

## Attachment B: 60-day Federal Register Crosswalk: High Level Summary of Revisions

For the 2027 contract year, based on 60-day Federal Register public comments from the Paperwork Reduction Act (PRA) and feedback from CMS subject matter experts (SMEs), Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) standardized documents have been revised to reflect policy changes and simplify information for plan members. The nine ANOC and nine EOC models are separated into 18 plan specific models (Cost-based plans, HMO-MA, HMO-MAPD, MSA, PDP, PFFS, PPO-MA, PPO-MAPD and DSNP). The changes will not result in an additional burden. Plan sponsors will still be required to use the standardized language and send the ANOCs to members by September 30, 2026, and EOCs to members by October 15, 2026. The table below summarizes the edits.

### Plan Type: Changes to all ANOC and EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Various throughout models	Included organizations' contact information instead of referring readers to other locations in the document, e.g. Member Services.
CMS	Various throughout models	Edited for plain language throughout the models, including use of contractions where appropriate and substituting simpler words.
CMS	Various throughout models	Removed the word "prescription" as an unnecessary modifier in "Medicare prescription drug coverage" and "Medicare prescription drug plan."
CMS	Various throughout models	Removed "please" throughout all models.
CMS	Various throughout models	Updated "our plan" in beneficiary-facing text rather than "the plan."
CMS	Various throughout models	Reorganized sections and subsections to simplify information.

Clarification Requested By	Chapter/Section	Change/Reason
CMS	ANOC, More Resources  EOC, Introductory Section	<p>Inserted plan instruction language regarding the requirement to provide the <i>Notice of Availability</i> to beneficiaries:</p> <p><i>Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in the relevant state or states in the plan’s service area and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.</i></p>
CMS	Various throughout models	Changed font to Source Sans Pro.
CMS	Various throughout models	Added plan instruction to “[insert URL],” “[insert direct URL to provider directory]” or “[insert direct URL to pharmacy directory]” when provider directory or pharmacy directory is referenced.
CMS	ANOC, Section 5, Get Help from Medicare  EOC, Section 2, Get help from Medicare	Inserted language referencing Medicare’s “Chat Live” feature on the Medicare.gov website as an option where beneficiaries can get help.

**Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, PDP ANOC and EOC models**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	Various throughout models	Updated and refined language describing the Medicare Prescription Payment Plan in several sections. Some instances reflect the new automatic renewal for beneficiaries who stay in the same Part D plan and do not opt out.

**Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS ANOC and EOC models**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	ANOC, More Resources  EOC, Chapter 1, Section 1.1	Removed the below language about Qualifying Health Coverage because the shared responsibility payment was phased out and no longer appears on tax forms:  <ul style="list-style-type: none"> <li>— <del>Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <a href="http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families">www.irs.gov/Affordable-Care-Act/Individuals-and-Families</a> for more information.</del></li> </ul>

**ANOC****Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, MSA, HMO MA, PPO MA, PDP ANOC models**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	Page 1	Edited first page to focus on deadlines to switch & primary resources. Changed first page to match the text below, preserving model-specific differences.
CMS	Page 1	Removed the “What to do now” checklist as it included actions unrelated to the main purpose of the ANOC, which is to explain plan changes.

Clarification Requested By	Chapter/Section	Change/Reason
CMS	About <i>[insert 2027 plan name]</i>	<p>Moved existing optional language about plans changing their name, plans consolidating, and plans transitioning from a D-SNP lookalike plan to “About <i>[insert 2027 plan name]</i>” section to flow better. Also, separated consolidation language and transition language into separate bullet points:</p> <ul style="list-style-type: none"> <li>• <i>[If the member is being enrolled into another plan due to a consolidation under 42 CFR 422.514, include the following text: On January 1, 2027, [insert MAO name] [insert plan/Part D sponsor in parentheses, as applicable, after listing required MAO names throughout this material] will be combining [insert 2026 plan name] with one of our plans, [insert 2027 plan name]. This material tells you about the differences between your current benefits in [insert 2026 plan name] and the benefits you’ll have on January 1, 2027, as a member of [insert 2027 plan name].]</i></li> <li>• <i>[If the member is being enrolled into another plan due to a transition from a D-SNP look-alike plan under 42 CFR 422.514, include the following text: On January 1, 2027, [insert MAO name] [insert plan/Part D sponsor in parentheses, as applicable, after listing required MAO names throughout this material] will be transitioning you from [insert 2026 D-SNP look-alike plan name] to [insert 2027 renewal plan name]. This material tells you about the differences between your current benefits in [insert 2026 plan name] and the benefits you’ll have on January 1, 2027, as a member of [insert 2027 plan name].]</i></li> <li>• <i>[It is additionally expected that, as applicable throughout the ANOC, every plan/sponsor that crosswalks a member from a non-renewed plan to a consolidated renewal plan or transitions a member from a D-SNP look-alike plan to a renewal plan meeting the criteria in 42 CFR 422.514(e) will compare benefits and costs, including cost sharing for drug tiers, from that member’s previous plan to the consolidated plan or renewal plan. Every plan/sponsor that transitions a member from a D-SNP look-alike plan to a renewal plan, as indicated above, is encouraged to include language about the transition in a cover letter that accompanies the ANOC.]</i></li> </ul>
CMS	Summary of Important Costs for 2027	<p>Removed introductory language from above the table to reduce redundancy because the table headings make the purpose of the table clear:</p> <p><del>The table below compares the 2026 costs and 2027 costs for [insert 2027 plan name] in several important areas. Please note this is only a summary of costs.</del></p>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Tables throughout models	Updated table formatting to be consistent and, for tables with comparisons between 2026 and 2027, to emphasize the 2027 column with a contrasting header cell and bolded text.
CMS	Section 1, Changes to the Provider Network; Changes to the Pharmacy Network	Separated previous single section that described “Changes to the Provider and Pharmacy” network (depending on plan type) together. Models now include two sections, so the provider network and pharmacy network descriptions are distinct.
CMS	Section 3, How to Change Plans (NOT COST PLAN, or HMO MA, or PPO MA)	<p>Updated language in section to clearly outline the steps a beneficiary would need to take when changing their plan:</p> <p>If you want to change plans for 2027, follow these steps:</p> <ul style="list-style-type: none"> <li>• <b>To change to a different Medicare health plan</b>, enroll in the new plan. You’ll be automatically disenrolled from <i>[insert 2027 plan name]</i>.</li> <li>• <b>To change to Original Medicare with Medicare drug coverage</b>, enroll in the new Medicare drug plan. You’ll be automatically disenrolled from <i>[insert 2027 plan name]</i>. <del>If you don’t enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section <i>[edit section number as needed]</i>).</del></li> <li>• <b>To change to Original Medicare without a drug plan</b>, you can send us a written request to disenroll <i>[insert if organization has complied with CMS guidelines for online disenrollment: or visit our website to disenroll online at <i>[insert URL]</i>]</i>. Call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) for more information on how to do this. Or call <b>Medicare</b> at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. <del>If you don’t enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section <i>[edit section number as needed]</i>).</del></li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<ul style="list-style-type: none"> <li>To learn more about Original Medicare and the different types of Medicare plans, visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>, check the <i>Medicare &amp; You 2027</i> handbook, call your State Health Insurance Assistance Program (go to Section <i>[edit section number as needed]</i> 5), or call 1-800-MEDICARE (1-800-633-4227). <i>[Plans can choose to insert if applicable: As a reminder, [insert MAO name] [insert plan/Part D sponsor in parentheses, as applicable, after listing required MAO names throughout this material] offers other [insert as applicable: Medicare health plans AND/OR Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.]]</i></li> </ul>
CMS	Section 3, Deadlines for Changing Plans	<p>Re-ordered and simplified language about the deadlines for changing plans, which now includes a bulleted list:</p> <p><b>Section 3.2 Are there other times of the year to make a change?</b></p> <p>In certain situations, people may have other chances to change their coverage during the year. Examples include people who:</p> <ul style="list-style-type: none"> <li>Have Medicaid</li> <li>Get Extra Help paying for their drugs</li> <li>Have or are leaving employer coverage</li> <li>Move out of our plan's service area</li> </ul>
CMS	Section 3, How to Change Plans	<p>Added plan instruction in third bullet point to include “at <i>[insert URL]</i>” for easier access to disenrolling online:</p> <p><b>To change to Original Medicare without a <del>prescription</del> drug plan</b>, you can send us a written request to disenroll <i>[insert if organization has complied with CMS guidelines for online disenrollment: or visit our website to disenroll online at [insert URL]]</i>.</p>
CMS	Section 4, Getting Help Paying for	<p>Removed and reworded plan instruction in introductory paragraph of this section:</p> <p>You may qualify for help paying for prescription drugs. <del><i>[Plans in states without both SPAPs and ADAPs, delete the next sentence.]</i></del> Different kinds of help are available:</p>

Clarification Requested By	Chapter/Section	Change/Reason
	Prescription Drugs	
CMS	Section 4, Getting Help Paying for Prescription Drugs	<p>Reorganized plan instructions at the beginning of the bullet point regarding prescription cost-sharing assistance for persons with HIV/AIDS and added one plan instruction specific to plans without an ADAP in their state(s):</p> <p><i>[Plans with no Part D drug cost sharing should delete this bullet.] [Plans without an ADAP in its state(s) should delete this bullet.] [Plans with an ADAP in its state(s) that DON'T provide Insurance Assistance should delete this bullet.]</i></p>

#### Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, PDP ANOC Models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Summary of Important Costs for 2027	Created separate rows for the Part D drug coverage deductible and copays to debulk table and facilitate comparison.
CMS	<p>Section 1.7, Drug Payment Stages</p> <p>Section 1.4, Drug Payment Stages (PDP)</p>	<p>Created a bulleted list with summaries of the three Drug Payment Stages Descriptions to simplify tables and make the information easier for a beneficiary to find:</p> <ul style="list-style-type: none"> <li> <b>Stage 1: Yearly Deductible</b>            You start in this payment stage each calendar year. During this stage, you pay the full cost of your <i>[insert as applicable: Part D OR brand name OR [tier name(s)]]</i> drugs until you've reached the yearly deductible. <i>[Plans with no deductible, replace text in this bullet with We have no deductible, so this payment stage doesn't apply to you.]</i> </li> <li> <b>Stage 2: Initial Coverage</b>  <i>[Plans with no deductible delete the first sentence]</i> Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach <i>\$(insert 2027 initial coverage limit)</i>.         </li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<ul style="list-style-type: none"> <li> <b>Stage 3: Catastrophic Coverage</b>            This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.         </li> </ul>
CMS	Section 1.7, Drug Costs in Stage 2: Initial Coverage	<p>Moved and refined optional language for plans that are changing the number of days in a one-month supply for prescriptions filled at a network pharmacy out of the table and placed it as introductory language before the table. This simplified the table to make it easier for a beneficiary to understand the information:</p> <p><i>[Plans with pharmacies that offer standard and preferred cost sharing should replace the preceding paragraph with the following: The table shows your cost per prescription for a one-month ([insert number of days in a one-month supply]-day) supply filled at a network pharmacy with standard and preferred cost sharing.] [Plans that are changing the number of days in its one-month supply should replace the preceding sentence with the following: We are changing the number of days in a one-month supply from a [xx]-day supply in 2026 to a [xx]-day supply in 2027. The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard and preferred cost sharing.]</i></p>
CMS	Section 1.6, Changes to Part D Drug Coverage	<p>Updated plan instruction to make sure the plan links directly to the drug list by adding “<i>[insert direct URL for drug list]</i>”.</p>
CMS	Section 1.7, Changes to Prescription Drug Benefits & Costs; Drug Costs in Stage 2: Initial Coverage	<p>Moved the first two sentences below out of the table and combined them with sentences preceding the table. Also, revised the last sentence to be clearer:</p> <p><i>[Insert if applicable: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.]</i> Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs <i>[insert as applicable: for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions]</i>, go to Chapter 6 of your <i>Evidence of Coverage</i>.</p>



Clarification Requested By	Chapter/Section	Change/Reason
		<p>Moved the following plan instruction from below both tables to be between the two tables:</p> <p><i>[Plans with pharmacies that offer standard and preferred cost sharing may replace the chart above with the one below to provide both cost-sharing rates.]</i></p>
CMS	Section 1.7, Changes to Prescription Drug Benefits & Costs; Changes to the Catastrophic Coverage Stage	<p>Removed the language about drug manufacturers paying a portion of the plan's full cost for covered Part D brand name drugs and biologics during Catastrophic Coverage Stage. This language was previously included to describe the new Manufacturer Discount Program:</p> <p><del>The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.</del></p>
CMS	Various throughout	Updated VBID Part D benefit language to reflect the elimination of the VBID benefit beginning in 2027, including changes to cost sharing where applicable.

**Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, HMO MA, PPO MA ANOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Summary of Important Costs for 2027	Updated “Doctor office visits” in table into two separate rows: “Primary care office visits” and “Specialist office visits” to reduce clutter and increase understanding of cost comparisons for a beneficiary.
CMS	Summary of Important Costs for 2027	Added description of inpatient hospital stays to improve beneficiary understanding:  <b>Inpatient hospital stays</b> Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you’re formally admitted to the hospital with a doctor's order. The day before you’re discharged is your last inpatient day.

**Changes to HMO MAPD, PPO MAPD, DSNP, PFFS, HMO MA, PPO MA ANOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Section 1.1, Changes to the Monthly Plan Premium	Removed instructional text about optional table rows and instead provided the optional language in table rows. This makes the correct approach clearer for plans and helps standardize the information beneficiaries will see:  <del><i>[Plans offering the following premiums must list separately in the table below: (1) Plan premium; (2) optional supplemental benefit premiums (only plans offering optional supplemental benefits during one or both of the comparison years); and (3) Part B premium reduction (only plans with Part B premium reductions during one or both of the comparison years).]</i></del>

**Changes to Cost, PFFS, PPO MA ANOC models**

Clarification Requested By	Chapter/Section	Change/Reason
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CMS	Section 1.2; Changes to Your Maximum Out- of-Pocket Amount	Removed the example of “POS benefits” as a supplemental benefit since it is not relevant:  <i>[Plans that include the costs of supplemental benefits (e.g., POS benefits) in the MOOP limit can revise this information as needed.]</i>
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**Changes to Cost, MSA, HMO MA, PPO MA ANOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	About <i>[insert 2027 plan name]</i>	<p>Added language to seventh bullet point to clarify that not having creditable drug coverage “for 63 days or more” will result in a late enrollment penalty in the future:</p> <ul style="list-style-type: none"> <li>This plan doesn’t include Medicare Part D drug coverage. Note: If you don’t have Medicare drug coverage, or creditable drug coverage (as good as Medicare’s), <b>for 63 days or more</b>, you may have to pay a late enrollment penalty if you enroll in Medicare drug coverage in the future.</li> </ul>

**Changes to MSA ANOC model**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Section 3.1	<p>Deleted Medicare Advantage Open Enrollment Period content:</p> <p><del>If you enrolled in a Medicare Advantage plan for January 1, 2027, and don’t like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without a separate Medicare drug plan) between January 1—March 31, 2027.</del></p>

**Changes to D-SNP ANOC model**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	Section 5, Questions?; Get Free Counseling about Medicare	<p>Removed the plan instruction for plans offering plans in multiple states since D-SNPs can develop and submit the ANOC at the PBP level, so they can provide this information at the state level:</p> <p><i><del>[Organizations offering plans in multiple states: Revise this section to use the generic name (State Health Insurance Assistance Program) when necessary, and include a list of names, phone numbers, and addresses for all SHIPs in your service area.]</del></i></p>
CMS	Section 5, Questions? Get Help from Medicaid	<p>Updated plan instruction to include opportunities to add state-specific information for beneficiaries:</p> <p><i>Call [insert state-specific name for Medicaid [insert state-specific Medicaid agency] at [insert Medicaid contact information]. TTY users [insert Medicaid TTY number] for help with Medicaid enrollment or benefit questions. [Insert any additional state-specific resources for assistance with questions about the enrollee's Medicaid benefits.]</i></p>

**Changes to Cost ANOC model**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	About <i>[insert 2027 plan name]</i>	<p>Added language to clarify that automatic enrollment in the plan will occur if the beneficiary does “not sign up for a different Medicare Advantage or Medicare drug plan” by December 7, 2026:</p> <ul style="list-style-type: none"> <li>• <b>If you do not sign up for a different Medicare Advantage or Medicare drug plan by December 7, 2026, you’ll automatically be enrolled in <i>[insert 2027 plan name]</i>.</b></li> </ul>
CMS	Section 3, How to Change Plans	<p>Updated third bullet point to simplify language and clarify that enrollment in a PDP does not result in automatic disenrollment from a Cost plan:</p> <p><b>To change to Original Medicare with Medicare drug coverage</b>, enroll in the new Medicare drug plan and send us a written request to disenroll from <i>[insert 2027 plan name]</i>. Call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) for more information on how to do this. Or call <b>Medicare</b> at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. Enrolling in the new drug plan will not automatically disenroll you from <i>[insert 2027 plan name]</i>.</p>
CMS	Sections 3.1 and 3.2	Updated language in two sections to clarify that the AEP applies only to “ <b>Medicare Advantage and drug</b> ” coverage.

**EOC Models****Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, MSA, HMO MA, PPO MA, PDP EOC models**


<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	Chapter 8, Section 1.7	<p>Removed language to align with Executive Order 14168:</p> <ul style="list-style-type: none"> <li>• Removed “sexual orientation” from Chapter 8, Section 1.7 and Chapter 11, Section 2.</li> <li>• Removed “gender” from Chapter 11, Section 2.</li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
	Chapter 11, Section 2	
CMS	Chapter 1, Section 4	Added “Summary of Important Costs for 2027” table.
CMS	Chapter 9, Section 2  Chapter 9, Section 7.2, 8.2  Chapter 7, Section 2	Added plan instruction in “State Health Insurance Assistance Program (SHIP)” section:  <i>[Insert SHIP name and contact information. Plans providing SHIP contact information in an exhibit should direct members to that exhibit.]</i>
CMS	Chapter 12, Definitions	Added "based on specific criteria" to the Prior Authorization definition:  <b>Prior Authorization</b> – Approval in advance to get services and/or certain drugs <b>based on specific criteria</b> . <i>[Plans can delete applicable sentences if it doesn't require prior authorization for any medical services and/or any drugs.]</i> Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.
CMS	Chapter 12, Definitions	Revised Chronic-Care Special Needs Plan definition:  <b>Chronic-Care Special Needs Plan (C-SNP)</b> – C-SNPs are SNPs that restrict enrollment to MA eligible people who have <b>specific, severe and chronic diseases. one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).</b>
CMS	Chapter 11, Section 3	Deleted 1557 related language from plan instruction:


Clarification Requested By	Chapter/Section	Change/Reason
		<p><i>[Note: You can include other legal notices, such as a notice of member non-liability or a notice about third-party liability. <del>or a nondiscrimination notice under Section 1557 of the Affordable Care Act.</del> These notices can only be added if they conform to Medicare laws and regulations. Plans can also include Medicaid-related legal notices.]</i></p>


#### Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, MSA, HMO MA, PPO MA EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 9, Section 8.2, Chapter 9A and 9B (DSNP)	<p>Revised Step 1, "Act quickly" section, 2nd bullet to clarify that beneficiaries can file an appeal after the deadline and who beneficiaries should contact:</p> <ul style="list-style-type: none"> <li>If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.</li> </ul>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Added 7<sup>th</sup> bullet to Outpatient diagnostic tests and therapeutic services and supplies row:</p> <ul style="list-style-type: none"> <li>Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.</li> </ul>
CMS	Chapter 12, Definitions  Chapter 10, Definitions	<p>Edited Rehabilitation Services definition:</p> <p><b>Rehabilitation Services</b> – These services include <del>inpatient rehabilitation care</del>, physical therapy (<del>outpatient</del>), speech and language therapy, and occupational therapy.</p>


Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Edited 11<sup>th</sup> bullet in Medicare Part B Drugs row:</p> <ul style="list-style-type: none"> <li>Certain oral End-Stage Renal Disease (ESRD) drugs <del>if the same drug is available in injectable form and the</del> covered under Medicare Part B <del>ESRD benefit covers it</del></li> </ul>
CMS	Chapter 12, Definitions  Chapter 10, Definitions	<p>Added Preventive Services definition:</p> <p><b>Preventive services</b> – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).</p>
CMS	Chapter 12, Definitions  Chapter 10, Definitions	<p>Added Referral definition:</p> <p><b>Referral</b> – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, your plan may not pay for services from a specialist.</p>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Deleted last bullet in Physician/Practitioner services, including doctor's office visits row:</p> <ul style="list-style-type: none"> <li><del>Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</del></li> </ul>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Revised title to match the name of the benefit under 42 CFR 410.17:</p> <p> <b>Cardiovascular disease screening tests</b><del>ing</del></p>
CMS	Chapter 4, Section 2,	Added Chronic pain management and treatment services row:




Clarification Requested By	Chapter/Section	Change/Reason
	Medical Benefits Chart	<p>Covered Service:</p> <p><b>Chronic pain management and treatment services</b></p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.</p> <p>What you pay:</p> <p>Cost sharing for this service will vary depending on individual services provided under the course of treatment.</p> <p><i>[List copayment / coinsurance / deductible]</i></p>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Added “and phosphate binder” to Medicare Part B drugs row, 12<sup>th</sup> bullet:</p> <ul style="list-style-type: none"> <li>• Calcimimetic <b>and phosphate binder</b> medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®</li> </ul>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Added Screening for Hepatitis C Virus infection row:</p> <p>Covered Service:</p> <p> <b>Screening for Hepatitis C Virus infection</b></p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> <li>• You’re at high risk because you use or have used illicit injection drugs.</li> <li>• You had a blood transfusion before 1992.</li> <li>• You were born between 1945-1965.</li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p> <p>What you pay:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.</p>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Revised Colorectal cancer screening row removing barium enema language and adding last bullet:</p> <p>Covered Service:</p> <p> <b>Colorectal cancer screening</b></p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> <li>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy <del>or barium enema</del>.</li> <li>• Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.</li> <li>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk</li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<p>patients from the last flexible sigmoidoscopy or <del>computed tomography colonography. barium enema.</del></p> <ul style="list-style-type: none"> <li>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.</li> <li>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• <del>Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.</del></li> <li>• <del>Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.</del></li> <li>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. <ul style="list-style-type: none"> <li>• <del>Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.</del></li> </ul> </li> </ul> <p><i>[Also list any additional benefits offered.]</i></p> <p>What you pay:</p> <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, <del>excluding barium enemas, for which coinsurance applies.</del> If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam <i>[and subject to copayment/coinsurance]. [Our plan should list applicable copayment and coinsurance.]</i></p> <p><i>[If applicable, list copayment and/or coinsurance charged for barium enema.]</i></p>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 9, Section 5.2, Step 1 and Step 3  Chapter 9A and 9B (DSNP - 2 instances), Section 6.2, Step 1 and Step 3	<p>Revised language due to new regulatory requirement at 422.568(b)(1)(ii) that goes into effect on January 1, 2027:</p> <p>Step 1: Decide if you need a standard coverage decision or a fast coverage decision.</p> <p>A standard coverage decision is usually made within <b>7 calendar days when the medical item or service is subject to our prior authorization rules</b>, 14 calendar days <b>for all other medical items and services</b>, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:</p>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Revised Smoking and tobacco use cessation counseling row:</p> <p>Covered Service:</p> <p> <b>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</b></p> <p><del>If you use tobacco, but don't have signs or symptoms of tobacco-related disease:</del> Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> <li>• Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease</li> <li>• Are competent and alert during counseling</li> <li>• A qualified physician or other Medicare-recognized practitioner provides counseling</li> </ul> <p><del>We cover 2 counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to 4 face-to-face visits.</del></p> <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p>

Clarification Requested By	Chapter/Section	Change/Reason
		<p><del>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover 2 counseling quit attempts within a 12-month period, and you pay the applicable cost sharing. Each counseling attempt includes up to 4 face-to-face visits.</del></p> <p><i>[Also list any additional benefits offered.]</i></p>
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Added “Pre-exposure prophylaxis (PrEP) for HIV prevention” as a preventive service:</p> <p>Covered Service:</p> <p> <b>Pre-exposure prophylaxis (PrEP) for HIV prevention</b></p> <p>If you don’t have HIV, but your doctor or other health care practitioner determines you’re at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> <li>• FDA-approved oral or injectable PrEP medication. If you’re getting an injectable drug, we also cover the fee for injecting the drug.</li> <li>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.</li> <li>• Up to 8 HIV screenings every 12 months.</li> </ul> <p>A one-time hepatitis B virus screening.</p> <p>What you pay:</p> <p>There is no coinsurance, copayment, or deductible for the PrEP benefit.</p>
CMS	Chapter 9, Section 5.3	<p>Deleted “that you haven’t gotten yet” in Step 1, 1<sup>st</sup> bullet:</p> <ul style="list-style-type: none"> <li>• If you’re appealing a decision we made about coverage for care <del>that you haven’t gotten yet</del>, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we’ll give you a fast appeal.</li> </ul>

**Changes to DSNP EOC model**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2.2	<p>Changed to “12 months” in the following paragraph:</p> <p>If you’re in the visitor/traveler area, you can stay enrolled in our plan <del>until December 31, 2026</del> for up to 12 months. If you don’t return to our plan’s service area <del>by December 31, 2026</del> within 12 months, you’ll be disenrolled from our plan.]</p>
CMS	Chapter 1, Section 3.1	<p>Removed the text “if you have one” from the following sentence in the 3rd paragraph:</p> <p>Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, <del>if you have one</del>. Sample membership card:</p>
CMS	Chapter 1, Section 4.5	<p>Revised sentence in 1<sup>st</sup> paragraph as follows since no enrollees in DSNPs will be subject to IRMAA since they all receive LIS:</p> <p>If you lose eligibility for this plan because of changes income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA).</p>
CMS	Chapter 1, Section 6	<p>Updated plan instruction (last paragraph) since each state has their own procedures:</p> <p><i>[Plans can instruct members how to keep their Medicaid information up to date as directed by the state. <del>instruct members to also call their county’s income maintenance agency directly to report changes to the State program. If this instruction is included, insert contact information for the appropriate agency]</del></i></p>
CMS	Chapter 2, Section 3	Deleted 1st plan instruction since all DSNP PBPs are state-specific:

Clarification Requested By	Chapter/Section	Change/Reason
		<del><i>[Organizations offering plans in multiple states: Revise the second and third paragraphs in this section to use the generic name (State Health Insurance Assistance Program or SHIP), and include a list of names, phone numbers, and addresses for all SHIPs in your service area.]</i></del>
CMS	Chapter 2, Section 3	Deleted plan instructions in 2nd paragraph since all DSNP PBPs are state-specific: <del><i>[Multiple state plans inserting information in an exhibit, replace rest of this paragraph with a sentence referencing the exhibit where members will find SHIP information.] [Multiple state plans inserting information in the EOC add: Here is a list of the State Health Insurance Assistance Programs in each state we serve.] [Multiple state plans inserting information in the EOC use bullets for the following sentence, inserting separate bullets for each state.]</i></del>
CMS	Chapter 2, Section 4	Deleted plan instructions in 2nd paragraph since all DSNP PBPs are state-specific: <del><i>[Multi state plans inserting information in an exhibit, replace the rest of this paragraph with a sentence referencing the exhibit where members will find QIO information.] [Multiple state plans inserting information in the EOC add: Here is a list of the Quality Improvement Organizations in each state we serve.] [Multi state plans inserting information in the EOC use bullets for the following sentence, inserting separate bullets for each state.]</i></del>
CMS	Chapter 2, Section 7	Added “for Part D” in plan instruction after chart in SPAP section: <i>[Plans with \$0 cost sharing for Part D should delete the below information on the Medicare Prescription Payment Plan.]</i>
CMS	Chapter 4, Section 2.2	Added “ <i>including the impact based on Medicaid requirements if applicable.</i> ” in 1st paragraph plan instruction since states may have varying policies regarding how being out of the area may impact their Medicaid eligibility, thus impacting their eligibility for the DSNP. <i>[If our plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules about getting the out-of-area coverage, including the impact based on Medicaid requirements if applicable. If you allow extended periods of enrollment out-of-area per the exception</i>

Clarification Requested By	Chapter/Section	Change/Reason
		<i>in 42 CFR 422.74(b)(4)(iii) (for more than 6 months up to 12 months) also explain that here based on the language suggested below.</i>
CMS	Chapter 8, Section 1.1	<p>Revised fourth paragraph due to the requirement for written translation of required languages to the following:</p> <p>Our plan has free interpreter services available to answer questions from non-English speaking members. <i>[If applicable, plans can insert information about the availability of written materials in languages other than English.]</i> We can also give you materials <i>in [insert if required to provide materials in any non-English languages per 42 CFR § 422.2267(a): in languages other than English including &lt;required languages&gt; and]</i> braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>).</p>
CMS	Chapter 8, Section 2	<p>Deleted text in last open bullet since all enrollees are duals and have LIS:</p> <p><del>○ If you're required to pay the extra amount for Part D because of your yearly income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to stay a member of our plan.</del></p>
CMS	Chapter 9B	<p>Added fourth plan instruction before Section 1 since 422.629(c) allows states to implement more stringent standards for appeals and grievances than the Medicare unified appeals and grievances regulations:</p> <p><i>[Plans should refer to its state Medicaid agency contract for any additional state requirements for timeframes or notice requirements that are more protective for the enrollee and make appropriate edits throughout Chapter 9.]</i></p>



Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 9A and 9B, Section 6.2	Deleted text from first paragraph in Step 1 since there is only one requirement: <del>To get a fast coverage decision, you must meet 2 requirements:</del>
CMS	Chapter 9B, Section 6.5	Deleted second sentence in 2nd to last bullet since enrollee can ask for a fast appeal for payment cases in AIP DSNPs: <ul style="list-style-type: none"><li><del>If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.</del></li></ul>
CMS	Chapter 10, Section 5	Deleted last bullet as language is not applicable to LIS/Medicaid eligible beneficiaries: <ul style="list-style-type: none"><li><del>If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.</del></li></ul>
CMS	Chapter 12	Deleted "prescription" in the Covered Drugs definition: <b>Covered Drugs</b> – The term we use to mean all the <del>prescription</del> drugs covered by our plan.
CMS	Chapter 10, Section 2.2 and 2.4	Added fourth sub-bullet: <ul style="list-style-type: none"><li><del>If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.</del></li></ul>
CMS	Chapter 10, Section 2.2 and 2.4 (Note Section)	Added “, no longer receive Extra Help,” since LEPs aren’t applicable to enrollees with LIS: <b>Note:</b> If you disenroll from Medicare drug coverage, <del>no longer receive Extra Help</del> , and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
CMS	Chapter 10, Section 3	Added “, no longer receive Extra Help,” in note under chart:

Clarification Requested By	Chapter/Section	Change/Reason
		<b>Note:</b> If you disenroll from Medicare drug coverage, <b>no longer receive Extra Help</b> , and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
CMS	Chapter 4, Section 3	<p>Changed language in the “Routine Eye Examination row” in “Covered only under specific conditions” column of the “Not Covered Chart.”</p> <p><del>Not covered under any condition</del></p> <p>One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.</p>

**Changes to Cost EOC model**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 1, Section 2.1	<p>Deleted plan instruction in second bullet:</p> <p><del>[Plans with grandfathered members who were outside of area prior to January 1999, insert: If you’ve been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you’re still eligible for our plan as long as you haven’t moved since before January 1999.]</del></p>
CMS	Chapter 10, Section 5	<p>Deleted plan instructions in bullets 6, 7, and 8:</p> <ul style="list-style-type: none"> <li><del>[Omit if not applicable]</del> If you intentionally give us incorrect information when you’re enrolling in our plan and that information affects your eligibility for our plan (We can’t make you leave our plan for this reason unless we get permission from Medicare first.)</li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<ul style="list-style-type: none"> <li><del>[Omit bullet if not applicable]</del> If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first.)</li> <li><del>[Omit bullet and sub-bullet if not applicable]</del> If you let someone else use your membership card to get medical care (We can't make you leave our plan for this reason unless we get permission from Medicare first.)</li> </ul>

### Changes to PFFS EOC model

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 10, Section 2.1	<p>Deleted plan instruction <i>[MA-only plans, omit]</i> in two instances since these are general directives for all Medicare beneficiaries:</p> <ul style="list-style-type: none"> <li><del>[MA-only plans, omit]</del> If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li> </ul> <p><del>[MA-only plans, omit]</del> <b>Note:</b> If you disenroll from Medicare drug coverage and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.</p>
CMS	Throughout model	Changed references to drug coverage to variable since Part D is optional for PFFS plans.

**Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, PDP EOC models**

<b>Clarification Requested By</b>	<b>Chapter/Section</b>	<b>Change/Reason</b>
CMS	Chapter 9, Section 6.6  Chapter 9A, Section 7.6 (DSNP)  Chapter 9B, Section 7.5 (DSNP)  Chapter 7, Section 6.6 (PDP)	<p>Added in a bullet for the 65-day filing timeframe, broke out the last sentence of this paragraph to its own bullet, and revised other text:</p> <p><b>Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.</b></p> <ul style="list-style-type: none"> <li>• If we say no to your Level 1 appeal, the written notice we send you will include <b>instructions on how to make a Level 2 appeal</b> with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.</li> <li>• <b>You must make your appeal request within 65 calendar days from the date on the written notice.</b></li> <li>• If, <del>however,</del> we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an <b>at-risk</b> determination under our drug management program, we'll automatically forward your request to the independent review entity <del>IRE</del>.</li> <li>• We'll send the information about your appeal to the independent review organization. This information is called your <b>case file</b>. <b>You have the right to ask us for a copy of your case file.</b> <i>[If a fee is charged, insert: We're allowed to charge you a fee for copying and sending this information to you.]</i></li> <li>• <b>You have a right to give the independent review organization additional information to support your appeal.</b></li> </ul>
CMS	Chapter 6, Section 3  Chapter 4, Section 3 (PDP)	<p>Changed "increases" to "changes" in second to last bullet:</p> <ul style="list-style-type: none"> <li>• <b>Drug price information.</b> This displays the total drug price, and information about <b>changes</b> <del>increases</del> in price from first fill for each prescription claim of the same quantity.</li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 5, Section 2.2  Chapter 3, Section 2.2 (PDP)	Added sentence for continuity:  <i>To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by [insert instructions].</i>
CMS	Chapter 2, Section 7	Deleted “and the U.S. Virgin Islands” in the “What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?” section:  Many states <del>and the U.S. Virgin Islands</del> offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.
CMS	Chapter 2, Section 7	Revised the “Medicare Prescription Payment Plan” paragraph:  <b>Medicare Prescription Payment Plan</b>  The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket <del>Medicare Part D drug</del> costs <del>for drugs covered</del> by our <del>plan</del> by spreading them across <del>monthly payments that vary throughout the calendar year</del> (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. <b>This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027.</b> <del>All plan members are eligible to participate in this payment option, no matter your income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option.</del> To learn more about this payment option, call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i> ) or visit Medicare.gov. <del>to find out if this payment option is right for you. (Placeholder for automatic election language).</del>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 5, Section 2.3	Corrected section reference in first plan instruction:  <i>[Plans that don't offer extended-day supplies: Delete Section 2.34.]</i>
CMS	Chapter 5, Section 4.2  Chapter 3, Section 4.2 (PDP)	Revised section:  <b>Getting plan approval in advance</b>  For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called <b>prior authorization</b> . This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i> ) or on our website <i>[insert direct URL to PA criteria]</i> .  <b>Trying a different drug first</b>  This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called <b>step therapy</b> . Our plan's step therapy criteria can be obtained by calling Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i> ) or on our website <i>[insert direct URL to ST criteria]</i> .
CMS	Chapter 5, Section 6  Chapter 3, Section 6 (PDP)	Revised section:  <b>Changes to drug coverage that affect you during this plan year</b> <ul style="list-style-type: none"> <li>• Adding new drugs to the Drug List and <b>immediately removing or making changes to a like drug on the Drug List.</b>; <del>if you are taking a drug you will likely hear about any changes after they are made.</del> <ul style="list-style-type: none"> <li>○ When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add</li> </ul> </li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<p>new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and <i>[Plans that don't use tiers can omit "on the same or lower cost-sharing tier and."]</i> with the same or fewer restrictions.</p> <ul style="list-style-type: none"> <li>○ We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.</li> <li>○ We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.]</li> </ul> <p><i>[All plan sponsors should include the remainder of this section.]</i></p> <ul style="list-style-type: none"> <li>• <b>Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List</b> <i>[Plans that inserted the section on Advance General Notice for immediate substitutions insert: ; if you are taking a drug you will hear about any changes before they take place]- with advance notice</i></li> </ul>
CMS	Chapter 9, Section 6.1  Chapter 7, Section 6.1	<p>Added "criteria" after prior authorization in second bullet of "Part D coverage decisions and appeals section:"</p> <ul style="list-style-type: none"> <li>• Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization <b>criteria</b>, or the requirement to try another drug first). <b>Ask for an exception. Section 6.2</b></li> </ul>
CMS	Chapter 12, Definitions  Chapter 10, Definitions (PDP)	<p>Added definition for Medication Therapy Management (MTM) program:</p> <p><b>Medication Therapy Management (MTM) program</b> – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.</p>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 12, Definitions  Chapter 10, Definitions (PDP)	Removed “selected” from Quantity Limits definition:  <b>Quantity Limits</b> – A management tool that is designed to limit the use of <del>selected</del> a drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
CMS	Chapter 1, Section 4.4	Revised “ <b>Medicare determines the amount of the Part D late enrollment penalty.</b> Here’s how it works:” section:  <ul style="list-style-type: none"> <li>To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium <del>and the average monthly plan premium and then</del> and round it to the nearest 10 cents. In the example here, it would be 14% times \$<i>[insert base beneficiary premium]</i>, which equals \$<i>[insert amount]</i>. This rounds to \$<i>[insert amount]</i>. This amount would be added <b>to the monthly plan premium for someone with a Part D late enrollment penalty.</b></li> </ul> <p>Three important things to know about the monthly Part D late enrollment penalty:</p> <ul style="list-style-type: none"> <li><b>The penalty may change each year</b> because the national base beneficiary <del>average monthly plan</del> premium can change each year.</li> </ul>
CMS	Chapter 5, Section 10.1  Chapter 3, Section 10.1 (PDP)	Added "or benzodiazepine" as required language and removed plan instruction:  <b>Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications</b>  We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid



Clarification Requested By	Chapter/Section	Change/Reason
		<p>or benzodiazepine <del>[insert if applicable: or benzodiazepine]</del> medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:</p> <ul style="list-style-type: none"> <li>• Requiring you to get all your prescriptions for opioid or benzodiazepine <del>[insert if applicable: or benzodiazepine]</del> medications from a certain pharmacy(ies)</li> <li>• Requiring you to get all your prescriptions for opioid or benzodiazepine <del>[insert if applicable: or benzodiazepine]</del> medications from a certain prescriber(s)</li> <li>• Limiting the amount of opioid or benzodiazepine <del>[insert if applicable: or benzodiazepine]</del> medications we'll cover for you</li> </ul>
CMS	<p>Chapter 6, Section 1.2 and Section 3</p> <p>Chapter 4, Section 1.2 and Section 3 (PDP)</p>	<p>Deleted “TRICARE” to the fourth bullet in the “<b>These payments <u>are included</u> in your out-of-pocket costs</b>” section:</p> <ul style="list-style-type: none"> <li>• Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, <del>TRICARE</del>, Indian Health Service, AIDS drug assistance programs, <i>[plans without an SPAP in its state delete next item]</i> State Pharmaceutical Assistance Programs (SPAPs), and most charities</li> <li>• <b>Out-of-Pocket Costs:</b> this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, <del>TRICARE</del>, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).</li> </ul>
CMS	Chapter 6, Section 1.2	<p>Added “certain insurance plans and government-funded health programs such as TRICARE and” in the ninth bullet of the “<b>These payments <u>aren’t included</u> in your out-of-pocket costs</b>” section:</p>

Clarification Requested By	Chapter/Section	Change/Reason
	Chapter 4, Section 1.2 (PDP)	<ul style="list-style-type: none"> <li>Payments for your drugs made by <b>certain insurance plans and government-funded health programs such as TRICARE</b> and the Veterans Health Administration (VA)</li> </ul>
CMS	Chapter 6, Section 1  Chapter 4, Section 1 (PDP)	<p>Deleted the first sub-heading in this chapter:</p> <p><del><b>Do you get Extra Help to pay for your drug coverage costs?</b></del></p>
CMS	Chapter 1, Section 3.4,  Chapter 1, Section 3.3 (PDP)	<p>Added sentence regarding drugs with negotiated prices in first paragraph:</p> <p><b>Section 3.4 Drug List (formulary)</b></p> <p>Our plan has a <i>List of Covered Drugs</i> (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in <i>[insert 2027 plan name]</i>. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare’s requirements. <b>Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6.</b> Medicare approved the <i>[insert 2027 plan name]</i> Drug List.</p> <p><b>Section 3.3 Drug List (formulary)</b></p> <p>Our plan has a <i>List of Covered Drugs</i> (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in <i>[insert 2027 plan name]</i>. <b>It also tells if a drug selected for negotiation is covered.</b> The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare’s requirements. Medicare approved the <i>[insert 2027 plan name]</i> Drug List.</p>

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 6, Section 4  Chapter 4, Section 4 (PDP)	<p>Added sentence to third paragraph:</p> <p>The Deductible Stage is the first payment stage for your drug coverage. <i>[Plans with a deductible for all drug types/tiers, insert: This stage begins when you fill your first prescription for the year. When you're in this payment stage, you must pay the full cost of your drugs until you reach our plan's deductible amount, which is \$[insert deductible amount] for 2027.] [Plans with a deductible amount other than \$0, add: The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.] [Plans with a deductible on only a subset of drugs, insert: You'll pay a yearly deductible of \$[insert deductible amount] on [insert applicable drug tiers] drugs. You must pay the full cost of your [insert applicable drug tiers] drugs until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible.] The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.</i></p>
CMS	Chapter 12, Definitions  Chapter 10, Definitions (PDP)	<p>Added "Maximum Fair Price" definition:</p> <p><b>Maximum Fair Price</b> – The price Medicare negotiated for a selected drug.</p>
CMS	Chapter 12, Definitions  Chapter 10, Definitions (PDP)	<p>Added "Selected Drug" definition:</p> <p><b>Selected Drug</b> – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.</p>

**Changes to HMO MAPD, PPO MAPD, DSNP, MSA EOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 12, Definitions	<p>Changed definition for Institutional Special Needs Plan (I-SNP) and Institutional-Equivalent Special Needs Plan (IE-SNP):</p> <p><b>Institutional Special Needs Plan (I-SNP)</b> – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs). <del>A plan that enrolls eligible people who continuously live or are expected to continuously live for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and health care status to the other named facility types. An Institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).</del></p> <p><b>Institutional-Equivalent Special Needs Plan (IE-SNP)</b> – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers. <del>A plan that enrolls eligible people living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to people who live in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.</del></p>

**Changes to HMO MAPD, PPO MAPD, DSNP EOC model**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2,	Deleted plan instructions regarding VBID:

Clarification Requested By	Chapter/Section	Change/Reason
	Plan instructions before Medical Benefits Chart	<p><del>[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits for enrollees with certain chronic conditions:</del></p> <ul style="list-style-type: none"> <li><del>• Plans can deliver to each clinically targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering a written notice when offering targeted supplemental or VBID benefits. (See CY 2027 Value-Based Insurance Design Communications and Marketing Guidelines).</del></li> <li><del>• If applicable, plans must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits.</del></li> <li><del>• If applicable, plans with VBID should mention reduced cost sharing for their MA benefits, as well as that members may qualify for a reduction or elimination of their cost sharing for Part D drugs in plans with VBID may include the reduction or elimination of their cost sharing for Part D drugs in Chapter 6, Section 2.]</del></li> <li><del>• [Insert if offering VBID Model benefits:</del></li> </ul> <p><del>Important Benefit Information for People with Certain Chronic Conditions</del></p> <ul style="list-style-type: none"> <li><del>• If you're diagnosed by a plan provider with any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for targeted supplemental benefits and/or reduced cost sharing:</del> <ul style="list-style-type: none"> <li><del>○ [List all applicable chronic conditions here.]</del></li> <li><del>○ [As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and then direct the enrollee that they will be provided additional information with how to take advantage of these additional supplemental benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).]</del></li> <li><del>○ For more detail, go to the <b>VBID</b> row in the below Medical Benefits Chart below.]</del></li> </ul> </li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<p><del>[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits for enrollees living in certain geographic areas:</del></p> <ul style="list-style-type: none"> <li><del>• Plans can deliver to each geographically targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).</del></li> <li><del>• Plans that choose to reduce cost sharing for an item or service, must include a summary of the additional supplemental benefits the enrollee would get as well as the activities and/or programs the member must complete to get the benefit.</del></li> <li><del>• If applicable, plans must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID.]</del></li> <li><del>• [Insert if offering VBID Model benefits:</del></li> <li><del>• Important Benefit Information for People Living in Certain Geographic Areas</del></li> <li><del>• If you live in certain geographic areas listed below, you may be eligible for targeted supplemental benefits and/or reduced cost sharing:</del></li> <li><del>• [List all applicable census tracts and blocks groups here (e.g., Census Tract 9800—Block Group 1); organize by county for readability].</del> <ul style="list-style-type: none"> <li><del>○ [Insert a phone number for enrollees to call for help with identifying eligibility and determining the enrollee's Census Tract and Block Group, include the plan web address for more information on supplemental benefits and/or reduced cost sharing for enrollees living in certain geographic areas.]</del></li> <li><del>○ [As applicable, plans can enter an explanation of how enrollees can identify the census tract and block group they live in. For example, plans can provide the link and</del></li> </ul> </li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<p><del>instructions/video on how to locate your own census tract and block by entering their address in <a href="https://geocoding.geo.census.gov/geocoder/geographies/address?form.">https://geocoding.geo.census.gov/geocoder/geographies/address?form.</a></del></p> <p><del>○ [As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and instruct the enrollee they will be provided additional information on how to take advantage of these additional supplemental benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).]</del></p> <p><del>○ For more detail, go to the <b>VBID</b> row in the Medical Benefits Chart below.]</del></p> <p>[Important Benefit Information for People Who Qualify for Extra Help:</p> <ul style="list-style-type: none"> <li><del>• If you get Extra Help to pay your Medicare drug coverage costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.</del></li> <li><del>• For more detail, go to the <b>VBID</b> row in the Medical Benefits Chart below.]</del></li> </ul> <p><del>[Instructions to plans offering VBID benefits for LIS Targeted Enrollees:</del></p> <ul style="list-style-type: none"> <li><del>• Plans can deliver to each LIS targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they're eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).</del></li> <li><del>• Plans who choose to reduce cost sharing for an item or service, including Part D drugs covered by MA-PD plan through member participation in a plan-sponsored disease management or similar program, must include a summary of the additional supplemental benefits they would get as well as the activities and/or programs the member must complete in order to get the benefit.</del></li> <li><del>• If applicable, plans must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits.</del></li> </ul>

Clarification Requested By	Chapter/Section	Change/Reason
		<ul style="list-style-type: none"> <li><del>If applicable, plans with VBD should mention that members may qualify for a reduction or elimination of their cost sharing for Part D drugs in Chapter 6, Section 2.</del></li> </ul>

### Changes to HMO MA, PPO MA, MSA EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Edited sixth, ninth and eleventh bullets in “Covered Service” column of “Medicare Part B drugs” row:</p> <p>Sixth bullet:</p> <ul style="list-style-type: none"> <li>Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. <del>Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them.</del></li> </ul> <p>Ninth bullet:</p> <ul style="list-style-type: none"> <li>Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. <del>As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does.</del></li> </ul> <p>Eleventh bullet:</p> <ul style="list-style-type: none"> <li>Certain oral End-Stage Renal Disease (ESRD) drugs <del>if the same drug is available in injectable form and the</del> covered under Medicare Part B <del>ESRD benefit covers it</del></li> </ul>



**Changes to HMO MAPD, PPO MAPD, DSNP, HMO MA, PPO MA EOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Deleted “Value-Based Insurance Design (VBID) Model” row:</p> <p>Covered Services:</p> <p><b><del>Value-Based Insurance Design (VBID) Model</del></b></p> <p><del><i>[Enrollees with chronic condition(s), enrollees who qualify for Extra Help, or enrollees in geographic areas that meet certain criteria may be eligible for VBID targeted supplemental benefits and/or reduced cost sharing. The eligibility criteria and benefits must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits and eligibility criteria here.]</i></del></p> <p><del><i>If this benefit is not applicable, plans should delete this row.]</i></del></p> <p><del><i>What you pay:</i></del></p> <p><del><i>[List copayment / coinsurance / deductible]</i></del></p>

**Changes to HMO MAPD, PPO MAPD, DSNP, Cost, PFFS, HMO MA, PPO MA EOC models**

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4, Section 2, Medical Benefits Chart	<p>Revised Dental Services row:</p> <p><b>Dental services</b></p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren’t covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams <del>after</del><del>prior</del> to <del>organ</del><del>kidney</del> transplantation. In addition, we cover:</p> <p><i>[List any additional benefits offered, such as diagnostic, preventive, and comprehensive dental care.]</i></p>