical services: changes to your benefits” your Annual Notice of Change lists the Optional Supplemental Benefits – Package 1 (Monthly Premium) as: | $29 for the following optional benefits:  -Dental Services  -Chiropractic  Services  -Eyewear  Acupuncture | $30 for the following optional benefits:  - Fee-for-Service  Dental Services\*  - Chiropractic Services  - Eyewear\*  - Acupuncture  \*Please refer to your 2010 Evidence of Coverage for detailed information. | You must pay a $30 monthly premium for the described services. |
| On page 5, under “Section 3. Medical services: changes to your benefits” your Annual Notice of Change lists the Routine (non-Medicare covered) Vision Services Eyewear (glasses, frames, lenses and contacts) as: | $25 copayment | $0 copayment | You will pay nothing for Routine (non-Medicare covered) Vision Services Eyewear (glasses, frames, lenses and contacts) |

[*Plans have the option to insert a paragraph further describing all changes from the original information. Plans should describe benefits/coverage changes by comparing the benefits/coverage information originally provided to the enrollee with the corrected benefits/coverage information.]*

You are not required to take any action in response to this document, but we recommend you keep this information for future reference. If you have any questions please call us at [enter customer service/member services, TTY number, and hours of operation].

*[Plans may add a closing]*

*[Insert the Federal Contracting Statement]*

*[As applicable, insert the Availability of Non-English Translations Disclaimer]*