Presbyterian Senior Care (HMO)
2023 Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call us at **(505) 923-8458** or **1-800-347-4766**. TTY users can call 711.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC), provides a complete list of coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **www.phs.org/medicare** or call **(505) 923-8458** or **1-800-347-4766**, TTY users can call 711, to view a copy of the EOC.

- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.

- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Presbyterian Senior Care (HMO)
2023 Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 to December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- If your plan has a premium, your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Presbyterian Health Plan, Inc.
P.O. Box 27489
Albuquerque, NM 87125
Fax: (505) 923-5385

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Presbyterian Senior Care at (505) 923-8458 or 1-800-347-4766. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Presbyterian Senior Care al (505) 923-8458 o 1-800-347-4766/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g. social security checks) may be considered your permanent residence address.

Presbyterian Senior Care (HMO)
2023 Individual Enrollment Request Form

Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join:			
Part D Drugs are included: ☐ **Presbyterian Senior Care (HMO) Plan 2 with Rx** - $0 per month ☐ **Presbyterian Senior Care (HMO) Plan 3 with Rx** - $118 per month			
Part D Drugs are not included: ☐ **Presbyterian Senior Care (HMO) Plan 1** - $0 per month			
Optional Supplemental Benefit: ☐ **Comprehensive Dental** - $9 per month			
FIRST Name:	LAST Name:		Middle Initial: (Optional)
Birth Date: (M M / D D / Y Y Y Y) (__ __ /__ __ /__ __ __ __)	Sex: ☐ M ☐ F	Phone Number: ( )	Email (Optional):
Permanent Residence Street Address (Don't enter a P.O. Box):			
City:	County:	State:	ZIP Code:
Mailing Address, if different from your permanent address (P.O. Box allowed):			
City:		State:	ZIP Code:
Your Medicare information:			
Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __			
Answer these important questions:			
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Presbyterian Senior Care? ☐ Yes ☐ No If yes, name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____			

Presbyterian Senior Care (HMO)
2023 Individual Enrollment Request Form

IMPORTANT – Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Presbyterian Senior Care.
- By joining this Medicare Advantage (MA) Plan, I acknowledge that Presbyterian Senior Care will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that Presbyterian Senior Care has worldwide emergency/urgent care services.
- I understand that when my Presbyterian Senior Care coverage begins, I must get all of my medical and prescription drug benefits from Presbyterian Senior Care. Benefits and services provided by Presbyterian Senior Care and contained in my Presbyterian Senior Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Presbyterian Senior Care will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	Today's Date:

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone Number:	Relationship to Enrollee:

Office Use Only:

Name of staff member, agent or broker (if assisted in enrollment):

_____

Broker NPN# _____ Date Received: _____

How was enrollment received: ☐ Walk-in with presentation ☐ In Home with presentation
☐ Seminar/Meeting ☐ Telephonic ☐ Walk-in without presentation
☐ In Home without presentation ☐ Mail in ☐ Email ☐ Faxed

Plan ID#_____Effective date of coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Section 2 – All fields on this page are optional Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

As part of your enrollment, do you want to receive any of the following materials via email?
☐ Plan Formulary ☐ Summary of Benefits ☐ Evidence of Coverage

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No, not of Hispanic, Latino/a or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ I choose not to answer

What's your race? Select all that apply.
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ I choose not to answer

All materials are available in Spanish and a machine-readable format through our website or by request. Other options, such as other languages, large print or Braille are available by request. Please contact Presbyterian Senior Care at (505) 923-6060 or 1-800-797-5343. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711.
Select one if you want us to send you information in a language other than English.
☐ Spanish ☐ Other _____

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center:

Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a payment option:

☐ Get a bill.

☐ Electronic Funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number:_____
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:
Type of Card: ☐ Visa ☐ MasterCard ☐ Discover
Name of Account holder as it appears on card: _____
Account number: _____ Expiration Date: _ _ / _ _ _ _ (MM/YYYY)

☐ Automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Presbyterian Senior Care the Part D-IRMAA.

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。