PRESBYTERIAN

Presbyterian MediCare PPO Plan 2 with Rx
offered by Presbyterian Insurance Company, Inc.

2023
Annual Notice of Changes

(505) 923-6060
1-800-797-5343
(TTY 711)

October 1 through March 31:
8 a.m. - 8 p.m., Sunday - Saturday

April 1 through September 30:
8 a.m. - 8 p.m., Monday - Friday

info@phs.org

www.phs.org/Medicare

PRESBYTERIAN

Important Information for Presbyterian MediCare PPO

Thank you for allowing Presbyterian MediCare PPO to be your partner in health! This document outlines the changes you can expect for the 2023 plan year. We also want to make sure you have access to important information such as your health plan's Provider Directory, Formulary, and Evidence of Coverage (EOC). See below for details on where to find the most current list of providers, pharmacies, and covered prescription drugs in your network, 24/7.

Visit www.phs.org/Medicare and select, "For Members" for information on how to access your:

- **Provider and Pharmacy Directory**
  The Provider and Pharmacy Directory lists all of the current in-network providers and pharmacies available through your health plan. You can find an up-to-date list of providers and pharmacies in our network, anytime.

- **Formulary**
  The Formulary lists generic and brand-name prescription drugs and the coverage amount or copayment you will need to pay for each prescription. Formularies will be available on October 15, 2022.

- **Evidence of Coverage (EOC)**
  The Evidence of Coverage is your contract with Presbyterian which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan. EOCs will be available on October 15, 2022.

Contact Us

The Presbyterian Customer Service Center is here to help. If you would like any of these materials mailed to you, please contact us at:

(505) 923-6060
1-800-797-5343
(TTY 711)

info@phs.org

October 1 to March 31:
8 a.m. to 8 p.m., seven days a week
(except holidays)

April 1 to September 30:
8 a.m. to 8 p.m., Monday to Friday
(except holidays)

PRESBYTERIAN

Presbyterian MediCare PPO Plan 2 with Rx offered by Presbyterian Insurance Company, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Presbyterian MediCare PPO Plan 2 with Rx. 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 www.phs.org/Medicare. You may also call customer service 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)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, 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 2023* handbook.

OMB Approval 0938-1051
(Expires: February 29, 2024)

☐ Once you narrow your choices 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, 2022, you will stay in Presbyterian MediCare PPO Plan 2 with Rx.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Presbyterian MediCare PPO Plan 2 with Rx.
- 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

- This document is available for free in Spanish.
- Please contact our Presbyterian Customer Service Center (customer service) at (505) 923-6060 or 1-800-797-5343 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week (except holidays) from **October 1 through March 31**, and Monday to Friday (except holidays) from **April 1 through September 30**.
- Customer service has free language services available for non-English speakers.
- This information is available in other formats. Contact the plan for more information.
- **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 Presbyterian MediCare PPO Plan 2 with Rx

- Presbyterian MediCare PPO is a Medicare Advantage plan with a Medicare contract. Enrollment in Presbyterian MediCare PPO depends on contract renewal.
- When this document says "we," "us," or "our," it means Presbyterian Insurance Company, Inc. When it says "plan" or "our plan," it means Presbyterian MediCare PPO Plan 2 with Rx.

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(Expires: February 29, 2024)

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Presbyterian MediCare PPO Plan 2 with Rx in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	$188	$186
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	**From in-network providers:** $6,700 **From in-network and out-of-network providers combined:** $10,000	**From in-network providers:** $6,700 **From in-network and out-of-network providers combined:** $10,000
Doctor office visits	**Primary care visits:** In-network: You pay a $15 copayment per visit. Out-of-network: You pay a $35 copayment per visit. **Specialist visits:** In-network: You pay a $50 copayment per visit. Out-of-network: You pay a $60 copayment per visit.	**Primary care visits:** In-network: You pay a $15 copayment per visit. Out-of-network: You pay a $35 copayment per visit. **Specialist visits:** In-network: You pay a $50 copayment per visit. Out-of-network: You pay a $60 copayment per visit.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**In-network:** Per admission, you pay a $325 copayment per day for days 1-5. **Out-of-network:** Per admission, you pay a $500 copayment per day for days 1-5. (No charge for the remainder of your stay)	**In-network:** Per admission, you pay a $325 copayment per day for days 1-5. **Out-of-network:** Per admission, you pay a $500 copayment per day for days 1-5. (No charge for the remainder of your stay)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $430 Copayment during the Initial Coverage Stage: • Drug Tier 1: $4 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: $95 • Drug Tier 5: 25% coinsurance	Deductible: $470 Copayment during the Initial Coverage Stage: • Drug Tier 1: $4 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: $95 • Drug Tier 5: 25% coinsurance

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Presbyterian MediCare PPO Plan 2 with Rx in 2023

If you do nothing by December 7, 2022, we will automatically enroll you in our Presbyterian MediCare PPO Plan 2 with Rx. This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through Presbyterian MediCare PPO Plan 2 with Rx. 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

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$188	$186
Optional Supplemental Dental Coverage This plan premium applies to you only if you enroll in our Comprehensive Dental Plan.	$19	$19

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

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 Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.phs.org/Medicare. You may also call customer service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 Provider Directory to see which pharmacies are in our network.**

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 customer service so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Emergency Care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	**In- and out-of-network:** You pay a $90 copayment per emergency department visit This copayment does not apply if you are admitted to the hospital within 24 hours for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.	**In- and out-of-network:** You pay a $95 copayment per emergency department visit This copayment does not apply if you are admitted to the hospital within 24 hours for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.

Cost	2022 (this year)	2023 (next year)
Emergency Care (continued) You have worldwide emergency coverage. • If you are admitted to the hospital within 24 hours, you do not have to pay your emergency room copayment. • Emergent air and ground transportation is covered to the nearest appropriate facility. You may need to file a claim for reimbursement unless the provider agrees to bill us	**Out-of-network** **$90 copayment**	**Out-of-network** **$95 copayment**
Outpatient diagnostic tests and therapeutic services and supplies: • Therapeutic Radiological Services	**In-network:** No Charge **Out-of-network:** You pay a 20% coinsurance	**In-network:** You pay a 20% coinsurance **Out-of-network:** You pay a 20% coinsurance

Cost	2022 (this year)	2023 (next year)
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network:** You pay a $90 copayment **Out-of-network:** You pay a 20% coinsurance	**In-network:** You pay a $95 copayment **Out-of-network:** You pay a 20% coinsurance

Cost	2022 (this year)	2023 (next year)
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstances (for example, major disaster). **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believe that your health would seriously deteriorate if you delayed treatment until you returned to our service area. Look in Chapter 3, Section 3.2 of your *Evidence of Coverage* for more information.	**In-network:** You pay a $15 copayment per visit **Out-of-network:** You pay a $65 copayment per visit	**In-network:** You pay a $15 copayment per visit **Out-of-network:** You pay a $60 copayment per visit

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact customer service for more information.

Starting in 2023, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help," and you haven't received this insert by October 1, 2022 please call customer service and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage).

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	The deductible is $430.	The deductible is $470.

Changes to Your Cost-sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides a standard cost-sharing. For information about the costs for a long-term supply for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1-Preferred Generic:** You pay $4 per prescription **Tier 2-Generic:** You pay $10 per prescription **Tier 3-Preferred Brand:** You pay $45 per prescription **Tier 4-Non-Preferred Drug:** You pay $95 per prescription **Specialty Tier:** You pay 25% coinsurance Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage). Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1-Preferred Generic:** You pay $4 per prescription **Tier 2-Generic:** You pay $10 per prescription **Tier 3-Preferred Brand:** You pay $45 per prescription **Tier 4-Non-Preferred Drug:** You pay $95 per prescription **Specialty Tier:** You pay 25% coinsurance Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage). Once you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call customer service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Presbyterian MediCare PPO Plan 2 with Rx

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 2023 Presbyterian MediCare PPO Plan 2 with Rx.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 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, please see Section 2.1 regarding 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 7.2).

As a reminder, Presbyterian offers other Medicare health 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 Presbyterian Medicare PPO Plan 2 with Rx.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Presbyterian Medicare PPO Plan 2 with Rx.

- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact customer service 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 4 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, 2023.

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, 2023, 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, 2023.

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 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New Mexico, the SHIP is called New Mexico Aging and Long-Term Services.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Mexico Aging and Long-Term Services 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 New Mexico Aging and Long-Term Services at 1-800-432-2080 or TTY (505) 476-4937. You can learn more about New Mexico Aging and Long-Term Services by visiting their website (www.nmaging.state.nm.us).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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 7 a.m. and 7 p.m., 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).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Mexico Department of Health AIDS Drug Assistance Program:

  New Mexico Department of Health AIDS Drug Assistance Program (ADAP)
  1190 S. St. Francis Dr.
  Santa Fe, NM 87502

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the New Mexico Department of Health AIDS Drug Assistance Program at (505) 827-2435.

SECTION 7 Questions?

Section 7.1 – Getting Help from Presbyterian MediCare PPO Plan 2 with Rx

Questions? We're here to help. Please call customer service at (505) 923-6060 or 1-800-797-5343. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week (except holidays) from **October 1 through March 31**, and Monday to Friday (except holidays) from **April 1 through September 30**. Read your 2023 *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 2023. For details, look in the 2023 *Evidence of Coverage* for Presbyterian MediCare PPO Plan 2

with Rx. 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 www.phs.org/Medicare. You may also call customer service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.phs.org/Medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – 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 2023*

Read the *Medicare & You 2023* handbook. Every year, this booklet 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.

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-592-7737 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-592-7737 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Navajo (Diné): Díí ats'íís dóó azee' bínda'í díłkidgo, Dinék'ehjí yadałti'iigi ła' bich'į' hadíídzih. Béésh bee hane'é t'áá jíík'e be' hódíílnih, 1-855-592-7737 (TTY: 711).

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-592-7737 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-592-7737 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-592-7737 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-592-7737 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-592-7737 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-592-7737 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-592-7737 (TTY: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-592-7737 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-592-7737 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के िए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करने के किए, बस हमें 1-855-592-7737 (TTY: 711) पर फोन करें . कोई व्यक्ति जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-592-7737 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-592-7737 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-592-7737 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-592-7737 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-592-7737 (TTY: 711). にお電話ください。日本語を話す人 者 が支援いたします。これは無 料のサー ビスです。