

## Attachment C: 97 Comments & Responses to Federal Register Notice #1 (60-day)

**Comment 1:** The plan recommends removing the “*Permissible Alterations/Modifications or Deletions of Standardized Language*” as well as Appendix A from all ANOC and EOCs and reverting back to a separate instructions document.

**Response:** CMS respectfully declines this suggestion since adding the “*Permissible Alterations/Modification or Deletions of Standardized Language*” and Appendix A to the models makes the instructions more easily accessible.

**CMS Action:** No action being taken at this time.

**Comment 2:** The plan suggests it is unnecessary to center all text in the “year” column and bold all text in the “next year” column in the PPO MAPD and Cost ANOCs. The plan believes bolding all text within a column deemphasizes information and the model should allow plans flexibility to center and/or bold text as needed.

**Response:** CMS respectfully declines this suggestion as this format was well-received by beneficiaries during consumer testing.

**CMS Action:** No action being taken at this time.

**Comment 3:** The plan believes that CMS should redesign Section 1.7 in the PPO MAPD & Cost ANOC models to be similar to Section 1.5 allowing for greater transparency and clarify for plan members. For example, allow the flexibility to construct the table with appropriate year over year Part D changes. The plan suggests the current instructional text and required text in Section 1.5 is confusing and does not address all Part D plan changes that beneficiaries may need or want to know about during the Annual Enrollment Period.

**Response:** CMS respectfully declines this suggestion at this time but will consider for future models.

**CMS Action:** No action being taken at this time.

**Comment 4:** The plan suggests the second paragraph beginning with “Extra Help” in Section 4, Medicare Prescription Payment Plan bullet of the PPO MAPD and Cost ANOCs should be revised to reference the full terms for “SPAP” and “ADAP” because the prior SPAP and ADAP bulleted language may not be included if not applicable to the plan.

**Response:** CMS respectfully declines this suggestion as plans are permitted to correct minor grammatical changes as described in the models under “*Permissible Alterations/Modifications or Deletions of Standardized Language.*”

**CMS Action:** No action being taken at this time.

**Comment 5:** The plan points out that there are several instances in all EOCs of “your plan” replacing “our plan” that are not appropriate.

Response: CMS agrees with this suggestion.

CMS Action: CMS replaced many instances of “our plan” that were part of a plan instruction with “your plan” throughout all ANOC and EOC models and will continue to review the models for additional instances.

**Comment 6:** The plan suggests Section 4, Summary of Important Costs for 2027 table in Chapter 1 of the PPO MAPD and Cost EOCs seems out of place and does not add value since more complete and detailed information can be found elsewhere in the document.

Response: CMS respectfully declines this suggestion as the table enables beneficiaries to review/compare important costs in one place.

CMS Action: No action being taken at this time.

**Comment 7:** The plan proposes the paragraph beginning with “If you already get help from one of these programs...” in Chapter 1, Section 4.1 of the PPO MAPD and Cost EOCs is in the wrong place since Extra Help and similar programs are not addressed until after this paragraph. In addition, the paragraph does not apply to plans without a monthly premium; therefore, the paragraph should follow the 2025 model EOC and be moved under “In some situations, our plan premium could be less.”

Response: CMS agrees with this suggestion.

CMS Action: CMS reorganized the EOC text in all Part D models, so the paragraph beginning with “If you already get help from one of these programs” follows the paragraph introducing these programs.

**Comment 8:** The plan points out table formatting is missing gridlines separating several benefit categories in Chapter 4, Medical Benefits Chart in the PPO MAPD and Cost EOCs.

Response: CMS respectfully declines this suggestion as it appears all horizontal lines are already there. Plans are permitted to correct formatting as described in the models under “*Permissible Alterations/Modifications or Deletions of Standardized Language.*”

CMS Action: No action being taken at this time.

**Comment 9:** The plan suggests that in PPO MAPD and Cost EOCs, Chapter 4, Medical Benefits Chart, Chronic pain management and treatment services row, the benefit category either needs to be omitted or the language in the payment column changed.

Response: CMS agrees with this suggestion that the inclusion of this service bundle is confusing.

**CMS Action:** CMS removed the Chronic pain management and treatment services row in the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, HMO MA and PPO MA EOC models (**changes in red text**):

<p><b><del>Chronic pain management and treatment services</del></b>  <del>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.</del></p>	<p><del>Cost sharing for this service may vary depending on individual services provided under the course of treatment or the healthcare professional providing the services. <i>{List copayment / coinsurance / deductible}</i></del></p>
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**Comment 10:** The plan recommends deleting the plan instruction related to barium enemas in Chapter 4, Medical Benefits Chart, Colorectal cancer screening row in the PPO MAPD and Cost EOCs since Medicare no longer covers barium enemas as a screening test.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS removed the plan instruction in the PPO MAPD and Cost EOCs as follows (**changes in red text**):

*~~{If applicable, list copayment and/or coinsurance charged for barium enema}~~*

**Comment 11:** The plan recommends the following language in the PPO MAPD EOC, Chapter 4, Medical Benefits Chart, Hospice care row be revised since it is incorrect for a PPO plan:

- If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised the PPO MAPD and PPO MA models as follows (**changes in red text**):

- If you get the covered services from an out-of-network provider, **your share of the costs for covered services may be higher** ~~pay the cost sharing under Original Medicare~~

**Comment 12:** The plan suggests that in Chapter 4, Section 2.2, Get care using your plan’s optional visitor/traveler benefit, of the Cost EOC only, “extended absence” was incorrectly replaced with “visitor/traveler” benefit throughout the section, and the instructional text incorrectly cites the Medicare Advantage regulation rather than the Cost regulation. Also, the first sentence of the model language stating a member must be disenrolled if continuously away from the plan’s service area for more than 6 months is also incorrect for Cost plans.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised Chapter 4, Section 2.2 of the Cost EOC model to include the correct language and regulatory citations, which reads as follows (**changes in red text**):

*[If your plan offers a visitor/traveler program to members who are temporarily absent from ~~out~~ of your service area for more than 90 days but less than a year, 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. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR 417.460(f)(2) ~~42 CFR 422.74(b)(4)(iii)~~ (for more than 90 days ~~6 months~~ up to 12 months) also explain that here based on the language suggested below.*

If you don't permanently move but are continuously away from our plan's service area for more than 90 days ~~6 months~~, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that will allow you to stay enrolled when you're outside of our service area for more than 90 days but fewer ~~less~~ than 12 months. *[Insert how covered services are provided while the member is out-of-area.]* Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help locating a provider when using the visitor/traveler benefit.

**Comment 13:** The plan points out that in the D-SNP, ANOC, Section 4 Get Help Paying for Prescription Drugs, last paragraph, the word "in" is missing in the sentence, "All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level."

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS updated the ANOC text in the D-SNP model in the last paragraph of Section 4 to read as follows (**changes in red text**): "All members are eligible to participate **in** the Medicare Prescription Payment Plan, regardless of income level."

**Comment 14:** The plan suggests language is inconsistent across models with respect to Low Income Subsidy (LIS) Rider in all Part D ANOCs, Section 1.7 or Section 5, Changes to Prescription Drug Benefits & Costs.

**Response:** CMS agrees with this suggestion and updated the text in multiple instances.

**CMS Action:** CMS updated Section 1.7 and Section 5 of the PPO MAPD and Cost ANOCs, as well as the Introduction, Section 1.2 (two instances), and Section 1.5 of the PDP ANOC model to include proper grammar when referencing the member services phone number (**changes in red text**):

...call Member Services **at** *[insert Member Services number]* (TTY users call *[insert TTY number]*) ...

**Comment 15:** The plan suggests that all Part D ANOCs, Section 1.7, Changes to Prescription Drug Benefits & Costs, have incorrect year references in the chart instruction.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised all instances of plan instructions regarding changing costs from “2025 to 2026” to “2026 to 2027” in the “2026 (this year)” column in Section 1.7 of the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, and PDP EOC models to read as follows (**changes in red text**):

*[Plans that are changing insulin cost sharing from 20256 to 20267, insert for each applicable tier: You pay \$[xx] per month supply of each covered insulin product on this tier.]*

**Comment 16:** The plan identifies that in the PPO MAPD EOC only, the cover page and first page of every chapter except 10, 11 and 12 has OMB approval number where it should be included in each chapter.

**Response:** CMS partially agrees with this suggestion and updated the text, so the OMB approval is only on the cover page.

**CMS Action:** CMS updated the PPO MAPD, D-SNP, Cost, and HMO MA EOCs so the OMB approval number is only on the cover page.

**Comment 17:** In the HMO MA, EOC, Chapter 7, Section 5.5, the plan suggests the following sentence does not read correctly: "If we say yes to your request: If the medical care is covered and you followed all the rules, we will send you the payment for cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request." Instead, the plan suggests the following to align with the HMO MAPD: “If we say yes to your request: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request.”

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised the HMO MA and PPO MA EOCs as follows (**changes in red text**):

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we’ll send you the payment **for our share of** the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven’t paid for the medical care, we’ll send the payment directly to the provider.

**Comment 18:** The plan suggests possible missing subsection header in D-SNP EOC, Chapter 9B, Section 7.6.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS added a subsection header to the D-SNP EOC as follows (changes in red text): “Section 7.6 How to make a Level 2 appeal.”

**Comment 19:** The plan suggests inconsistency in the Medicare Rights & Protections section in Chapters 6, Section 1.8, How to get more information about your rights, and Chapter 8, Section 1.8 since the URL is missing or not spelled out in some EOCs.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS updated the HMO MA EOC to include a hyperlink to the Medicare Rights & Protections publication in Chapter 6, Section 1.8.

In Chapter 8, Section 1.8, the hyperlink in the HMO MAPD, Cost, and MSA EOCs was updated to read as follows (changes in red text): “Medicare Rights & Protections”

**Comment 20:** The plan identifies an inconsistency in Chapter 6, Section 1.1 in HMO MAPD, PPO MAPD and the other EOCs. The plan suggests using term “materials” instead of “information” in all models.

**Response:** CMS agrees that the language should be aligned across all models.

**CMS Action:** CMS revised the sentence about providing information in non-English languages in Chapters 6 and 8, Section 1.1 of the D-SNP, PFFS, HMO MA, PPO MA and PDP EOCs to use the word “information” instead of “materials” for consistency with the remainder of the section and the other models as follows (changes in red text):

We can also give you materials information in *[insert if required to provide materials in any non-English languages per 42 CFR § 422.2267(a): in languages other than English including <required languages> and]* braille, in large print, or other alternate formats at no cost if you need it.

**Comment 21:** The plan points out that in all EOCs, Chapter 4, Section 2, Medical Benefits Chart, a horizontal gridline needs to be added to separate the benefit rows in some areas.

**Response:** CMS respectfully declines this suggestion as it appears all horizontal lines are already there. Plans are permitted to correct formatting as described in the models under “*Permissible Alterations/Modifications or Deletions of Standardized Language.*”

**CMS Action:** No action being taken at this time.

**Comment 22:** The plan identifies that in all ANOCs, Section 1.5 and Section 1.7, the Value-Based Insurance Design (VBID) instruction and section around VBID should be removed for policy consistency.

**Response:** CMS agrees with this suggestion.

CMS Action: CMS removed the text below in all applicable ANOC models (**changes in red text**):

~~*[Instructions to plans that offered Value-Based Insurance Design (VBID) Model benefits in 2026: VBID Model participating plans that were approved to offer VBID Model benefits in 2026 should update this section to reflect changes to coverage for any 2026 VBID Model benefits that will end beginning 2027. If a previous VBID Model benefit is to be offered through another authority for 2027, these changes must be reflected, and all applicable disclaimers must be used.]*~~

~~*[If VBID Model Part D cost-sharing reduction or elimination were offered in 2026, insert section to reflect changes in Part D cost-sharing, as applicable 2027.]*~~

### **Changes to your VBID Part D Benefit**

~~*[VBID Model participating plans that were approved to offer Part D reduced or eliminated cost sharing in 2026 should update this section to reflect all Part D changes in cost-sharing reduction or elimination beginning 2027.]*~~

**Comment 23:** In the D-SNP, EOC only, Chapter 6, Section 3, the language in 2027 model currently states *[Plans with no cost sharing for Part D drugs, should move the information in Section 3 to Chapter 5, delete the rest of Chapter 6, and add: You pay nothing for Part D drugs covered by our plan.]* The plan asks for clarification if the line "You pay nothing..." should go to Chapter 5 with Section 3 or be added to Chapter 6.

Response: CMS respectfully declines this suggestion as the instruction addresses the concern. Plans with no cost sharing for Part D drugs should move the information in Chapter 6, Section 3 to Chapter 5, delete the remaining sections of Chapter 6, and insert the text "You pay nothing for Part D covered drugs covered by our plan" under the "Chapter 6: What you pay for Part D drugs" heading.

CMS Action: No action being taken at this time.

**Comment 24:** The plan suggests the OMB footer with approval date be added at the beginning of multiple chapters to reflect the PPO MAPD EOC.

Response: CMS partially agrees with this suggestion and updated the text, so the OMB approval is only on the cover page.

CMS Action: CMS updated the PPO MAPD, D-SNP, Cost, and HMO MA EOC models so the OMB approval number is only on the cover page.

**Comment 25:** The plan notes that the instructions in the "About" section of the D-SNP ANOC appear to allow only D-SNP lookalikes to use the following paragraph, but the paragraph is also relevant for non-D-SNPs as follows:

*[If the member is being enrolled into another plan due to a transition from a D-SNP lookalike 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]*.]

Response: CMS agrees with this suggestion and updated the text with a new paragraph.

CMS Action: CMS updated the text in the D-SNP ANOC to include plan instructions for beneficiaries who are leaving a D-SNP plan to enroll in another plan within the organization (changes in red text):

*[If the member is being enrolled into another plan due to a transition from one D-SNP plan to another plan within the organization, 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 lookalike 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].]*

**Comment 26:** The plan requests the flexibility to reference “copay” or “copayment” in the following language in Section 1.5 in all ANOCs: “[*For benefits with a copayment insert: \$[insert 2027 copayment amount] copayment [insert language as needed to accurately describe the benefit, e.g., per office visit].*”]

Response: CMS respectfully declines this suggestion as plans are permitted to correct minor grammatical changes as described in the models under “*Permissible Alterations/Modifications or Deletions of Standardized Language.*”

CMS Action: No action being taken at this time.

**Comment 27:** In the HMO MAPD, PPO MAPD, and D-SNP ANOCs, Section 1.7, the plan recommends that three options be variables, per the following: “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 *[insert as applicable: for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions]*, go to Chapter 6 of your Evidence of Coverage.”

Response: CMS respectfully declines this suggestion as all three variables are already included.

CMS Action: No action being taken at this time.

**Comment 28:** In the HMO MAPD, PPO MAPD and D-SNP ANOCs, Section 1.7, the plan requests an option to include insulin cost sharing even if there is no change from year to year to reduce member confusion: For example: “[*Plans that are changing insulin cost sharing from*

2026 to 2027, insert for each applicable tier: You pay \$/xx/ per month supply of each covered insulin product on this tier.]”

Response: CMS respectfully declines this suggestion as the ANOC is meant to be a summary of changes.

CMS Action: No action being taken at this time.

**Comment 29:** In the HMO MAPD, PPO MAPD and D-SNP ANOCs, Section 1.7, the plan requests an option to include mail order cost sharing even if there is no change from year to year to reduce member confusion. For example: “[Plans that are changing costs for mail-order prescriptions from 2026 to 2027 insert: Your cost for a one-month (*insert number of days in a one-month supply*) mail-order prescription is \$/xx/.]”

Response: CMS respectfully declines this suggestion as the ANOC is meant to be a summary of changes.

CMS Action: No action being taken at this time.

**Comment 30:** In the HMO MAPD, PPO MAPD and D-SNP ANOCs, Section 1.7, the plan recommends the language, “You pay \$/xx/ per month supply of each covered insulin product on this tier.” be updated to account for the lesser of \$35 *[or less if filed cost share is less than \$35]* or Maximum Fair Price (MFP): “You pay no more than \$/xx/ per month supply of each covered insulin product on this tier.”

Response: CMS respectfully declines this suggestion as adding details about the MFP or negotiated price would introduce unnecessary complexity.

CMS Action: No action being taken at this time.

**Comment 31:** In the HMO MAPD, PPO MAPD and D-SNP ANOCs, Section 1.7, the plan requests updates to the instructions as follows: “[Plans that cover excluded drugs under an enhanced benefit in 2027 with \$0 cost sharing in this stage, insert the following, as applicable: If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.]”

Response: CMS respectfully declines this suggestion. Instead, CMS will remove the “Changes to the Catastrophic Stage” from the ANOC as the changes are not new for 2027.

CMS Action: CMS removed the “Changes to the Catastrophic Stage” section from the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP ANOC models (~~changes in red text~~):

### ~~Changes to the Catastrophic Coverage Stage~~

~~[Plans that cover excluded drugs under an enhanced benefit in 2027, insert the following, as applicable: If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.]~~

~~*[Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following: **If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You can have cost sharing for excluded drugs that are covered under our enhanced benefit.**]*~~

~~*For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.*~~

**Comment 32:** The plan recommends reviewing D-SNP ANOC, Section 3, Part D late enrollment penalty (LEP) content and either removing the sentence regarding the LEP or adding text to further describe the LEP.

Response: CMS agrees with the suggestion to remove sentence about the LEP.

CMS Action: CMS removed the language below about LEP as follows (**changes in red text**):

**To change to Original Medicare without a drug plan**, you can send us a written request to disenroll *[insert if organization has complied with CMS guidelines for online disenrollment: or visit our website to disenroll online at [insert URL]].* Call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. ~~*If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section [edit section number as needed]).*~~

**Comment 33:** In the HMO MAPD, PPO MAPD and D-SNP ANOCs, Summary of Important Costs for 2027, the plan requests the option to include insulin cost sharing even if it does not differ from cost sharing for other drugs on the same tier by updating the following language: “[Insert if insulin cost sharing differs from cost sharing for other drugs on the same tier: You pay \$/xx/ per month supply of each covered insulin product on this tier.]” to [or less if filed cost share is less than \$35] or Maximum Fair Price (MFP).

Response: CMS respectfully declines this suggestion as adding details about the MFP or negotiated price would introduce unnecessary complexity.

CMS Action: No action being taken at this time.

**Comment 34:** The plan requests optional additional premium language in the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 5, Section 7, Types of drugs we don't cover, as follows: “In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: *[Insert if applicable: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)]*,” or swap with alternative text, “for which you may pay a copay” as optional text to include.

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the text in Chapter 5, Section 7 of the HMO MAPD, PPO MAPD, Cost, PFFS and PDP EOCs to reference cost sharing as follows (**changes in red text**):

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: *[Insert if applicable: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may have cost sharing ~~be charged an additional premium. More information is provided below.~~)]*

**Comment 35:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 1, Section 4, the plan suggests the option to include insulin cost sharing even if it does not differ from cost sharing for other drugs on same tier to reduce member confusion by updating “[Insert if insulin cost sharing differs from cost sharing for other drugs on the same tier: You pay \$/xx/ per month supply of each covered insulin product on this tier.]” to account for the lesser of \$35 [or less if filed cost share is less than \$35] or Maximum Fair Price (MFP), “You pay no more than \$/xx/ per month supply of each covered insulin product on this tier.”

Response: CMS respectfully declines this suggestion as adding details about the MFP or negotiated price would introduce unnecessary complexity.

CMS Action: No action being taken at this time.

**Comment 36:** In the D-SNP ANOC, Summary of Important Costs for 2027, the plan recommends the following example that includes language for members who qualify for Low Income Subsidy (LIS) as they do not pay a Part D deductible: “If you receive Extra Help, this payment stage doesn't apply to you. If you do not qualify for Extra Help, the deductible is \$615.00 (Tier 2: Preferred Brand, Tier 3: Non-Preferred Drug, and Tier 4: Specialty Tier) except for covered insulin products and most adult Part D vaccines.”

Response: CMS respectfully declines this suggestion, but updated text to include plan instruction for plans with no deductible.

CMS Action: CMS added a plan instruction to the Part D drug coverage deductible row in the Summary of Important Costs for 2027 table (**changes in red text**): *[Plans with no deductible can delete this row.]*

**Comment 37:** In the D-SNP ANOC, Summary of Important Costs for 2027, the plan suggests language for members who qualify for LIS as they would not pay their filed cost shares if greater than \$0. For example: If you receive Extra Help, Copayment during the Initial Coverage Stage: Drug Tier 2 - Preferred Brand: \$0.00 - \$12.65\* per prescription. You pay \$0.00 - \$12.65\* per month supply of each covered insulin product on this tier. If you do not qualify for Extra Help, Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 2: Preferred Brand: 25% You won't pay more than \$35.00 per month supply of each covered insulin product on this tier.

Response: CMS respectfully declines this suggestion. All enrollees who are eligible for a D-SNP qualify for the LIS for the entire year. The plan should only include the LIS cost-sharing levels.

CMS Action: No action being taken at this time.

**Comment 38:** The plan provided the following example of suggested language for the D-SNP ANOC, Section 1.7, for members who qualify for LIS as they would not pay a Part D deductible:

Stage 1: Yearly Deductible

You start in this payment stage each calendar year. If you receive Extra Help, this payment stage doesn't apply to you. If you do not qualify for Extra Help, during this stage, you pay the full cost of your Tier 2: Preferred Brand, Tier 3: Non-Preferred Drug, and Tier 4: Specialty Tier drugs until you have reached the yearly deductible.

•Stage 2: Initial Coverage

If you receive Extra Help, 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 Out-of-Pocket costs reach \$2,100. If you do not qualify for Extra Help, 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 Out-of-Pocket costs reach \$2,100.

Response: CMS respectfully declines this suggestion as there are already instructions in this section that plans with no deductible should replace the language with "Because we have no deductible, this payment stage doesn't apply to you."

CMS Action: No action being taken at this time.

**Comment 39:** The plan provided the following example of suggested language for members who qualify for LIS as they would not pay a Part D deductible for the D-SNP ANOC, Section 1.7:

Yearly Deductible

If you receive Extra Help, this payment stage doesn't apply to you. If you do not qualify for Extra Help, the deductible is \$615.00. During this stage, you pay \$0.00 cost sharing for drugs on Tier 1: Preferred Generic and Tier 5: Supplemental Drugs and the full cost of drugs on Tier 2: Preferred Brand, Tier 3: Non-Preferred Drug, and Tier 4: Specialty Tier until you've reached the yearly deductible.

Response: CMS respectfully declines this suggestion. All enrollees who are eligible for a D-SNP qualify for the LIS for the entire year. The plan should only include the LIS cost-sharing levels.

CMS Action: No action being taken at this time.

**Comment 40:** The plan provided the following example for the D-SNP ANOC, Section 1.7, for D-SNP members who qualify for LIS as they would not pay their file cost shares if greater than \$0:

Tier Example:

If you do not qualify for Extra Help:

Tier 2: Preferred Brand: You pay 25% of the total cost. You won't pay more than \$35.00 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25%.

If you receive Extra Help:

Tier 2: Preferred Brand: You pay \$0.00 - \$12.65 per prescription. You pay \$0.00 - \$12.65 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$0.00 - \$12.65.

Response: CMS respectfully declines this suggestion. All enrollees who are eligible for a D-SNP qualify for the LIS for the entire year. The plan should only include the LIS cost-sharing levels.

CMS Action: No action being taken at this time.

**Comment 41:** The plan suggests removing VBID language in all EOCs, Chapter 4, Section 2 since VBID ended.

[Important Benefit Information for People Who Qualify for Extra Help:

- If you get Extra Help to pay your Medicare drug program costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.]

Response: CMS agrees with this suggestion.

CMS Action: CMS removed all instances of the following text in the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, HMO MA and PPO MA EOCs (changes in red):

~~[Important Benefit Information for People Who Qualify for Extra Help:~~

- ~~• If you get Extra Help to pay your Medicare drug program costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.]~~

**Comment 42:** The plan recommends flexibility in references to “copay” or “copayment” in instructions within the Chapter 4, Medical Benefits Chart in all EOCs.

Response: CMS respectfully declines this suggestion as plans are permitted to correct minor grammatical changes as described in the models under “*Permissible Alterations/Modifications or Deletions of Standardized Language.*”

CMS Action: No action being taken at this time.

**Comment 43:** The plan suggests the instruction in the D-SNP EOC, cover (introduction) should be updated so the paragraph can be used for D-SNP transitions as the plan recommends the following language is more suitable for a D-SNP transition vs. the consolidation paragraph option:

“[If the member is being enrolled into another plan due to a transition from a D-SNP lookalike 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 lookalike 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]*.]”

**Response:** CMS respectfully declines this suggestion as this language does not exist in the D-SNP EOC model.

**CMS Action:** No action being taken at this time.

**Comment 44:** In the D-SNP EOC, Chapter 1, Section 4, Summary of Important Costs for 2027, the plan suggests including the following language for members who qualify for LIS since they would not pay a Part D deductible:

“If you receive Extra Help, this payment stage doesn't apply to you. If you do not qualify for Extra Help, the deductible is \$615.00 (Tier 2: Preferred Brand, Tier 3: Non-Preferred Drug, and Tier 4: Specialty Tier) except for covered insulin products and most adult Part D vaccines.”

**Response:** CMS partially agrees with this suggestion and updated the text.

**CMS Action:** CMS added the following plan instruction to the Part D drug coverage deductible row in the table as follows (**changes in red text**): *[Plans with no deductible can delete this row.]*

**Comment 45:** In the D-SNP EOC, Chapter 1, Section 4, the plan suggests the following language for members who qualify for LIS since they would not pay their filed cost shares if greater than \$0:

If you receive Extra Help, copayment during the Initial Coverage Stage:

Drug Tier 2 - Preferred Brand: \$0.00 - \$12.65\* per prescription. You pay \$0.00 - \$12.65\* per month supply of each covered insulin product on this tier.

If you do not qualify for Extra Help, copayment/coinsurance during the Initial Coverage Stage:

Drug Tier 2: Preferred Brand: 25%. You won't pay more than \$35.00

**Response:** CMS respectfully declines this suggestion. All enrollees who are eligible for a D-SNP qualify for the LIS for the entire year. The plan should only include the LIS cost-sharing levels.

**CMS Action:** No action being taken at this time.

**Comment 46:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 1, Section 4, the insulin language does not account for Maximum Fair Price. The plan recommends the language is updated to account for the lesser of \$35 [or less if filed cost share is less than \$35] or Maximum Fair Price. For example, the plan suggests: You pay no more than \$\$[xx] per month supply of each covered insulin product on this tier.

Response: CMS respectfully declines this suggestion as adding details about the MFP or negotiated price would introduce unnecessary complexity.

CMS Action: No action being taken at this time.

**Comment 47:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 6, Section 5.4, the plan recommends adding the number of day supply under each Tier (in rows) vs. standard, preferred and mail order columns since the day supply can vary by Tier. The plan provided the following example:

“Cost-Sharing Tier 1 (*[insert description]*) [*insert if applicable: (up to a [insert number of days]-day supply)*]”

Response: CMS respectfully declines the suggestion in order to maintain clarity and continuity.

CMS Action: No action being taken at this time.

**Comment 48:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 6, Section 5.2, the plan recommends the option to insert a footnote including insulin cost sharing even if it is the same cost sharing for other drugs on the same tier per the following example:

*[Plans that offer cost sharing for insulin that differs from the cost sharing for other drugs on the same tier, insert the following footnote: You won't pay more than \$35 [update the cost-sharing amount, if lower than \$35] for a one-month supply of each covered insulin product regardless of the cost-sharing tier [modify as needed if plan offers multiple cost-sharing amounts for insulins (e.g., preferred and non-preferred insulins)] [insert only if plan's benefit design includes a deductible:, even if you haven't paid your deductible].]*

Response: CMS respectfully declines the suggestion in order to maintain clarity and continuity.

CMS Action: No action being taken at this time.

**Comment 49:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 6, Section 5.4, the plan proposes an option to insert a footnote including insulin cost sharing even if it does not differ from cost sharing for other drugs on the same tier per the following example:

*[For plans that offer insulin cost sharing different from the cost sharing applicable to the other drugs on the same tier, insert the following if these cost sharing levels are applicable: You won't pay more than [inset the applicable language: \$70 [update the cost-sharing amount, if lower than \$70] for up to a 2-month supply or \$105 [update the cost sharing amount, if lower than \$105] for up to a 3-month supply of each covered insulin product regardless of the cost sharing*

*tier [modify as needed if plan offers multiple cost-sharing amounts for insulins (e.g., preferred and non-preferred insulins)] [insert only if plan's benefits design includes a deductible: , even if you haven't paid your deductible].*

Response: CMS respectfully declines the suggestion in order to maintain clarity and continuity.

CMS Action: No action being taken at this time.

**Comment 50:** In the HMO MAPD, PPO MAPD and D-SNP EOCs, Chapter 4, Medical Benefits Chart, Colorectal cancer screening row, second bullet, the plan recommends changing “payment may be made for” to ”coverage of”: ...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

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the second bullet in the Colorectal cancer screening row of the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA and PPO MA EOCs as follows (changes in red text):

- Computed tomography colonography for patients 45 years 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 coverage of~~ 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.

**Comment 51:** In the HMO MAPD, PPO MAPD and D-SNPs EOCs, Chapter 4, Medical Benefits Chart, Screening for Hepatitis C virus infection row, the plan recommends changing the words “pay for” to “cover”: If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the Screening for Hepatitis C Virus infection row in the HMO MAPD, PPO MAPD, D-SNP, Cost, MSA, PFFS, HMO MA and PPO MA EOCs to read as follows (changes in red text):

If you were born between 1945-1965 and aren't considered high risk, we ~~pay for~~ cover a screening once.

**Comment 52:** The plan recommends fixing inconsistencies in capitalization for each benefit in Chapter 4, Medical Benefits Chart in all EOCs except PDP.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the following benefit rows in the Medical Benefits Chart for all EOC models that include the benefit: Help with certain chronic conditions (except MSA), Physician/practitioner services, including doctor's office visits, Screening for Hepatitis C virus infection, Special supplemental benefits for the chronically ill (except MSA, Cost), and Supervised exercise therapy.

**Comment 53:** The plan suggests removing language referencing Value Based Insurance Design (VBID).

Response: CMS agrees with this suggestion.

CMS Action: CMS removed the text below in all applicable ANOC and EOC models (**changes in red text**).

ANOC - Section 1.5 (HMO MAPD, PPO MAPD, DSNP, HMO MA, PPO MA):

*[Instructions to plans that offered Value-Based Insurance Design (VBID) Model benefits in 2026: VBID Model participating plans that were approved to offer VBID Model benefits in 2026 should update this section to reflect changes to coverage for any 2026 VBID Model benefits that will end beginning 2027. If a previous VBID Model benefit is to be offered through another authority for 2027, these changes must be reflected, and all applicable disclaimers must be used.]*

*[If VBID Model Part D cost-sharing reduction or elimination were offered in 2026, insert section to reflect changes in Part D cost-sharing, as applicable 2027.]*

ANOC – Section 1.7 (HMO MAPD, PPO MAPD, DSNP, PDP):

**Changes to your VBID Part D Benefit**

*[VBID Model participating plans that were approved to offer Part D reduced or eliminated cost sharing in 2026 should update this section to reflect all Part D changes in cost-sharing reduction or elimination beginning 2027.]*

EOC – Chapter 4, Section 2 (All except MSA, PDP):

**Important Benefit Information for People Who Qualify for Extra Help:**

- *[If you get Extra Help to pay your Medicare drug program costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.]*

**Comment 54:** Throughout all ANOCs in section 1.5, the plan recommends changing the format of all content in the 2027 column from bold to not bolding text.

Response: CMS respectfully declines this suggestion as this format was well-received by beneficiaries during consumer testing.

CMS Action: No action being taken at this time.

**Comment 55:** In the HMO MAPD ANOC, Section 1.6, the plan recommends adding the following language (second paragraph below) if a plan does not cover excluded drugs:

Changes to the Catastrophic Coverage Stage [Plans that cover excluded drugs under an enhanced benefit in 2027, insert the following, as applicable: If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.] [Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage, insert the following: If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You can have cost sharing for excluded drugs that are covered under our enhanced benefit.]

[Plans that do not cover excluded drugs: If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.]

Response: CMS respectfully declines this suggestion. Instead, CMS will remove the Changes to the Catastrophic Stage as the changes are not new for 2027.

CMS Action: CMS removed the Changes to the Catastrophic Stage section from the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, and PDP ANOCs.

**Comment 56:** In the HMO MAPD ANOC, Section 3 - How to Change Plans, the plan recommends updating language in section to add clear language outlining the steps a beneficiary needs to take when changing their plan and provided example language.

Response: CMS respectfully declines this suggestion at this time but will consider for future models.

CMS Action: No action being taken at this time.

**Comment 57:** The plan recommends changing the Preventive Services definition in Chapter 12 in all EOCs to the following:

Preventive Services – These are health care services that help you stay healthy and find health problems early, before they become serious. It can include regular checkups, screenings, and

vaccines that help protect you from illness or catch health conditions in their early stages—when treatment usually works best.

For example:

- Screenings like Pap tests can find signs of cancer early.
- Vaccines such as flu shots help protect you from getting sick.
- Mammograms can detect breast cancer before it causes symptoms

Response: CMS agrees with this suggestion to align with the Medicare.gov definition.

CMS Action: CMS revised the definition in all EOCs except PDP to the following: (changes in red text):

**Preventive services** – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health. ~~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).~~

**Comment 58:** The plan suggests implementing an interactive digital-first ANOC format with embedded navigation and visuals.

Response: CMS respectfully declines this suggestion at this time but will consider for future models.

CMS Action: No action being taken at this time.

**Comment 59:** The plan suggests publishing a plain-language glossary for consistency.

Response: CMS respectfully declines this suggestion at this time but will consider for future models.

CMS Action: No action being taken at this time.

**Comment 60:** The plan suggests providing visual flowcharts for drug payment stages and key concepts.

Response: CMS respectfully declines this suggestion at this time but will consider for future models.

CMS Action: No action being taken at this time.

**Comment 61:** The plan suggests moving the accessibility and nondiscrimination notices to a single appendix or CMS-hosted link.

**Response:** CMS respectfully declines this suggestion at this time but will consider for future models.

**CMS Action:** No action being taken at this time.

**Comment 62:** The plan suggests establishing CMS-led member usability testing before each model's final release.

**Response:** CMS respectfully declines this suggestion as CMS recently conducted consumer testing for the ANOC and EOC models.

**CMS Action:** No action being taken at this time.

**Comment 63:** In Section 1.7, Changes to Prescription Drug Benefits & Costs, the plan suggests adding variable language to all ANOCs that includes out-of-pocket threshold drug coverage changes only.

**Response:** CMS respectfully declines this suggestion in order to maintain clarity and continuity.

**CMS Action:** No action being taken at this time.

**Comment 64:** The plan recommends the Summary of Important Costs for 2027 chart in all ANOCs be optional.

**Response:** CMS respectfully declines this suggestion as the chart enables beneficiaries to review/compare important costs in one place.

**CMS Action:** No action being taken at this time.

**Comment 65:** In the HMO MAPD, PPO MAPD, D-SNP, PFFS, MSA and PDP ANOCs, Section 3, How to Change Plans, second bullet, the plan recommends changing the second bullet to read, "To change to Original Medicare and stand-alone Medicare drug coverage".

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised the text in all ANOCs to the following (**changes in red text**):

To change to Original Medicare with **separate** Medicare drug coverage, enroll in the new Medicare drug plan. You'll be automatically disenrolled from *[insert 2027 plan name]*.

**Comment 66:** In the HMO MAPD, PPO MAPD, D-SNP, PFFS, MSA and PDP ANOCs, Section 1.7, Drug Costs in Stage 2: Initial Coverage, the plan proposes the language, "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.” be replaced with “*The number of days in a one-month supply has changed from [XX] in 2026 to [XX] in 2027.*”

Response: CMS respectfully declines this suggestion since the sentence is accurate currently.

CMS Action: No action being taken at this time.

**Comment 67:** In the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, HMO MA and PPO MA ANOCs, Summary of Important Costs for 2027, the plan recommends revising the paragraph under Inpatient hospital stays to read: “Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.”

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the Inpatient hospital stays description in all ANOCs and EOCs, (except MSA, PDP) as follows (**changes in red text**):

Includes **various** inpatient **hospital stays such as acute care, inpatient** rehabilitation **and** long-term care **hospitals, and other types of inpatient hospital services. An inpatient hospital stay** care starts the day you're formally admitted **to the hospital** with a doctor's order **and ends** the day before you're discharged **is your last inpatient day.**

**Comment 68:** In the Cost, MSA, HMO MA and PPO MA ANOCs, About section, the plan recommends adding the following sentence to the current language, “The penalty is added to your monthly premium.” to clarify that the late enrollment penalty is a monthly cost instead of a one-time fee.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the last bullet point in the About *[insert 2027 plan name]* section of the Cost, PFFS, MSA, HMO MA, and PPO MA ANOCs as follows (**changes in red text**):

- 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), for 63 days or more, you may have to pay a late enrollment penalty **that is added to your monthly premium** if you enroll in Medicare drug coverage in the future.

**Comment 69:** In the PPO MAPD EOC, Chapter 1, Section 4, Summary of Important Costs for 2027, the plan recommends changing “network” to “in-network” in the Maximum out-of-pocket amount row in the Your Costs in 2027 column to maintain consistency throughout the document.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the Your Costs in 2027 column in the Maximum out-of-pocket amount row as follows (**changes in red text**): **From in-network providers: *[Insert 2027 MOOP amount]***

**Comment 70:** The plan suggests including the OMB approval number and expiration date one time on the cover page of the EOC and not throughout the document.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the PPO MAPD, D-SNP, Cost, and HMO MA EOCs so the OMB approval number is only on the cover page.

**Comment 71:** In the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP EOCs, Chapter 5, Section 10.1, Drug Management Program (DMP) to help members safely use opioid medications; Chapter 3, Section 10.1 (PDP), the plan proposes use of the term “prescriber(s)” in lieu of “doctor(s)” in this section.

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the PPO MAPD, Cost, and PFFS EOCs as follows (**changes in red text**): Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain ~~doctor(s)~~ **prescriber(s)**

**Comment 72:** In all ANOCs, More Resources section, the plan recommends either removing the instruction in the ANOC referencing the 5% alternative language threshold or revising the language to be more generic without mentioning specific languages, e.g., "This material is available for free in other languages. Please call Member Services for more information."

Response: CMS rejects the suggestions to remove or revise the plan instruction since CMS provides the methodology so plans can conduct their own analysis prior to CMS posting languages.

CMS Action: No action being taken at this time.

**Comment 73:** In the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP ANOCs, Section 1.6, Changes to Part D Drug Coverage, Changes to Our Drug List section, there is a sentence that explains where members can find a copy of their formulary; however, the reference to "provided electronically" doesn't account for plans that post their formularies online. The plan suggests

adding a variable option to select an online posting option, e.g., "...OR [posted online at <insert URL>]."

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the first paragraph in HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP EOCs to read as follows (**changes in red text**):

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is [\[\[insert: in this envelope\]](#) *OR* [\[insert: provided electronically\]](#) *OR* [\[insert: posted online at \[insert URL\]\]](#).

**Comment 74:** In the ANOCs with Part D, Drugs Costs in Stage 2: Initial Coverage section, cost-sharing tables, the models include instructions to add both insulin and mail-order cost-sharing changes; however, the plan recommends removing the instructions to streamline the chart, and revise the existing sentence referring members to the EOC to the following: "For more information about the costs of vaccines, or information about the costs [\[insert as applicable: for a long-term supply; for insulin cost-sharing, at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions\]](#), go to Chapter 6 of your Evidence of Coverage."

Response: CMS respectfully declines this suggestion. Plans are instructed to insert the text as applicable; therefore, CMS does not agree that the text unnecessarily adds to the complexity and length of the document.

CMS Action: No action being taken at this time.

**Comment 75:** The plan recommends removing the Summary of Important Costs for 2027 chart from all ANOCs.

Response: CMS respectfully declines this suggestion as the chart enables beneficiaries to review/compare important costs in one place.

CMS Action: No action being taken at this time.

**Comment 76:** In the D-SNP ANOC, Summary of Important Costs for 2027, the current language variations for SNP only addresses the different levels of cost sharing assistance, and not cost sharing during the deeming period when a member loses their Medicaid eligibility; therefore, the plan suggests adding language or instructions for plans that have full Medicare cost sharing assistance, when the member loses Medicaid, and the member is responsible for the Medicare cost share during the deeming period. In the MOOP section, the plan suggests adding variable language to explain this situation: "[\[If you lose Medicaid coverage, you pay the](#)

applicable Medicare cost-sharing amounts and those amounts will count toward the maximum out-of-pocket amount]."

Response: CMS respectfully declines this suggestion as the ANOC is meant to be a summary of changes and cost sharing during the deeming period is addressed in the EOC.

CMS Action: No action being taken at this time.

**Comment 77:** In the D-SNP ANOC, Summary of Important Costs for 2027, the current language in the Part D section for deductible and tier cost-sharing does not account for adding language/instructions to indicate what happens if member loses LIS; therefore, the plan recommends adding variable language for that scenario: "... *[insert if Medicare cost share applies during loss of LIS:, if you don't qualify for Extra Help,]*."

Response: CMS respectfully declines this suggestion as beneficiaries will not lose Extra Help during the year.

CMS Action: No action being taken at this time.

**Comment 78:** In the D-SNP ANOC, Section 1.2, the plan suggests adding language in the first variable for plans that have full Medicare cost sharing assistance, when the member loses Medicaid, and the member is responsible for the Medicare cost share during the deeming period. The plan recommends adding the following instruction: "[If you lose Medicaid coverage, you pay the applicable Medicare cost-sharing amounts, and those amounts will count towards the maximum out-of-pocket amount.]"

Response: CMS respectfully declines this suggestion as the ANOC is meant to be a summary of changes and cost sharing during the deeming period is addressed in the EOC.

CMS Action: No action being taken at this time.

**Comment 79:** In the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP ANOCs, Sections 1.3 and 1.4, the plan suggests adding variable language or instructions for plans that produce a combined provider/pharmacy directory. The plan also suggests adding variable language for a Notice of Availability sent with the ANOC when directories are not included with the ANOC.

Response: CMS agrees with the suggestion to include plan instruction for plans that produce a combined provider/pharmacy directory. CMS respectfully declines to add language for when directories are not included with the ANOC because Section 5 already describes how to access the provider/pharmacy directories through the plan's website.

CMS Action: CMS added the following in the HMO MAPD, PPO MAPD, D-SNP, Cost and PFFS ANOCs (changes in red text):

## Changes to the Provider Network:

*[Plans with combined Provider and Pharmacy Directories may combine and edit the Provider and Pharmacy Directory sections (including section titles) to describe the combined document. Plans should renumber sections as needed and revise references to Provider Directory to use the actual name of the document throughout the model.]*

## Changes to the Pharmacy Network:

*[Plans with combined Provider and Pharmacy Directories may combine and edit the Provider and Pharmacy Directory sections (including section titles) to describe the combined document. Plans should renumber sections as needed and revise references to Pharmacy Directory to use the actual name of the document throughout the model.]*

**Comment 80:** In the D-SNP ANOC, Section 1.5, Changes to Benefits & Cost for Medical Services, the plan suggests adding language in the first variable for members who have full Medicare cost sharing assistance, when the member loses Medicaid, and the member is responsible for the Medicare cost share during the deeming period: “[Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within <x> month(s), then you are still eligible for membership in our plan. This is called a period of deemed continued eligibility. However, during this period, your cost-sharing and premiums you pay us may change.]”

**Response:** CMS respectfully declines this suggestion as the ANOC is meant to be a summary of changes and cost sharing during the deeming period is addressed in the EOC.

**CMS Action:** No action being taken at this time.

**Comment 81:** In the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP ANOCs, Section 1.7, the plan suggests removing coverage gap information in the two sentences where it is referenced.

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS removed the sentence in all Part D ANOCs about Coverage Gap Stage and Coverage Gap Discount Program no longer existing because these changes are not new for 2027 as follows:(changes in red text):

~~The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.~~

**Comment 82:** In all EOCs, Chapter 1, Section 4.1, the paragraph starting with “If you already get help from one of these programs...” appears before the drug programs are described;

therefore, the plan suggests moving the paragraph below the discussion of the LIS Rider or removing from Section 4.1 altogether.

Response: CMS agrees with this suggestion.

CMS Action: CMS reorganized the EOC text in all Part D models, so the paragraph beginning with “If you already get help from one of these programs” follows the paragraph introducing these programs.

**Comment 83:** In all EOCs, cover page and Chapter 8, the plan recommends either removing the instructions referencing the 5% alternative language threshold or revising the language to be more generic without mentioning specific languages, e.g., "This material is available for free in other languages. Please call Member Services for more information." Alternatively, the plan suggests clarifying in the instructions that the prior year translation requirement is sufficient if the upcoming year’s information is not released timely.

Response: CMS rejects the suggestions to remove or revise the plan instruction since CMS provides the methodology so plans can conduct their own analysis prior to CMS posting languages.

CMS Action: No action being taken at this time.

**Comment 84:** In all EOCs, Chapter 1, Section 4, Summary of Important Costs for 2027, the multi-plan sponsor recommends either removing the table from Chapter 1 or allowing plans to refer members to the appropriate EOC chapters and sections (1, 4, or 6) that already contain complete and accurate cost-sharing and benefit details.

Response: CMS respectfully declines this suggestion and suggests multi-plan sponsors create EOCs for each individual plan if there is too much information.

CMS Action: No action being taken at this time.

**Comment 85:** In all EOCs with Chapter 4, Medicare Benefits Chart, Cardiac rehabilitation services, the benefit description does not include coverage limits regarding duration, e.g.: services are considered reasonable and necessary up to 36 sessions without individual review, patients generally 2 to 3 sessions per week for 12 - 18 weeks, and claims to extend beyond 18 weeks should be reviewed by consultants not to exceed 72 sessions for 36 weeks; therefore, the plan suggests adding more information about coverage specifics.

Response: CMS agrees with this suggestion.

CMS Action: Updated the Cardiac rehabilitation services row in all EOCs except PDP to include a more comprehensive description of the benefit and limitations as follows (**changes in red text**):

### Cardiac rehabilitation services

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's [*insert as appropriate: referral OR order*].

Our plan also ~~covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.~~ covers these comprehensive programs if you've had at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart and lung transplant
- Stable chronic heart failure

Coverage limitations:

You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.

*[Also list any additional benefits offered.]*

**Comment 86:** In all EOCs, Chapter 1, Section 4.1, Plan premium, in the paragraph that starts with, "If you already get help from...", the plan suggests revising "one of these programs" to a variable that includes "this program" in the sentence: "If you already get help from [*insert as applicable: one of these programs OR this program*], the information about premiums in this Evidence of Coverage [*insert as applicable: may OR does*] not apply to you."

**Response:** CMS agrees with this suggestion.

**CMS Action:** CMS revised the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP EOCs as follows (**changes in red text**):

If you *already* get help from [*insert as applicable: one of these programs OR this program*], the information about premiums in this *Evidence of Coverage* [*insert as applicable: may OR does*] not apply to you. [*If not applicable, omit information about the LIS Rider*] We [*insert as appropriate: have included OR sent you*] a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*) which tells you about your drug coverage. [*Plans may indicate LIS Rider mail date.*] If you don't have this insert, call Member Services at [*insert Member Services number*] (TTY users call [*insert TTY number*]) and ask for the *LIS Rider*.

**Comment 87:** In all EOCs, Chapter 1, Section 4.1, Plan premium, in the sentence that starts with, "The Extra Help program...", the plan suggests revising to align with the second sentence "one of these programs" to a variable that includes "this program" in the sentence: "If you qualify, enrolling in *[insert as applicable: one of these programs OR this program]* might lower your monthly plan premium."

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, and PDP EOCs as follows (*changes in red text*):

*[Insert as appropriate, depending on whether SPAPs are discussed in Chapter 2: There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs; OR The Extra Help program helps people with limited resources pay for their drugs.]* Learn more about *[insert as applicable: these programs OR this program]* in Chapter 2, Section 7. If you qualify, enrolling in *[insert as applicable: one of these programs OR this program]* might lower your monthly plan premium.

**Comment 88:** In the HMO MAPD, PPO MAPD, D-SNP and PDP EOCs, Chapter 1, Section 3.3 and PDP, Chapter 1, Section 3.2, the plan suggests aligning the verbiage and punctuation across all EOCs for consistency when addressing the same topic.

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the cover pages of HMO MAPD and D-SNP EOCs as follows: following (*changes in red text*):

HMO MAPD EOC:

1. **For questions about this document, call Member Services at *[insert Member Services number]* (TTY users call *[insert TTY number]*).**

D-SNP EOC:

1. This document gives the details of your Medicare *[insert if applicable: and <state-specific name for Medicaid> If the state-specific name doesn't include the word: Medicaid, plans should add: (Medicaid) after the name for this instance.]*
2. **For questions about this document, call Member Services at *[insert Member Services number]*. (TTY users call *[insert TTY number]*).**

**Comment 89:** In all EOCs, Chapter 2, Section 4, Quality Improvement Organization (QIO) section, the plan suggests adding "who are" to the sentence "*[Insert state-specific QIO name]* has a group of doctors and other health care professionals **who are** paid by Medicare to check on and help improve the quality of care for people with Medicare."

Response: CMS agrees with this suggestion and updated the text in two instances.

CMS Action: CMS updated Chapter 2, Section 4 of all EOC models as follows (**changes in red text**): *[Insert state-specific QIO name]* has a group of doctors and other health care professionals **who are** paid by Medicare to check on and help improve the quality of care for people with Medicare.

CMS also updated Chapter 9, Sections 7.2, 8.2, 10.3 and Chapter 12, QIO definition of all EOCs (except PDP) as follows (**changes in red text**): The **Quality Improvement Organization** is a group of doctors and other health care ~~experts~~-professionals **who are** paid by the federal government to check on and help improve the quality of care for people with Medicare.

**Comment 90:** In all EOCs, Chapter 2, Section 4, QIO section, the plan suggests replacing the word "got" with "have received" in the sentence "You have a complaint about the quality of care you have received."

Response: CMS respectfully declines this suggestion as plain language is used.

CMS Action: No action being taken at this time.

**Comment 91:** In all EOCs, Chapter 3, Section 7.2, the plan suggests replacing the word "copayment" with "cost-sharing" in the sentence, "During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the cost-sharing for oxygen)." since members may have coinsurance not copayment.

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the sentence about the beneficiary's responsibility for oxygen in HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA, and PPO MA EOCs as follows (**changes in red text**):

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for **applicable cost sharing** ~~the copayment~~ for oxygen).

**Comment 92:** In all EOCs, Chapter 4, Medical Benefits Chart, Colorectal cancer row, the plan suggests adding an "s" to "year" in "for patients 45 years."

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the text in the Colorectal cancer screening row in applicable EOC models as follows (**changes in red text**):

Computed tomography colonography for patients 45 ~~years~~ 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.

**Comment 93:** In all EOCs, Chapter 9, Section 6.4, How to ask for a coverage decision, including an exception, the plan suggests removing "will" after "we'll" from the sentence: "If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal."

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the EOC in the HMO MAPD model as follows: (changes in red text):

If our answer is no to part or all of what you asked for, we'll ~~will~~ send you a written statement that explains why we said no. We'll also tell you how you can appeal.

**Comment 94:** In the HMO MAPD and PPO MAPD EOCs, Chapter 9, Sections 7.2, 7.3 and 8.3, the plan suggests revising "it's" to "their" in the sentences that refer to reviewers (plural).

Response: CMS agrees with this suggestion.

CMS Action: CMS updated the text under Step 3 of the HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA, and PPO MA EOCs as follows: (changes in red text):

**Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you ~~their-it's~~ decision.**

**Comment 95:** In HMO MAPD EOC, Chapter 12, Income Related Monthly Adjustment Amount (IRMAA) definition, the plan suggests removing "not" from the sentence "Less than 5% of people with Medicare are affected, so most people won't pay a higher premium."

Response: CMS agrees with this suggestion.

CMS Action: CMS revised the sentence as follows (changes in red text): Less than 5% of people with Medicare are affected, so most people won't ~~not~~ pay a higher premium.

**Comment 96:** In all EOCs, Chapter 4, Medical Benefits Chart, Dental services row, the plan suggests clarifying that the first paragraph refers to the Medicare-covered benefit only in the row subhead, e.g., "Dental services – Medicare" then create a second row for supplemental dental services if a plan files them.

Response: CMS respectfully declines this suggestion as CMS will keep the original language.

CMS Action: No action being taken at this time.

**Comment 97:** In all EOCs, Chapter 4, Medical Benefits Chart, Durable medical equipment row, the plan suggests adding clarifying language that continuous glucose monitors (CGMs) are covered under the DME benefit when prescribed for conditions that are covered under Part B.

Response: CMS respectfully declines this suggestion as CMS will keep the original language.

CMS Action: No action being taken at this time.