

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 D-SNP). 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.

Changes to all ANOC and EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Throughout	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.

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, HMO MA, PPO MA ANOC and EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	ANOC; Summary of Important Costs for 2027 EOC; Chapter 1, Section 4, Summary of Important Costs for 2027	Revised the Inpatient hospital stays description 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 .

ANOC

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA, PPO MA and PDP ANOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Section 3; How to Change Plans	Revised the second bullet to clarify separate Medicare drug coverage (changes in red text): <ul style="list-style-type: none"> To change to Original Medicare with separate Medicare drug coverage, enroll in the new Medicare drug plan. You'll be automatically disenrolled from <i>[insert 2027 plan name]</i>.

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP ANOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Section 1.7; Changes to Prescription Drug Benefits & Costs	Removed sentence about the Coverage Gap Stage and Coverage Gap Discount Program no longer existing because these changes are not new for 2027 (changes in red text): The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.
CMS	Section 1.7; Changes to the Catastrophic Stage	Removed the Changes to the Catastrophic Stage section as these changes are not new for 2027 (changes in red text): Changes to the Catastrophic Coverage Stage <i>[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.]</i> <i>[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.]</i> For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your <i>Evidence of Coverage</i>.

<p>CMS</p>	<p>Section 1.7; Changes to Prescription Drug Benefits & Costs</p>	<p>Revised all instances of plan instructions regarding changing costs from “2025 to 2026” to “2026 to 2027” in the “2026 (this year)” column (changes in red text):</p> <p><i>[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.]</i></p>
<p>CMS</p>	<p>Section 1.6; Changes to Part D Drug Coverage, Changes to Our Drug List section</p>	<p>Updated the first paragraph to read as follows (changes in red text):</p> <p>Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is <i>[[insert: in this envelope] OR [insert: provided electronically] OR [insert: posted online at [insert URL]]]</i>.</p>

Changes to HMO MAPD, PPO MAPD, D-SNP, HMO MA, PPO MA, and PDP ANOC models

<p>Clarification Requested By</p>	<p>Chapter/Section</p>	<p>Change/Reason</p>
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<p>CMS</p>	<p>Section 1.5; Changes to Benefits & Costs for Medical Services (except PDP)</p> <p>Section 1.7; Changes to Prescription Drug Benefits & Costs (except HMO MA, PPO MA)</p>	<p>Removed the text below referencing Value-Based Insurance Design (VBID) (changes in red text):</p> <p>Section 1.5:</p> <p><i>[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.]</i></p> <p>Section 1.7:</p> <p><i>[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.]</i></p> <p><u>Changes to your VBID Part D Benefit</u></p> <p><i>[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.]</i></p>
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Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, and PFFS ANOC models

<p>Clarification Requested By</p>	<p>Chapter/Section</p>	<p>Change/Reason</p>
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<p>CMS</p>	<p>Sections 1.3; Changes to the Provider Network</p> <p>Section 1.4; Changes to the Pharmacy Network</p>	<p>Added the following in the Changes to the Provider Network (first paragraph below) and Changes to the Pharmacy Network (second paragraph below) (changes in red text):</p> <p>Section 1.3:</p> <p><i>[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.]</i></p> <p>Section 1.4:</p> <p><i>[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.]</i></p>
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Changes to Cost, PFFS, MSA, HMO MA, and PPO MA ANOC models

<p>Clarification Requested By</p>	<p>Chapter/Section</p>	<p>Change/Reason</p>
<p>CMS</p>	<p>About <i>[insert 2027 plan name]</i> section</p>	<p>Updated the last bullet point to include a phrase about the late enrollment penalty being added to the beneficiary’s monthly premium (changes in red text):</p> <ul style="list-style-type: none"> • 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.

Changes to PPO MAPD, Cost, and PDP ANOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Sections 1.7 and 5 (PPO MAPD, Cost) Introduction, Sections 1.2, and 1.5 (PDP)	Revised several instances of paragraphs that provide contact information for Member Services to have proper grammar (changes in red text): ...call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) ...

Changes to D-SNP ANOC model

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Section 4; Get Help Paying for Prescription Drugs	Added “in” to the following sentence (changes in red text): All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level
CMS	About <i>[insert 2027 plan name]</i>	Added a new paragraph with plan instructions for beneficiaries leaving a D-SNP plan and enrolling into another plan within the organization (changes in red text): <ul style="list-style-type: none"> <i>[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 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>

<p>CMS</p>	<p>Section 3; How to Change Plans</p>	<p>Removed the language below about late enrollment penalty (changes in red text):</p> <p>To change to Original Medicare without a drug plan, 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> 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 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]).</p>
<p>CMS</p>	<p>Summary of Important Costs for 2027; Part D drug coverage deductible row</p>	<p>Added the following plan instruction (changes in red text):</p> <p><i>[Plans with no deductible can delete this row.]</i></p>

EOC Models

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA, PPO MA and PDP EOC models

Clarification Requested By	Chapter/Section	Change/Reason
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<p>CMS</p>	<p>Chapter 2; Section 4, Quality Improvement Organization (QIO) section</p> <p>Chapter 9; Section 7.2, How to make a Level 1 appeal to change your hospital discharge date, 8.2, 10.3, Chapter 12 QIO definition</p>	<p>Updated all EOCs to the following (changes in red text):</p> <p>Chapter 2; Section 4, all EOCs:</p> <p><i>[Insert state-specific QIO name]</i> 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.</p> <p>Chapter 9, Section 7.2, 8.2, 10.3, Chapter 12 QIO definitions, all EOCs (except PDP) (changes in red text):</p> <p>The Quality Improvement Organization is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare.</p>
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Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, MSA, HMO MA and PPO MA EOC models

<p>Clarification Requested By</p>	<p>Chapter/ Section</p>	<p>Change/Reason</p>
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<p>CMS</p>	<p>Chapter 4; Medical Benefits Chart, Colorectal cancer screening</p>	<p>Revised the second bullet point of the Colorectal cancer screening row to reflect proper grammar and more accurate coverage description (changes in red text):</p> <ul style="list-style-type: none"> • 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. 		
<p>CMS</p>	<p>Chapter 4; Medical Benefits Chart, Chronic pain management</p>	<p>Removed the Chronic pain management row to reduce beneficiary confusion about this service bundle (changes in red text):</p> <table border="1" data-bbox="642 818 1887 1162"> <tr> <td data-bbox="642 818 1503 1162"> <p>Chronic pain management and treatment services 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> </td> <td data-bbox="1503 818 1887 1162"> <p>Cost sharing for this service may vary depending on individual services provided under the course of treatment or the healthcare professional providing the services. {List copayment/coinsurance/deductible}</p> </td> </tr> </table>	<p>Chronic pain management and treatment services 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>Cost sharing for this service may vary depending on individual services provided under the course of treatment or the healthcare professional providing the services. {List copayment/coinsurance/deductible}</p>
<p>Chronic pain management and treatment services 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>Cost sharing for this service may vary depending on individual services provided under the course of treatment or the healthcare professional providing the services. {List copayment/coinsurance/deductible}</p>			

CMS	Chapter 12; Preventive services definition	Revised definition to align with Medicare.gov description of service (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).
CMS	Chapter 4; Medical Benefits Chart	Updated inconsistencies in capitalization for the following benefit rows: Help with certain chronic conditions (except MSA), Physician/practitioner services, including doctor’s office visits, Hepatitis C virus infection, Special supplemental benefits for the chronically ill (except MSA, Cost), and Supervised exercise therapy.
CMS	Chapter 4; Medical Benefits chart, Screening for Hepatitis C virus infection row	Updated Screening for Hepatitis C Virus infection row 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.

CMS	Chapter 4; Medicare Benefits Chart, Cardiac rehabilitation services	<p>Updated the Cardiac rehabilitation services row to include a more comprehensive description of the benefit and limitations as follows (changes in red text):</p> <p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's <i>[insert as appropriate: referral OR order]</i>.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>Coverage limitations:</p> <p>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.</p> <p><i>[Also list any additional benefits offered.]</i></p>
CMS	Chapter 3; Section 7.2, Rules for oxygen equipment, supplies, and maintenance	<p>Revised the sentence about the beneficiary's responsibility for oxygen as follows (changes in red text):</p> <p>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).</p>

CMS	Chapter 9; Sections 7.2, 7.3 and 8.3 Chapter 7; Sections 6.3, 7.2 and 7.3	Updated text under Step 3 to the following (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's decision.
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Changes to D-SNP EOC model

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 9B; Section 7.6	Added a missing subsection header regarding Level 2 appeals to reflect the same format as in Chapter 9A (changes in red text): Section 7.6 How to make a Level 2 appeal
CMS	Chapter 1; Section 4, Summary of Important Costs for 2027	Added the following plan instruction to the Part D drug coverage deductible row as follows (changes in red text): <i>[Plans with no deductible can delete this row.]</i>

Changes to HMO MAPD EOC model

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 9; Section 6.4, How to ask for a coverage decision, including an exception	Revised language to reflect accurate grammar 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.

CMS	Chapter 12; Income Related Monthly Adjustment Amount (IRMAA) definition	Revised IRMAA definition to reflect accurate grammar (changes in red text): Less than 5% of people with Medicare are affected, so most people won't not pay a higher premium.
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Changes to PPO MAPD EOC model

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 1; Section 4, Summary of Important Costs for 2027, Maximum out-of- pocket amount row	Updated the Your Costs in 2027 column to read as follows (changes in red text): From in-network providers: <i>[Insert 2027 MOOP amount]</i>

Changes to Cost EOC model

Clarification Requested By	Chapter/ Section	Change/Reason
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<p>CMS</p>	<p>Chapter 4; Section 2.2, Get care using your plan’s optional visitor/traveler benefit</p>	<p>Revised paragraphs about the visitor/traveler program to include accurate timeframes and regulatory citations (changes in red text):</p> <p><i>[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.</i></p> <p>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 <i>[specify areas where the visitor/traveler program is being offered]</i> 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. <i>[Insert how covered services are provided while the member is out-of-area.]</i> 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.</p>
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Changes to PPO MAPD and PPO MA EOC models

<p>Clarification Requested By</p>	<p>Chapter/ Section</p>	<p>Change/Reason</p>
<p>CMS</p>	<p>Chapter 4; Medical Benefits Chart, Hospice care row</p>	<p>Updated last bullet point in the Hospice care row to accurately reflect beneficiary’s potential cost share responsibility (changes in red text):</p> <ul style="list-style-type: none"> If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare your share of the costs for covered services may be higher

Changes to HMO MA and PPO MA EOC model

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 7; Section 5.5, If you're asking us to pay for our share of a bill you got for medical care	<p>Revised the following sentence to accurately reflect the plan's cost share responsibility for medical care (changes in red text):</p> <ul style="list-style-type: none"> • 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.

Changes to PPO MAPD, Cost, and PFFS EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 5; Section 10.1, Drug Management Program (DMP) to help members safely use opioid medications	<p>Replaced "doctor(s)" with "prescriber(s)" in the following sentence for accuracy (changes in red text):</p> <ul style="list-style-type: none"> • Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)prescriber(s)

Changes to PPO MAPD, D-SNP, Cost and HMO MA EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Cover page	Removed all instances of the OMB approval number except in the footer on the cover page.

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

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 5; Section 7, Types of drugs we don't cover	<p>Revised variable language regarding drug coverage to reference potential cost sharing instead of a potential additional premium (changes in red text):</p> <p>In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: <i>[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.)]</i></p>

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS and PDP EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 1; Section 4.1, Plan premium	<p>Revised paragraph to include variable language regarding the number of programs available to beneficiaries as follows (changes in red text):</p> <p>If you <i>already</i> get help from <i>[insert as applicable: one of these programs OR this program]</i>, the information about premiums in this <i>Evidence of Coverage</i> <i>[insert as applicable: may OR does]</i> not apply to you. <i>[If not applicable, omit information about the LIS Rider]</i> We <i>[insert as appropriate: have included OR sent you]</i> a separate document, called the <i>Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs</i>, (also known as the <i>Low-Income Subsidy Rider</i> or the <i>LIS Rider</i>) which tells you about your drug coverage. <i>[Plans may indicate LIS Rider mail date.]</i> If you don't have this insert, call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>) and ask for the <i>LIS Rider</i>.</p>

CMS	Chapter 1; Section 4.1, Plan premium	<p>Revised another paragraph about programs to help with drug costs to include variable language regarding the number of programs available to beneficiaries as follows (changes in red text):</p> <p><i>[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.]</i> Learn more about <i>[insert as applicable: these programs OR this program]</i> in Chapter 2, Section 7. If you qualify, enrolling in <i>[insert as applicable: one of these programs OR this program]</i> might lower your monthly plan premium.</p>
CMS	Chapter 1; Section 4.1, Plan premium	Reorganized paragraphs so the paragraph beginning with “If you already get help from one of these programs” follows the paragraph introducing these programs.

Changes to HMO MA EOC model

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 6; Section 1.8, How to get more information about your rights	Updated to include a hyperlink to the Medicare Rights & Protections publication.

Changes to HMO MAPD, Cost, MSA EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 8; Section 1.8, How to get more information about your rights	Updated the hyperlink to “ Medicare Rights & Protections ” instead of the actual hyperlink for consistency.

Changes to D-SNP, PFFS, HMO MA, PPO MA, and PDP EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 6, Section 1.1 Chapter 8; Section 1.1	Revised the sentence about providing information in non-English languages 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 <i>[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]</i> braille, in large print, or other alternate formats at no cost if you need it

Changes to HMO MAPD, PPO MAPD, D-SNP, Cost, PFFS, HMO MA, and PPO MA EOC models

Clarification Requested By	Chapter/ Section	Change/Reason
CMS	Chapter 4; Section 2, The Medical Benefits Chart shows your medical benefits and costs	Removed all references to VBID Part D benefits (changes in red text): [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.]

Changes to HMO MAPD and D-SNP EOC models

Clarification Requested By	Chapter/Section	Change/Reason
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CMS	Cover pages	<p>Updated text to the following (changes in red text):</p> <p>HMO MAPD EOC:</p> <ol style="list-style-type: none"> For questions about this document, call Member Services at <i>[insert Member Services number]</i> (TTY users call <i>[insert TTY number]</i>). <p>D-SNP EOC:</p> <ol style="list-style-type: none"> This document gives the details of your Medicare <i>[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.]</i> For questions about this document, call Member Services at <i>[insert Member Services number]</i>. (TTY users call <i>[insert TTY number]</i>).
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Changes to PPO MAPD and Cost EOC models

Clarification Requested By	Chapter/Section	Change/Reason
CMS	Chapter 4; Medical Benefits Chart, Colorectal cancer screening	<p>Removed plan instruction related to barium enemas as follows (changes in red text):</p> <p><i>[If applicable, list copayment and/or coinsurance charged for barium enema.]</i></p>