DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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TO: All Medicare Advantage Organizations, Prescription Drug Plans, and Section 1876 Cost Plans

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SUBJECT: Issuance of Contract Year 2026 Standardized Materials

This memo announces the release of Contract Year (CY) 2026 Standardized Materials. These include the following: Annual Notice of Change (ANOC); Evidence of Coverage (EOC); ANOC Errata Notice; EOC Errata Notice; Provider Directory; Part D Explanation of Benefits (EOB); Excluded Provider Model, Formulary (Comprehensive and Abridged); Low Income Subsidy (LIS) Rider; Pharmacy Directory; LIS Premium Summary Table; Prescription Transfer Letter; Notice of Formulary Change; Transition Letter; and (optional) Member Request for Refusal Notice.

In alignment with President Trump's efforts to empower patients through price transparency, the CY 2026 ANOC and EOC models have been reformatted to more clearly and consistently communicate what beneficiaries pay for specific healthcare services.

The CY 2026 ANOC and EOC models reflect updates based on the consumer testing conducted by CMS. The updates include:

- Reducing the number of pages
- Eliminating redundant Section and Sub-Section headings and content
- Updating language to focus on impact on enrollees
- Greater use of plain language
- Increasing the number of references to direct contacts
- Modifying fonts
- Formatting tables

Historically, along with the standardized materials listed above, CMS has released annual ANOC and EOC Standardized Materials Instructions that outline specific regulatory requirements and operational guidance. To reduce the administrative burden and number of reference documents,

this year CMS has either listed the relevant regulatory requirements below, integrated plan instructions directly into the models, or included operational guidance and instructions that support existing regulations in Appendix A, which may be found at the end of the models. Please see the following list of regulatory requirements that were previously described in the ANOC and EOC instructions:

- 42 C.F.R. § 422.2267(b) for permissible alterations
- 42 C.F.R. §§ 422.2267(e)(1) and 423.2267(e)(1) for EOC mailing requirements
- 42 C.F.R. §§ 422.2267(e)(3) and 423.2267(e)(3) for ANOC mailing requirements
- 42 C.F.R. § 423.2267(e)(11) for LIS Rider mailing requirements

The changes (not including grammar or most formatting edits) to each of the standardized materials are summarized below.

Annual Notice of Change (ANOC)

All models

- Simplified charts and related plan instructions
- Added plan instruction regarding Notice of Availability in More Resources section
- Added direct URL link to pharmacy and provider directories
- Added direct URL link to plan website in Section 3, third bullet point
- Added plan instruction regarding transitioning members from a D-SNP look-alike to a renewal plan in "About *[insert 2026 plan name]*" section, sixth bullet

All Part D models

- Edited Medicare Prescription Payment Plan language in several instances
- Removed plan instruction regarding replacing brand name drugs with new generic equivalents in Section 1.6
- Added direct URL link to drug list in Section 1.6
- Edited Medicare Prescription Payment Plan language to reflect automatic election renewal process in Section 2

All models except PDP

- Removed references to Qualifying Health Coverage in More Resources section

D-SNP, Cost, PFFS, MSA, and HMO MA models only

- Removed plan instruction regarding I-SNPs prior to "More Resources" section

HMO MAPD, PPO MAPD, D-SNP, HMO MA, and PPO MA models only

- Removed VBID language or heavily edited related plan instruction in several instances

Cost and PFFS models only

- Removed Point of Sale (POS) reference in Section 1.2

- Added plan instruction for those not offering Part D in "About *[insert 2026 plan name]*" section

D-SNP model only

- Added language regarding Medicare enrollee options when ending membership in Section 3.2
- Added plan instruction to insert any additional state-specific resources for assistance with questions about the enrollee's Medicaid benefits in Section 5, Get Help from Medicaid
- Removed first plan instruction in Section 5, Get Free Counseling About Medicare

Cost model only

- Edited enrollment language throughout model

MSA model only

- Removed Open Enrollment Period language in Section 3.1

Evidence of Coverage (EOC)

All models

- Removed references to "gender identity" and "sexual orientation"
- Added direct URL links to pharmacy and provider directories
- Added plan instruction regarding Notice of Availability
- Added a table summarizing monthly costs for members in Chapter 1, Section 4
- Added "Chat Live" and "Write" information to table in Chapter 2, Section 2
- Added plan instruction regarding non-English materials in Chapter 8, Section 1.1
- Removed 1557 language from plan instruction in Chapter 11, Section 3
- Revised "Chronic-Care Special Needs Plan (C-SNP)" definition in Chapter 12

All Part D models

- Removed "prescription" preceding "drug coverage" in most cases
- Edited Medicare Prescription Payment Plan language in several instances
- Added language regarding the Medicare Drug Price Negotiation Program in Chapter 1, Section 3.4; Chapter 6, Section 4
- Added direct URL link to formulary in Chapter 1, Section 3.4
- Removed "and the U.S. Virgin Islands" in Chapter 2, Section 7, What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?
- Edited prior authorization description in Chapter 5, Section 4.2, Getting plan approval in advance
- Clarified that there are criteria requirements for prior authorization and step therapy in Chapter 5, Section 4.2
- Revised language regarding Drug List changes in Chapter 5, Section 6
- Edited creditable coverage language in Chapter 5, Section 9.3
- Added benzodiazepine in three instances in Chapter 5, Section 10.1
- Removed "TRICARE" from Chapter 6, Section 1.2

- Changed Chapter 6, Section 1.2 from blue optional to black required text
- Revised language by replacing "changes in price" to "increases in price" in Chapter 6, Section 3, fifth bullet
- Added "independent" before "review organization" throughout Chapter 7, Section 6.4
- Added sub-bullet about filing appeal request within 65 days of written notice in Chapter 9, Section 6.6, Step 1
- Added "Maximum Fair Price," "Medication Management Therapy," and "Selected Drugs" definitions to Chapter 12

All models except PDP

- Removed references to Qualifying Health Coverage in Chapter 1, Section 1.1
- Revised Cardiovascular disease tests row to include screening in Chapter 4, Medical Benefits Chart (MBC)
- Significant edits made to "Colorectal cancer screening" row in Chapter 4, MBC
- Revised "Dental services" row by replacing "after kidney" with "prior to organ" in the last sentence, Chapter 4, MBC
- Clarified phosphate binder medications are included under the ESRD payment system in the "Medicare Part B drugs" row in Chapter 4, MBC
- Added bullet to "Outpatient diagnostic tests and therapeutic services and supplies" regarding examples of covered diagnostic non-laboratory tests in Chapter 4, MBC
- Removed last bullet in "Physician/Practitioner services, including doctor's office visits" in Chapter 4, MBC
- Revised "Smoking and tobacco use cessation" to define coverage criteria in Chapter 4, MBC
- Added "Chronic pain management and treatment services," "Screening for Hepatitis C Virus infection," and "Pre-exposure prophylaxis (PrEP) for HIV prevention" rows in Chapter 4, MBC
- Updated language regarding contacting the Quality Improvement Organization in Chapter 7, Section 7.2, Step 1, Act quickly
- Updated language regarding timeline requirements for standard coverage decisions with prior authorization requests in Chapter 9, Steps 1 and 3
- Revised "Rehabilitation Services" and added "Preventive services" and "Referral" definitions to Chapter 12

PPO MAPD, D-SNP, Cost, PFFS, and PPO MA models only

- Added language regarding seeing a women's health specialist or finding a network specialist to Chapter 6, Section 1.1, last paragraph

All models except MSA, HMO MA and PPO MA

- Added language about automatic deliveries for new prescriptions in Chapter 5, Section 2.2, Option 2
- Edited "Quantity Limits" definition in Chapter 12

HMO MAPD, PPO MAPD, D-SNP, PPO MA, and HMO MA models only

- Removed VBID language or heavily edited related plan instruction in several instances

HMO MAPD, PPO MAPD and MSA models only

- Revised "Institutional Special Needs Plan (I-SNP)" definition in Chapter 12

MSA, HMO MA, and PPO MA models only

- Removed last sentence of sixth and ninth bullets in "Medicare Part B drugs" in Chapter 4, MBC

D-SNP model only

- Edited first paragraph to clarify IRMAA for D-SNP members in Chapter 1, Section 4.5
- Revised plan instruction on how members can keep their Medicaid information updated in Chapter 1, Section 6
- Removed multi-state plan instructions in Chapter 2, Section 3
- Clarified plan instruction regarding varying State Medicaid policies and visitor/travel enrollment length in Chapter 4, Section 2.2
- Removed language regarding member responsibility to pay extra for Part D in Chapter 8, Section 2
- Inserted plan instruction to refer to state Medicaid agency contract for more requirements in Chapter 9B
- Removed select information on fast coverage decisions in Chapters 9A and 9B, Section 6.2, Step 1
- Removed fee charge plan instruction Chapter 9B, Section 7.5, Step 1, fourth bullet
- Added "no longer receive Extra Help" in several instances in Chapter 10, Section 2
- Added plan instruction on deeming in Chapter 10, Section 5, second bullet
- Removed "prescription" from "Covered Drugs" definition in Chapter 12

Cost model only

- Removed plan instruction regarding service area grandfathering in Chapter 1, Section 2
- Removed multiple plan instructions in Chapter 10, Section 5

PFFS model only

- Removed some MA-only plan instructions in Chapter 10, Section 2.1

MSA model only

- Removed paragraph about calling Member Services in Chapter 5, Section 1, number 3
- Removed "Chronic Care Special Needs Plan" definition in Chapter 10

Formulary (Abridged and Comprehensive)

- Updated capitalization of formulary for consistency

Transition Letter

- Simplified language throughout for increased readability
- Updated the term "criteria for coverage" to "coverage rules"
- Updated appeal window timeframe to 65 calendar days from the date of a written coverage determination notice under the section, "What if my coverage request is denied?"

Notice of Formulary Change

- Added the following instruction: References to Member Services may be changed to the name your plan uses
- Removed the phrase "insert term plan prefers" throughout

LIS Premium Summary

- Updated capitalization of Extra Help throughout
- Updated the customer service hours for the Social Security Administration

Low Income Subsidy (LIS) Rider

- Updated capitalization of Extra Help throughout
- Removed the language pertaining to plans offering VBID reduced or eliminated cost sharing for Part D drugs targeted to LIS enrollees.
- Updated benefit parameters for CY 2026
- Removed "or deductible level" from the following instruction: *[Insert* this statement for LIS members who have been LIS eligible and now have a decrease in their cost sharing, or for those newly LIS eligible with a retroactive effective date:*]* to reflect the CY 2025 IRA change which eliminated the deductible level for LIS members

Part D Explanation of Benefits (EOB) All Exhibits and Plan Instructions

Throughout

- Changed instructions from "insert TrOOP limit" to "insert Out-of-Pocket threshold"

Cover Page

- Changed "Your Medicare Number" to "Member Identification Number" and revised instructions for plans to insert the member identification number and/or other member number typically used in member communications

Chart 2

- Removed "TRICARE" from below "Out-of-Pocket Costs include:"
- Inserted "TRICARE" below "Out-of-Pocket Costs DON'T include payments made for:"

Chart 3 for members without LIS who are in the initial coverage stage

- Under "You're in Stage 2: Initial Coverage," second bullet, added "*[insert if applicable: generic/tier levels]"*

Important things to know about your drug coverage and your rights

Medicare Prescription Payment Plan

- Replaced “drug costs” with “costs for drugs covered by your plan”

*Note: The location of changes may vary between the models referenced above.
All standardized materials are located at:
http://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html and https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials
Organizations and sponsors must ensure that their CY 2026 materials are compliant with CMS requirements. Questions should be directed to your CMS Account Manager or Marketing Reviewer.