健保計畫簡介

* [Plans may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]
* [Plans may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost-sharing for its dual eligible population.]
* [Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the ANOC.]
* [Throughout the document update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.).]
* [Where the ANOC uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]
* [Plans may change references to terms such as “member,” “customer,” “beneficiary,” “enrollee,” “member services,” “care coordinator,” “primary care provider,” “prior authorization (PA)” as instructed by the state or based on plan preference and update them consistently throughout the ANOC.]
* [Where the model material instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Throughout the ANOC, plans must follow the applicable style rules of the state, if any. For instance, where the model material instructs inclusion of a date or time, plans must use the specific format requested by the state Medicaid program. Other items covered by a state-specific style guide or similar document should also be updated accordingly.]
* [*Plans should refer to the Member Handbook as needed using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the ANOC and Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]
* [Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:
* Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert:**本節下頁繼續**).
* Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.
* Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.
* Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.
* Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.
* Avoid separating a heading or subheading from the text that follows when paginating the model.
	+ Use universal symbols or commonly understood pictorials.
* Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.
* Consider using regionally appropriate terms or common dialects in translated models.
* Include instructions and navigational aids in translated models in the translated language rather than in English.]

**<Plan name>[insert plan type**]由[**insert sponsor name**]提供

2024*年度變更通知*

[Optional: insert member name]

[Optional: insert member address]

簡介

[If there are any changes to the plan for 2024, insert：您目前已加入本計畫。明年，我們的[insert as applicable:福利、承保範圍、規則、[和]費用]將有一些變更。本[insert as applicable:章節**or** Annual Notice of Changes]將告知您這些變更的内容以及何處可以找到有關這些變更的更多資訊。要獲取有關費用、福利或規則的更多資訊，請查閲Member Handbook，它位於我們的網站上，網址為：[insert URL]。關鍵術語及其定義按英文字母順序列於 Member Handbook的最後一章中。]

[If there are no changes whatsoever for 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), insert:您目前已加入本計畫。明年，我們的福利、承保範圍[和]規則[insert if applicable:和費用]將不會發生變更。但是，您仍應閱讀本[insert as applicable:章節 **or** Annual Notice of Changes]以瞭解您的承保選擇。要獲取有關費用、福利或規則的更多資訊，請查閲Member Handbook， 它位於我們的網站上，網址為：[insert URL]。 關鍵術語及其定義按英文字母順序列於 Member Handbook的最後一章中。 ]

**其他資源**

* [Plans that meet the 5% alternative language or Medicaid required language threshold insert:可免費獲取本文檔的[insert the languages that meet the threshold]版本。]
* 您可以以其他格式（如大字體、盲文或音訊）免費獲取本年度變更通知。請致電[insert Member Services toll-free phone and TTY numbers, and days and hours of operation]。通話是免費的。
* [Plans also simply describe:
	+ how they request a member’s preferred language other than English and/or alternate format,
	+ how they keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time, **and**
	+ how a member can change a standing request for preferred language and/or format.]
* 我們提供免費口譯服務來回答您可能對我們的健保或藥物計劃提出的任何問題。若需要口譯員，請致電[insert phone number]。 會有能夠說[insert language]的人員協助您。這是一項免費服務。[This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.]

[*Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly.* Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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# 免責聲明

* [*Plans* must include *all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidance and included in any state-specific guidance provided by <insert state>*。] [Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.]

# 查閲您明年的Medicare和[Insert state-specific name of Medicaid program]（Medicaid）承保範圍

請務必現在查閲您的承保範圍，以確保它在明年仍能滿足您的需求。如果它不能滿足您的需求，您可以退出本計畫。有關明年您的福利變更的更多資訊，請參閱**第E節**。

如果您選擇退出本計畫，您的Medicare[delete Medicare if the end date is the same for Medicare and Medicaid]會員資格將在您提出請求當月的最後一天終止。[If there is a different end date for Medicaid coverage enter a description here.]只要您符合條件，您仍將受保於Medicare和[Insert name of Medicaid program]計畫。

如果您退出本計畫，您可以獲得以下資訊：

* **第G2節**表格中的Medicare選項[insert reference, as applicable]。
* **第G2節**中的[*Insert name of Medicaid program*]服務[insert reference, as applicable]。

|  |
| --- |
| B1. <plan name>相關資訊* [Insert plan’s legal or marketing name]是一項同時與Medicare和Medicaid簽訂合同的健保計畫，旨在為會員同時提供這兩項計畫的福利。
* [*insert plan name*]下的承保範圍涵蓋的合格健康承保範圍稱為「最低基本承保範圍」。它可滿足《病患保護與平價醫療法案》(ACA) 的個人分擔責任要求。請造訪美國國稅局 (IRS)，網站：[www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families)有關個人分擔責任要求的更多資訊。
* 當本*《年度變更通知》*提及「我們」、「我們的」或「本計畫」時，它指的是[insert plan name]。
 |
| B2. 必須完成的重要事項* **請查看我們的福利**[insert if applicable:**和費用**]**是否有任何可能會影響到您的變更。**
	+ 是否有任何變更會影響您所使用的服務？
	+ 請查閲福利[insert if applicable:和費用]的變更以確保它們明年仍適用於您。
	+ 請參閱**第E1節**瞭解更多本計畫福利[insert if applicable:和費用]變更的資訊。
	+ **請查看我們的處方藥承保範圍是否有任何可能會影響到您的變更。**
	+ 您使用的藥物會被承保嗎？[insert if applicable and adjust language as needed:它們是否屬於不同的費用分攤層級？]您仍然可以使用相同的藥房嗎？
	+ 請查閲這些變更以確保我們的藥物承保範圍在明年對您仍有效。
	+ 有關我們的藥物承保範圍變更的資訊，請參閱**第E2節**。
	+ [*All plans with any Medicare Part D cost-sharing insert*:自去年以來，您的用藥費用可能已經上漲。
	+ 請與您的醫生討論可能為您提供的低費用備擇方案；這可以為您節省全年的年度自付費用。
	+ 請記住，您的計畫福利決定了您自己的用藥費用到底會有多大的變化 。]
* **請查看您的醫療服務提供者和藥房明年是否會加入我們的網路。**
	+ 您的醫生（包括您的專科醫師）在我們的網路中嗎？您的藥房呢？您使用的醫院或其他醫療服務提供者呢？
	+ 有關我們的*《*醫療服務提供者與藥房名錄*》*的資訊，請參閱**第D節**。
* **請考慮您在計畫中的總體費用。**
	+ [*Insert if applicable*:您會為經常使用的服務和處方藥自付多少費用？]
	+ 與其他承保選項相比，總費用如何？
* **請想一想，您是否對本計畫感到滿意。**
 |

| **如果您決定繼續使用<2024 plan name>：** | **如果您決定改變投保計畫：** |
| --- | --- |
| 如果您想明年繼續使用本計畫，那麽就很簡單了——您無需做任何事情。如果您不換保，那麽您將會自動加入<2024 plan name>。 | [Plans should revise this paragraph as necessary]如果您認為其他承保可以更好地滿足您的需求，您可以更換計畫（請參閱**第G2節**瞭解更多資訊）。如果您加入新計畫或更改為Original Medicare，您的新承保將在下個月的第一天啟動。 |

# 本計畫名稱的變更

[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]

2024年1月1日，本計畫名稱從<2023 plan name>更改為<2024 plan name>。

[Insert language to inform members whether they will get new plan ID cards and how, as well as how the name change affects any other member communication.]

# 我們網路醫療服務提供者和藥房的變更

[Plans with no changes to network providers and pharmacies insert:我們沒有對明年的網路醫療服務提供者和藥房進行任何更改。

但是，您務必瞭解我們可能會在這一年中對我們的網路進行更改。如果您的醫療服務提供者退出本計畫，您將享有某些權利和保護。如需瞭解更多資訊，請參閱《會員手冊》**第3章**。]

[Plans with changes to provider and/or pharmacy networks, insert:我們的[insert if applicable:醫療服務提供者][和][insert if applicable:藥房]網路[insert as applicable:已經]於2024年發生了變更。

**請查閲2024 Provider and Pharmacy Directory**以瞭解您的醫療服務提供者或藥房是否在我們的網路中。已更新的Provider and Pharmacy Directory 位於我們的網站上，網址為：<web address>。您也可以撥打頁面底部的電話號碼聯繫會員服務部，以獲取已更新的醫療服務提供者資訊或要求我們向您郵寄一份 Provider and Pharmacy Directory。

您務必瞭解我們也可能在這一年中對我們的網路進行更改。如果您的醫療服務提供者退出本計畫，您將享有某些權利和保護。如需瞭解更多資訊，請參閱《會員手冊》**第3章**。]

# 明年的福利[insert if applicable:和費用]變更

## E1. 醫療服務的福利[insert if applicable:和費用]變更

[If there are no changes in benefits or in cost-sharing, replace the rest of the section with:您的醫療服務福利[insert if applicable:或您支付的金額]沒有變更。我們的福利[insert if applicable:以及您為這些承保醫療服務支付的費用]，2024年將與2023年完全相同。]

我們正在更改某些醫療服務的承保範圍[insert if applicable:以及您明年將為這些承保的醫療服務支付的費用]。下表描述了這些變更。

[The table must include:

* all new benefits that will be added or 2023 benefits that will end for 2024;
* new or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; **and**
* all changes in cost-sharing for 2024 for covered medical services, including any changes to service category out-of-pocket maximums.]

[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits: VBID Model participating plans should update this section to reflect coverage for any new VBID Model benefits that will be added for CY 2024 benefits, and/or for previous CY 2023 VBID Model benefits that will end for CY 2024. Specific to the VBID Model benefits, the table must include: (1) all new VBID Model benefits that will be added for 2024, except for the hospice benefit component (which has separate ANOC instructions to VBID participating plans and Part D cost-sharing reduction or elimination which should be listed in Section 2.5), including mandatory supplemental benefits such as the flexibility to cover new and existing technologies or Food and Drug Administration (FDA) approved medical devices or 2023 benefits that will end for 2024 such as cash or monetary rebates; and (2) all changes in cost-sharing for all VBID Model benefits for 2024.

Note that for CY 2024, plans wishing to communicate the removal of cash or monetary rebates and its replacement with different supplemental benefits may do so but must use the following language: CMS取消了2024年的現金福利。您會獲得[please identify and insert tin these brackets supplemental benefits that your organization is offering in lieu of cash or monetary rebates]，它取代了您在2023年獲得的現金福利。請查閲Member Handbook中有關補充福利的更多資訊]。]

|  | **2023（今年）** | **2024（明年）** |
| --- | --- | --- |
| **[Insert benefit name**] | [For benefits that were not covered in 2023, insert:[insert benefit name]**不**在承保範圍內。][For benefits with a copay insert:您支付**$<2023 共付額>**共付額[ insert language as needed to accurately describe the benefit, e.g., “per office visit”]。] | [For benefits that will not be covered in 2024, insert:[insert benefit name]**不**在承保範圍內。][For benefits with a copay insert:您支付**$<2024 共付額>**共付額[insert language as needed to accurately describe the benefit, e.g., “per office visit”]。] |
| **[Insert benefit name**] | [Insert 2023 cost or coverage, using format described above.] | [Insert 2024 cost or coverage, using format described above.] |

## E2. 處方藥承保範圍的變更

**我們藥物清單的變更**

[Plans that did not include a List of Covered Drugs in the envelope, insert:您將獲得一份單獨郵寄的2024年《承保藥物清單》。]

[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert:已更新的《承保藥物清單》位於我們的網站上，網址為：<web address>。您也可以撥打頁面底部的電話號碼聯繫會員服務部，以獲取更新的藥物資訊或要求我們向您郵寄《承保藥物清單》。]

[Plans that included a List of Covered Drugs in the envelope, insert:我們在此信封中向您發送了一份2024年《承保藥物清單》副本。]*該《承保藥物清單》*也稱為「藥物清單」。

[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with:我們沒有對明年的藥物清單進行任何更改。但是，在獲得Medicare和/或州政府批准的情況下，我們可以在全年不時更改此藥物清單。更多相關資訊，請參閱2024年「藥物清單」。]

我們對藥物清單進行了更改，包括更改我們承保的藥物以及適用於我們承保的某些藥物的限制。

請查閲藥物清單以**確保您的藥物將在明年得到承保，**並瞭解是否有任何限制。

如果您受到藥物承保變化的影響，我們鼓勵您：

* 與您的醫生（或其他開藥者）一起尋找我們承保的不同藥物。
	+ 您可以撥打頁面底部的電話號碼聯繫會員服務部[*insert if applicable:*或聯繫您的護理協調員]索取治療相同病症的《承保藥物清單》。
	+ 此清單可幫助您的醫療服務提供者找到可能對您有效的承保藥物。
* [Plans should include the following language if they have an advance transition process for current members:]配合您的醫生（或其他處方師），並要求我們破例承保該藥物。
	+ 您可以在明年之前提出例外申請，我們將在收到您的請求（或您的處方師的支持聲明）後72小時內給您答覆。
	+ 要瞭解申請例外必須做什麼，請參閱您的*《會員手冊》***第9章**或撥打頁面底部的號碼聯繫會員服務部。
	+ 如果您在申請破例方面需要幫助，請聯繫會員服務部[insert if applicable:或您的護理協調員]。請參閱您的*《會員手冊》***第2章和第3章**以瞭解有關如何聯繫您的護理*協調員*的更多資訊。
* [Plans should include the following language if all current members will not be transitioned in advance for the following year:]要求我們支付臨時供應的藥物。
	+ 在某些情況下，我們會在日曆年的前[must be at least 90]天內承保**臨時**藥物供應。
	+ 該臨時供藥最多為[insert supply limit (must be the number of days in plan’s one-month supply)]天。（要瞭解更多關於何時可以獲得以及如何索取臨時供應的資訊，請參閱*《會員手冊》***第5章**。）
	+ 當您獲得臨時藥物供應時，請與您的醫生討論當您的臨時供應用完時該怎麼辦。您可以改用本計畫承保的其他藥物，也可以要求我們為您破例承保您當前的藥物。

[Plans may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]

[Include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]

**處方藥費用的變更[option for plans with two drug payment stages**]

[VBID Model participating plans approved to offer Part D reduced or eliminated cost-sharing should update this section to reflect coverage for any new VBID Model Part D cost-sharing reduction or elimination for all VBID Model benefits for 2024.]

[Plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), should include the following information in the ANOC.]

[Only plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage, etc.), include the following information in this section of the ANOC. Plans with one payment stage do not include the information in this section.]

[If there are no changes in prescription drug costs, insert:2024年您為處方藥支付的金額沒有變更。請閱讀下文，瞭解有關您的處方藥承保範圍的更多資訊。]

根據本計畫，您的Medicare D部份處方藥承保有兩個支付階段。您支付多少金額取決於您在獲得處方配藥或續藥時所處的階段。以下是這兩個階段：

| **階段1：****初始承保階段** | **階段2：****重額承保階段** |
| --- | --- |
| 在此階段，本計畫支付您的部份藥物費用，而您則支付自己的份額。您的份額稱為共付額。當您為今年第一個處方配藥時，這個階段就開始了。 | 在此階段，該計畫將支付您的所有藥物費用，直至2024年12月31日。在您支付了一定數額的自付費用後，此階段就開始了。 |

當您的處方藥自付費用總額達到[*insert as applicable****:* $<TrOOP amount*>***]，初始承保階段就結束了。屆時，重額承保階段則開始。本計畫涵蓋您從那時到年底的所有藥物費用。有關您將為處方藥支付多少費用的更多資訊，請參閱您的*《會員手冊》***第6章**。

## E3. 階段1：「初始承保階段」

在初始承保階段，本計畫會支付您的承保處方藥的一部份費用，而您則支付您的份額。您的份額稱為共付額。共付額取決於藥物所在的分攤費用層級以及您從哪裡獲得藥物。每次配藥時，您都要支付共付額。如果您的承保藥物費用低於共付額，您則支付較低的價格。

[Insert if applicable:**我們已將藥物清單上的一些藥物移至更低或更高的藥物層級。**如果您的藥物從一個層級轉移到另一個層級，這可能會影響您的共付額。要瞭解您的藥物是否移至不同層級，請在我們的藥物清單中查看。]

下表顯示了您在我們[*insert number of tiers*]個藥物層級中每個層級内的藥物費用。這些金額**僅**在您處於初始承保階段時適用。

[Plans must list all drug tiers in the following table.]

|  | **2023（今年）** | **2024（明年）** |
| --- | --- | --- |
| **層級<Tier number>中的藥物**([Insert short description of tier (e.g., generic drugs)]) 在網絡藥房配製的<Tier number>層級藥物的一個月供應量費用 | [Insert 2023 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] | [Insert 2024 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] |
| **層級<Tier number>中的藥物**([Insert short description of tier (e.g., generic drugs)]) 在網絡藥房配製的<Tier number>層級藥物的一個月供應量費用 | [Insert 2023 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] | [Insert 2024 [cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] |

當您的處方藥自付費用總額達到[insert as applicable: **$<TrOOP amount>**]，初始承保階段就結束了。屆時，重額承保階段則開始。[Insert as applicable:本計畫涵蓋您從那時到年底的所有藥物費用。If the plan covers excluded drugs under an enhanced benefit or Medicaid drugs with cost-sharing in this stage insert:本計劃承保您所有的D部分藥物直到年底。您可能需要為<insert as applicable:我們的增強福利/醫療補助>]承保的排除藥物分攤費用。請參閱您的*《會員手冊》***第6章**，瞭解有關您需為處方藥支付多少費用的更多資訊。

## E4. 第2階段：「重額承保階段」

當您的處方藥費用達到[insert as applicable: **$<TrOOP amount>**]的自付費用限額時，重額承保階段就開始了。您將一直處於重額承保階段，直到該日曆年結束為止。

* [Plans that do not reduce the copays for Medicaid covered drugs or excluded drugs under an enhanced benefit in the catastrophic coverage stage should insert the following language:要查找有關您的Medicare和[insert name of the Medicaid program]承保的處方藥的更多資訊，請參閱《承保藥物清單》,[insert reference, as applicable]。]

**處方藥費用的變更**[option for plans with a single payment stage]

[Plans with one payment stage (i.e., those with no cost-sharing for all Medicare Part D drugs), include the following information.]

[If there are no changes in prescription drug costs, insert: 2024年您為處方藥支付的金額沒有變更。請閱讀下文，瞭解有關您的處方藥承保範圍的更多資訊。]

[Insert if applicable:**我們已將藥物清單上的一些藥物移至更低或更高的藥物層級。**[Insert if applicable:如果您的藥物從一個層級轉移到另一個層級，這可能會影響您的共付額。]要瞭解您的藥物是否移至不同層級，請在藥物清單中查看。]

下表顯示了您在我們[*insert number of tiers*]個藥物層級中每個層級内的藥物費用。

[Plans must list all drug tiers in the following table.]

|  | 2023（今年） | **2024（明年）** |
| --- | --- | --- |
| **層級<Tier number>中的藥物**([Insert short description of tier (e.g., generic drugs)]) 在網絡藥房配製的<Tier number>層級藥物的一個月供應量費用 | [Insert 2023 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] | [Insert 2024 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] |
| **層級<Tier number>中的藥物**([Insert short description of tier (e.g., generic drugs)])在網絡藥房配製的<Tier number>層級藥物的一個月供應量費用 | [Insert 2023 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] | [Insert 2024 cost-sharing:您一個月供應量的共付額（[insert number of days in a one-month supply]-天）為**$<XX>/處方**。] |

# 行政變更

[Insert this section if applicable. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below. Plans that choose to omit this section should renumber the remaining sections as needed.]

|  | **2023（今年）** | **2024（明年）** |
| --- | --- | --- |
| [Insert a description of the administrative process/item that is changing] | [Insert 2023 administrative description] | [Insert 2024 administrative description] |
| [Insert a description of the administrative process/item that is changing] | [Insert 2023 administrative description] | [Insert 2024 administrative description] |

# 選擇計畫

## G1. 繼續使用本計畫

我們希望讓您能保持計畫會員身份。您無需做任何事情即可留在本計畫中。如果您**不**換至其他Medicare計畫或換至Original Medicare，您將自動保持為我們2024年計畫的投保會員。

## G2. 改變投保計畫

[Plans should add any additional Medicaid information as directed by the state.]大多數擁有Medicare的人可以在一年中的特定時間終止其會員資格。由於您擁有[Insert name of Medicaid program]，您可以在以下每個**特殊投保時段**終止您在本計畫中的會員資格或轉換到不同的計畫：

* 一月至三月
* 四月至六月
* 七月至九月

除了這三個特殊投保期外，您還可以在以下時段終止您在本計畫中的會員資格：

* **年度投保期**，從10月15日持續到12月7日。如果您在此期間選擇新計畫，您在本計畫中的會員資格將于12月31日結束，而您在新計畫中的會員資格將于1月1日開始。
* **Medicare Advantage (MA) 開放投保期**，從1月1日持續到3月31日。如果您在此期間選擇新計畫，新計畫的會員資格將從下個月的第一天開始。

當您有資格更改您的投保時，可能還有其他情況發生。例如：

* 您搬出了我們的服務地區，
* 您獲得[Insert name of Medicaid Program]或額外補助的資格發生了變化，**或者**
* 如果您最近剛剛搬入、搬出療養院或長期護理機構或目前正在其中接受護理。

**您的Medicare服務**

您可以透過三種方式獲得Medicare服務。選擇這些選項之一，您就將自動終止您在本計畫中的會員資格。[*Insert additional option to change to another integrated program as directed by the state.*]

|  |  |
| --- | --- |
| **1. 您可以換至：****另一項Medicare健保計畫**[Insert additional instructions regarding Medicaid as directed by the state.] | **您需要做的是：**致電1-800-MEDICARE (1-800-633-4227)聯繫Medicare，營業時間為每週7天、全天24小時。聽語障服務專線 (TTY) 使用者應致電1-877-486-2048。有關長者整合照護方案 (PACE) 的查詢，請致電1-855-921-PACE (7223)。如您需要幫助或更多資訊： * + 請致電[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]如需瞭解更多資訊或查找您所在地區的當地[insert name of SHIP office]辦事處，請造訪[insert website address] 。

**或者**投保新的Medicare計畫。當您的新計畫開始承保時，您將會自動退出本計畫。[Insert impact on Medicaid enrollment as directed by the state.] |
| **2. 您可以換至：****含單獨的Medicare處方藥計畫的Original Medicare**[Insert additional instructions regarding Medicaid as directed by the state.] | **您需要做的是：**致電1-800-MEDICARE (1-800-633-4227)聯繫Medicare，營業時間為每週7天、全天24小時。聽語障服務專線 (TTY) 使用者應致電1-877-486-2048。如您需要幫助或更多資訊： * 請致電[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]如需瞭解更多資訊或查找您所在地區的當地[insert name of office]辦事處，請造訪[insert website address]。

**或者**投保新的Medicare處方藥計畫。當您的Original Medicare承保開始時，您將自動退出本計畫。[Insert impact on Medicaid enrollment as directed by the state.] |
| **3. 您可以換至：****不含單獨的Medicare處方藥計畫的Original Medicare** [Insert additional instructions regarding Medicaid as directed by the state.]**注**：如果您轉換到Original Medicare並且沒有投保單獨的Medicare處方藥計畫，Medicare可能會為您投保某一藥物計畫，除非您告訴Medicare您不想加入。只有在您已從其他來源（例如雇主或工會）獲得藥物承保的情況下，您才應該放棄處方藥承保。如果您對是否需要藥物承保有疑問，請致電[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.] | **您需要做的是：**致電1-800-MEDICARE (1-800-633-4227)聯繫Medicare，營業時間為每週7天、全天24小時。聽語障服務專線 (TTY) 使用者應致電1-877-486-2048。如您需要幫助或更多資訊： * 請致電[Insert contact information regarding state SHIP program including name of program, phone number, days and hours of operation, TTY number and website address.]

當您的Original Medicare承保開始時，您將自動退出本計畫。[Insert impact on Medicaid enrollment as directed by the state.] |

**您的**[**insert name of state Medicaid program**]**服務**

有關您如何在離開本計畫後獲取[insert name of Medicaid program]服務的問題，請聯繫[insert name of program as directed by the state, phone number, days and hours of operation, and TTY number and website if applicable]。請詢問加入另一項計畫或返回 Original Medicare 會如何影響您獲得[insert name of Medicaid program]承保範圍。

# 獲取幫助

## H1. 本計畫

如果您有任何問題，我們隨時為您提供幫助。請在所列的營業日期和時間内，撥打頁面底部的電話號碼聯繫會員服務部。通話是免費的。

**閱讀您的*《會員手冊》***

您的*《會員手冊》*是對本計畫所供福利的合法詳細描述。它涵蓋了關於2024年福利[insert if applicable:和費用]的詳細資訊。並解釋了您的權利以及獲得我們承保的服務和處方藥時應遵循的規則。

[If the ANOC is sent or provided separately from the Member Handbook, include the following:2024年《會員手冊》將於10月15日發布。][Insert if applicable:您還可以查閲<attached **or** enclosed **or** separately mailed>《會員手冊》，瞭解是否有其他福利[insert if applicable:或費用]變更會影響您。]*《會員手冊》*的最新副本可在我們的網站<web address>上找到。您也可以撥打頁面底部的電話號碼聯繫會員服務部，要求我們向您郵寄2024年*《會員手冊》*。

**我們的網站**

您可以造訪我們的網站，網址為：<web address>。貼心提示：我們的網站上有關於我們的醫療服務提供者和藥房網路（*《醫療服務提供者與藥房名錄》*）和我們的藥物清單（*《承保藥物清單》*）的最新資訊。

## H2. [Insert name of the State Health Insurance Assistance Program (SHIP)]

您也可以致電SHIP。在[Insert name of state]，SHIP被稱為[Insert name of program]。Insert name of program]可以幫助您了解您的計劃選擇並回答有關轉換計劃的問題。[Insert name of program]與我們或任何保險公司或健保計畫無關。[Insert name of program]有訓練有素的咨詢員[insert in every county or locations]並且服務是免費的。[Insert name of program]的電話號碼是[TTY phone number is optional]。需瞭解更多資訊或查找您所在地區的當地[Insert name of program]辦事處，請造訪[insert website address]。

## H3. [Insert State-specific name for Ombudsperson Program]

[Insert this section if there is an ombudsperson program in the state. Include a description of what the program can do, whether the services are free, and phone number. Please refer to an example of language below.]

[Optional language example: The Ombudsperson Program can help you if you have a problem with our plan. The ombudsperson’s services are free and available in all languages. The Ombudsperson Program:

* 作為您的代言人開展工作。如果您有問題或投訴，他們可以回答問題，並且可以幫助您瞭解該怎麼做。
* 確保您擁有與您的權利和保護以及如何解決您的疑慮相關的資訊。
* 該計畫與我們或任何保險公司或健保計畫無關。監察員計畫的電話號碼是[insert phone number]。]

## H4. Medicare

要直接從Medicare獲取資訊，請致電1-800-MEDICARE (1-800-633-4227)，每週7天、每天24小時開通。聽語障服務專線 (TTY) 使用者應致電1-877-486-2048。

**Medicare網站**

您可以造訪Medicare網站 ([www.medicare.gov](http://www.medicare.gov))。如果您選擇退出本計畫並加入另一項Medicare計畫，Medicare網站有關於費用、承保範圍和質量評級的資訊，可幫助您對不同計畫進行比較。

您可以使用Medicare網站上的Medicare計畫搜索器查找有關您所在地區可用的Medicare計畫的資訊。（計畫相關資訊，請參閱[www.medicare.gov](http://www.medicare.gov/)並按一下「查找計劃」。）

***2024年Medicare & You***

您可以閱讀*2024年Medicare & You*。每年秋季，這本小冊子都會郵寄給擁有Medicare的人。它總結了Medicare福利、權利和保護，並回答了有關Medicare的最常見問題。該手冊還提供西班牙文、中文和越南文版本。

如果您沒有這本小冊子的副本，則可以在Medicare網站上獲取 ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](http://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) 或致電1-800-MEDICARE (1-800-633-4227)，每週7天，每天24小時提供服務。聽語障服務專線 (TTY) 使用者應致電1-877-486-2048。

[*Insert any additional sections as required by the state, such as the QIO or additional resources that might be available.*]

## H5. [Insert state-specific name of Medicaid program]

[Insert a description of the state Medicaid program’s role and how to receive assistance from the state.]

## H6. [Insert additional resources if applicable]

[If applicable, insert a new section for each additional resource, including contact information and a description of their role.]