

## Presbyterian UltraFlex (HMO-POS) and Presbyterian Senior Care (HMO) Plan 2 with Rx 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](http://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.
- For Presbyterian Senior Care (HMO), 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.
- For Presbyterian Senior Care (HMO) Plan 2 with Rx, 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).
- For Presbyterian UltraFlex (HMO-POS), our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

**Presbyterian UltraFlex (HMO-POS) and Presbyterian Senior Care (HMO) Plan 2 with Rx  
2023 Individual Enrollment Request Form**

<p><b>Who can use this form?</b> People with Medicare who want to join a Medicare Advantage Plan</p> <p><b>To join a plan, you must:</b></p> <ul style="list-style-type: none"> <li>• Be a United States citizen or be lawfully present in the United States</li> <li>• Live in the plan’s service area</li> </ul> <p><b>Important:</b> To join a Medicare Advantage Plan, you must also have both:</p> <ul style="list-style-type: none"> <li>• Medicare Part A (Hospital Insurance)</li> <li>• Medicare Part B (Medical Insurance)</li> </ul>	<p><b>Reminders:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>
<p><b>When do I use this form?</b> You can join a plan:</p> <ul style="list-style-type: none"> <li>• Between October 15 to December 7 each year (for coverage starting January 1)</li> <li>• Within three months of first getting Medicare</li> <li>• In certain situations where you’re allowed to join or switch plans</li> </ul> <p>Visit <b>Medicare.gov</b> to learn more about when you can sign up for a plan.</p>	<p><b>What happens next?</b> Send your completed and signed form to: Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125 Fax: (505) 923-5385</p> <p>Once we process your request to join, we’ll contact you.</p>
<p><b>What do I need to complete this form?</b></p> <ul style="list-style-type: none"> <li>• Your Medicare Number (the number on your red, white and blue Medicare card)</li> <li>• Your permanent address and phone number</li> </ul> <p><b>Note:</b> 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.</p>	<p><b>How do I get help with this form?</b> Call Presbyterian 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.</p> <p><b>En español:</b> Llame a Presbyterian 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.</p>
	<p><b>Individuals experiencing homelessness</b> 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.</p>

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**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 UltraFlex (HMO-POS) with Rx** - \$0 per month.  
Available in these counties: Bernalillo, Cibola, Curry, Lincoln, Quay, Rio Arriba, Sandoval, Santa Fe, Socorro, Torrance, and Valencia.

\_\_\_\_\_ **Presbyterian Senior Care (HMO) Plan 2 with Rx** - \$0 per month.  
Available in these counties: Bernalillo, Cibola, Rio Arriba, Sandoval, Santa Fe, Socorro, Torrance, and Valencia.

**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: <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number: (    )	Email (Optional):
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Permanent Residence Street Address (Don't enter a P.O. Box):

City:	County:	State:	ZIP Code:
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Mailing Address, if different from your permanent address (P.O. Box allowed):

City:	State:	ZIP Code:
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**Your Medicare information:**

Medicare Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Presbyterian UltraFlex or Presbyterian Senior Care?  Yes  No

If yes, name of other coverage: \_\_\_\_\_

Member number for this coverage: \_\_\_\_\_

Group number for this coverage: \_\_\_\_\_

**Presbyterian UltraFlex (HMO-POS) and Presbyterian Senior Care (HMO) Plan 2 with Rx  
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 UltraFlex or Presbyterian Senior Care.
- By joining this Medicare Advantage (MA) Plan, I acknowledge that Presbyterian UltraFlex and 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 UltraFlex and Presbyterian Senior Care have worldwide emergency/urgent care services.
- I understand that when my Presbyterian UltraFlex or Presbyterian Senior Care coverage begins, I must get all of my medical and prescription drug benefits from Presbyterian UltraFlex or Presbyterian Senior Care. Benefits and services provided by Presbyterian UltraFlex and Presbyterian Senior Care and contained in my Presbyterian UltraFlex or Presbyterian Senior Care “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Presbyterian UltraFlex or 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:
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**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: \_\_\_\_\_

**Presbyterian UltraFlex (HMO-POS) and Presbyterian Senior Care (HMO) Plan 2 with Rx  
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**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    Chinese    Korean    Vietnamese  
 Asian Indian    Filipino    Native Hawaiian    White  
 Black or African American    Guamanian or Chamorro    Other Asian    I choose not to answer  
 Other Pacific Islander    Samoan

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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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 the Part D-IRMAA.

## 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' bída'í díłkidgo, Dinék'ehjí yadałti'iigi ła' bich'í' hadíídzih. Béesh bee hane'é t'áá jíik'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 quý vị cần thông dịch viên xin gọi 1-855-592-7737 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 드리고자 무료 통역 서비스를 제공하고 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 लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, 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。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。