## Errata Sheet to the

## <Plan Name>

## Annual Notice of Change, Evidence of Coverage

## <Current Year>

*[Insert date]*

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

This letter is to let you know of some corrections to your [enter current year and plan name] Annual Notice of Change, Evidence of Coverage (ANOC/EOC). The corrections to the <plan name> ANOC/EOC are found in the paragraph and chart below. There is no action required on your part; however, if you have any questions after reviewing this notice you may contact [enter plan name] at [enter customer service/member services and TTY number] during [enter hours of operation].

[*Please use this paragraph to* *clearly describe all corrections to benefits/coverage information, including services, premium, and cost-sharing information. When describing benefits/coverage changes, do so by comparing the benefits/coverage information originally provided to the enrollee with the corrected benefits/coverage information. Plan sponsors must also list all corrections in the chart below.]*

This notice serves as an amendment to your <plan name> ANOC/EOC and replaces the applicable sections noted in the chart below.  Please keep this updated information with your current <plan name>ANOC/EOC materials for future reference.

**Changes to your benefits in the ANOC/EOC**

|  |  |  |
| --- | --- | --- |
| **Location of Error In [Current Year] ANOC/EOC** | Original Benefit/Cost-Sharing Information | Corrected Benefit/Cost-Sharing Information |
| [Insert ANOC, EOC, page number, Section, and Title of Section] | [insert original (incorrect) information] | [insert corrected information] |
| **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:  -DHMO 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. |
| 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 |

*[Insert the Federal Contracting Statement]*

*[Insert a statement that the document is available in alternate formats or languages]*

*[Insert a phone number the beneficiary can call for the information in other formats or languages]*

[ Material ID]

Contract # PBP affected

Contract # PBP affected (if letter is for multiple contracts)