

[MA-only PPO models]
[2024 ANOC model]

[Insert 2024 plan name] ([insert plan type]) offered by [insert MAO name] [insert DBA names in parentheses, as applicable, after listing required MAO names]

Annual Notice of Changes for 2024

[Optional: insert member name]

[Optional: insert member address]

You are currently enrolled as a member of [insert 2023 plan name]. Next year, there will be changes to the plan's costs and benefits. **Please see page 4 for a Summary of Important Costs, including Premium.**

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at [insert URL]. [Insert as applicable: You can also review the attached OR enclosed OR separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.] You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital).
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check to see if your primary care doctors, specialists, hospitals and other providers will be in our network next year.
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in *[insert plan name]*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with *[insert plan name]*.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- *[Plans that meet the 5% alternative language threshold insert: This document is available for free in [insert languages that meet the 5% threshold].]*
- Please contact our Member Services number at *[insert member services phone number]* for additional information. (TTY users should call *[insert TTY number]*.) Hours are *[insert days and hours of operation]*. This call is free.
- *[Plans must insert language about availability of alternate formats (e.g., braille, large print, audio) as applicable.]*
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *[insert 2024 plan name]*

- *[Insert Federal contracting statement.]*
- When this document says “we,” “us,” or “our,” it means *[insert MAO name] [insert Plan in parentheses, as applicable, after listing required MAO names throughout this document]*. When it says “plan” or “our plan,” it means *[insert 2024 plan name]*.

*[Insert as applicable: [insert Material ID] CMS Approved [MMDDYYYY]
OR [insert Material ID]]*

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for [insert 2024 plan name] in several important areas. **Please note this is only a summary of costs.**

[If using Medicare FFS amounts (e.g., Inpatient and SNF cost sharing) the plan must insert the 2023 Medicare amounts and must insert: These are 2023 cost-sharing amounts and may change for 2024. [Insert plan name] will provide updated rates as soon as they are released. Member cost-sharing amounts may not be left blank.]

Cost	2023 (this year)	2024 (next year)
Monthly plan premium [Plans with no optional supplemental benefits delete the following.] (See Section [edit section number as needed] 2.1 for details.)	[Insert 2023 premium amount]	[Insert 2024 premium amount]
[Plans with no deductible may delete this row.] Deductible	[Insert 2023 deductible amount]	[Insert 2024 deductible amount] [If an amount other than \$0, add: except for insulin furnished through an item of durable medical equipment.]
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered [insert if applicable: Part A and Part B] services. (See Section [edit section number as needed] 2.2 for details.)	From network providers: [insert 2023 in-network MOOP amount] From in-network and out-of-network providers combined: [insert 2023 combined MOOP amount]	From network providers: [insert 2024 in-network MOOP amount] From in-network and out-of-network providers combined: [insert 2024 combined MOOP amount]
Doctor office visits	Primary care visits: [insert 2023 cost sharing for PCPs] per visit Specialist visits: [insert 2023 cost sharing for specialists] per visit	Primary care visits: [insert 2024 cost sharing for PCPs] per visit Specialist visits: [insert 2024 cost sharing for specialists] per visit
Inpatient hospital stays	[Insert 2023 cost sharing]	[Insert 2024 cost sharing]

[If Section 1 does not apply, plans should omit it and renumber remaining sections as needed.]

SECTION 1 We Are Changing the Plan's Name

[Plans that are changing the plan name, as approved by CMS, include Section 1, using the section title above and the following text:

On January 1, 2024, our plan name will change from *[insert 2023 plan name]* to *[insert 2024 plan name]*.

[Insert language to inform members if they will receive new ID cards and how, as well as if the name change will impact any other member communication.]

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *[insert 2024 plan name]* in 2024

[If the member is being enrolled into another plan due to a consolidation or due to a transition from a D-SNP look-alike plan under 42 CFR 422.514, include Section 1, using the section title above and the text below. It is additionally expected that, as applicable throughout the ANOC, every plan/sponsor that cross walks a member from a non-renewed plan to a consolidated renewal plan or transitions a member from a D-SNP look-alike plan to a renewal plan meeting the criteria in 42 CFR 422.514(e) will compare benefits and costs from that member's previous plan to the consolidated plan or the renewal plan. Every plan/sponsor that transitions a member from a D-SNP look-alike plan to a renewal plan, as indicated above, is encouraged to include language about the transition in a cover letter that accompanies the ANOC.]

On January 1, 2024, *[insert MAO name]* *[insert Plan in parentheses, as applicable, after listing required MAO names throughout this document]* will be combining *[insert 2023 plan name]* with one of our plans, *[insert 2024 plan name]*. The information in this document tells you about the differences between your current benefits in *[insert 2023 plan name]* and the benefits you will have on January 1, 2024 as a member of *[insert 2024 plan name]*.

If you do nothing by December 7, 2023, we will automatically enroll you in our *[insert 2024 plan name]*. This means starting January 1, 2024, you will be getting your medical coverage through *[insert 2024 plan name]*. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for “Extra Help,” you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

[Plans offering the following premiums must list separately in the table below: (1) Plan premium; (2) optional supplemental benefit premiums (only plans offering optional supplemental benefits during one or both of the comparison years); and (3) Part B premium reduction (only plans with Part B premium reductions during one or both of the comparison years.)]

Cost	2023 (this year)	2024 (next year)
<p>Monthly premium</p> <p><i>[If there are no changes from year to year, plans may indicate in the column that there is no change for the upcoming benefit year. However, the premium must also be listed.]</i></p> <p>(You must also continue to pay your Medicare Part B premium.)</p>	<i>[Insert 2023 premium amount]</i>	<i>[Insert 2024 premium amount]</i>

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

[Plans that include the costs of supplemental benefits in the MOOP limit may revise this information as needed.]

Medicare requires all health plans to limit how much you pay “out-of-pocket” for the year. These limits are called the “maximum out-of-pocket amounts.” Once you reach this amount, you generally pay nothing for covered *[insert if applicable: Part A and Part B]* services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
<p>In-network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays [insert if plan has a deductible: and deductibles]) from network providers count toward your in-network maximum out-of-pocket amount. [Plans with no premium delete the following sentence.] Your plan premium does not count toward your maximum out-of-pocket amount.</p>	<p>[Insert 2023 in-network MOOP amount]</p>	<p>[Insert 2024 in-network MOOP amount]</p> <p>Once you have paid [insert 2024 in-network MOOP amount] out-of-pocket for covered [insert if applicable: Part A and Part B] services from network providers, you will pay nothing for your covered [insert if applicable: Part A and Part B] services from network providers for the rest of the calendar year.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays [insert if plan has a deductible: and deductibles]) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. [Plans with no premium delete the following sentence.] Your plan premium does not count toward your maximum out-of-pocket amount.</p> <p>[If there are no changes from year to year, plans may indicate in the column that there is no change for the upcoming benefit year. However, the premium must also be listed.]</p>	<p>[Insert 2023 combined MOOP amount]</p>	<p>[Insert 2024 combined MOOP amount]</p> <p>Once you have paid [insert 2024 combined MOOP amount] out-of-pocket for covered [insert if applicable: Part A and Part B] services, you will pay nothing for your covered [insert if applicable: Part A and Part B] services from in-network or out-of-network providers for the rest of the calendar year.</p>

Section 2.3 – Changes to the Provider Network

[Insert if applicable: We included a copy of our current *Provider Directory* in the envelope with this document.] Updated directories are [insert if applicable: also] located on our website at [insert URL]. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*, which we will mail within three business days.

[Insert applicable section: For a plan that does not have changes in its provider network] There are no changes to our network of providers for next year.

[Insert applicable section: For a plan that has changes in its provider network] There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

[All plans must insert the following] It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

[If there are no changes in benefits or in cost sharing, revise heading to “There are no changes to your benefits or amounts you pay for medical services” and replace the rest of this section with: Our benefits and what you pay for these covered medical services will be exactly the same in 2024 as they are in 2023.]

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

[The table must include: (1) all new benefits that will be added or 2023 benefits that will end for 2024, including any new optional supplemental benefits (plans must indicate these optional supplemental benefits are available for an extra premium); (2) new/changing limitations or restrictions, including referrals, prior authorizations, and Part B step therapy for CY2024 Part C benefits; and (3) all changes in cost sharing for 2024 for covered medical services, including any changes to service category, out-of-pocket maximums, and cost sharing for optional supplemental benefits (plans must indicate these optional supplemental benefits are available for an extra premium). Note that beginning July 2023, cost-sharing for insulin furnished through an item of DME is subject to a coinsurance cap of \$35 for one-month’s supply of insulin.]

[If using Medicare FFS amounts (e.g. Inpatient and SNF cost sharing) the plan must insert the 2023 Medicare amounts and must insert: These are 2023 cost-sharing amounts and may change for 2024. [Insert plan name] will provide updated rates as soon as they are released. Member cost-sharing amounts may not be left blank.]

[Instructions to plans offering 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), 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; and (2) all changes in cost sharing for all VBID Model benefits for 2024.

Cost	2023 (this year)	2024 (next year)
<p><i>[Insert benefit name]</i></p>	<p><i>[For benefits that were not covered in 2023 [Insert benefit name] is <u>not</u> covered.]</i></p> <p><i>[For benefits with a copayment insert: You pay a \$[insert 2023 copayment amount] copay [insert language as needed to accurately describe the benefit (e.g., per office visit)].]</i></p> <p><i>[For benefits with a coinsurance insert: You pay [insert 2023 coinsurance percentage] % of the total cost [insert language as needed to accurately describe the benefit (e.g., for up to one visit per year)].]</i></p>	<p><i>[For benefits that are not covered in 2024 [Insert benefit name] is <u>not</u> covered.]</i></p> <p><i>[For benefits with a copayment insert: You pay a \$[insert 2024 copayment amount] copay [insert language as needed to accurately describe the benefit (e.g., per office visit)].]</i></p> <p><i>[For benefits with a coinsurance insert: You pay [insert 2024 coinsurance percentage] % of the total cost [insert language as needed to accurately describe the benefit, e.g., for up to one visit per year]].]</i></p>
<p><i>[Insert benefit name]</i></p>	<p><i>[Insert 2023 cost/coverage, using format described above.]</i></p>	<p><i>[Insert 2024 cost/coverage, using format described above.]</i></p>

SECTION 3 Administrative Changes

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

Description	2023 (this year)	2024 (next year)
<p><i>[Insert a description of the administrative process/item that is changing]</i></p>	<p><i>[Insert 2023 administrative description]</i></p>	<p><i>[Insert 2024 administrative description]</i></p>

Description	2023 (this year)	2024 (next year)
<i>[Insert a description of the administrative process/item that is changing]</i>	<i>[Insert 2023 administrative description]</i>	<i>[Insert 2024 administrative description]</i>

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in [insert 2024 plan name]

To stay in our plan, you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our [insert 2024 plan name].

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section [edit section number as needed] 6), or call Medicare (see Section [edit section number as needed] 8.2).

[Plans may choose to insert if applicable: As a reminder, [insert MAO name] [insert Plan in parentheses, as applicable, after listing required MAO names throughout this document] offers other [insert as applicable: Medicare health plans AND/OR Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.]]

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from [insert 2024 plan name].

- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *[insert 2024 plan name]*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - 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]*. Contact Member Services if you need more information on how to do so.
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

[Organizations offering plans in multiple states: Revise this section to use the generic name (State Health Insurance Assistance Program) when necessary, and include a list of names, phone numbers, and addresses for all SHIPs in your service area.]

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In *[insert state]*, the SHIP is called *[insert state-specific SHIP name]*.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. [Insert state-specific SHIP name] counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call [insert state-specific SHIP name] at [insert SHIP phone number]. [Plans may insert the following: You can learn more about [insert state-specific SHIP name] by visiting their website ([insert SHIP website]).]

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. [Plans in states without SPAPs, delete the next sentence.] Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).
- [Plans without an SPAP in their state(s) should delete this bullet.] [Organizations offering plans in multiple states: Revise this bullet to use the generic name (State Pharmaceutical Assistance Program) when necessary, and include a list of names for all SPAPs in your service area.] **Help from your state’s pharmaceutical assistance program.** [Insert state name] has a program called [insert state-specific SPAP name] that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- [Plans without an ADAP in their state(s), should delete this bullet.] **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the [insert State-specific ADAP information]. **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment

worker of any changes in your Medicare Part D plan name or policy number. [Insert State-specific ADAP contact information.]

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call [insert State-specific ADAP contact information].

SECTION 8 Questions?

Section 8.1 – Getting Help from [insert 2024 plan name]

Questions? We're here to help. Please call Member Services at [insert member services phone number]. (TTY only, call [insert TTY number].) We are available for phone calls [insert days and hours of operation]. [Insert if applicable: Calls to these numbers are free.]

Read your 2024 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 *Evidence of Coverage* for [insert 2024 plan name]. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at [insert URL]. [Insert as applicable: You can also review the attached OR enclosed OR separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.] You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at [insert URL]. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.