PRESBYTERIAN

Presbyterian Dual Plus (HMO D-SNP)
offered by Presbyterian Health Plan, Inc.

Contract ID: H3204-013-004

2024
Annual Notice of Changes

(505) 923-7675
1-855-465-7737
(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 Dual Plus (HMO D-SNP)

Thank you for allowing Presbyterian Dual Plus to be your partner in health! This document outlines the changes you can expect for the 2024 plan year. We also want to make sure you have access to important information such as your 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, 2023.

- **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, 2023.

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) 923-7675
1-800-465-7737
(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)

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.

Presbyterian exists to ensure all of the patients, members, and communities we serve can achieve their best health.

www.phs.org/Medicare

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Annual Notice of Changes for 2024

Contract ID: H3204-013-004

You are currently enrolled as a member of Presbyterian Dual Plus (HMO D-SNP). 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*.

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 2024 "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 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 Presbyterian Dual Plus (HMO D-SNP).
   - 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 Presbyterian Dual Plus (HMO D-SNP).
   - Look in section 3.2, page 16, to learn more about your choices.
   - 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) 923-7675 or 1-855-465-7737 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**. This call is free.
- Customer service has free language interpreter services available for non-English speakers.
- This information is available in other formats. Contact the plan for 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 Dual Plus (HMO D-SNP)

- Presbyterian Dual Plus is an HMO Special Needs Plan (SNP) with a Medicare contract and a contract with the State of New Mexico Human Services Department Medicaid program. Enrollment in Presbyterian Dual Plus (HMO D-SNP) depends on contract renewal.
- Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.
- When this document says "we," "us," or "our," it means Presbyterian Health Plan, Inc. When it says "plan" or "our plan," it means Presbyterian Dual Plus (HMO D-SNP).

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(Expires: February 29, 2024)

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Presbyterian Dual Plus (HMO D-SNP) in several important areas. **Please note this is only a summary of costs.** If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	$36.40 Based on your level of Low-Income Subsidy, your plan premium could be paid by Medicare.	$35.60 Based on your level of Low-Income Subsidy, your plan premium could be paid by Medicare.
Deductible	$226 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	$226 You will be notified if Medicare changes this amount for 2024. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Doctor office visits	**Primary care visits:** You pay 20% per visit **Specialist visits:** You pay 20% per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	**Primary care visits:** You pay 20% per visit **Specialist visits:** You pay 20% per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**Per admission, you pay:** $1,556 for each benefit period. Days 1-60: $0 copayment Days 61-90: $389 copayment Days 91 and beyond: $778 copayment If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	**Per admission, you pay:** $1,556 for each benefit period. Days 1-60: $0 copayment Days 61-90: $389 copayment Days 91 and beyond: $778 copayment If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. You will be notified if Medicare changes this amount for 2024.
Part D prescription drug coverage (See Section 2.6 for details.)	**Deductible:** $505 except for covered insulin products and most adult Part D vaccines. **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.45 copay; • Or $4.15 copay; • Or 15% coinsurance **For all other covered drugs:** • $0 copay; • Or $4.30; • Or $10.35; • Or 15% coinsurance	**Deductible:** $545 except for covered insulin products and most adult Part D vaccines. **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.55 copay; • Or $4.50 copay; **For all other covered drugs:** • $0 copay; • Or $4.60; • Or $11.20;

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 1: Preferred Generic $0 • Drug Tier 2: Generic $11 • Drug Tier 3: Preferred Brand $47 You pay $35 per month supply of each covered insulin product on this tier • Drug Tier 4: Non-Preferred Drug 43% coinsurance You pay $35 per month supply of each covered insulin product on this tier • Drug Tier 5: Specialty 25% coinsurance **Catastrophic Coverage:** • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this s called coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• Drug Tier 1: Preferred Generic $0 • Drug Tier 2: Generic $20 • Drug Tier 3: Preferred Brand 18% of the total cost. You pay $35 per month supply of each covered insulin product on this tier • Drug Tier 4: Non-Preferred Drug 48% of the total cost You pay $35 per month supply of each covered insulin product on this tier • Drug Tier 5: Specialty You pay 25% of the total cost. **Catastrophic Coverage:** • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount 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.)	$8,300 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,850 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Presbyterian Dual Plus (HMO D-SNP) in 2024

If you do nothing in 2023, we will automatically enroll you in our Presbyterian Dual Plus (HMO D-SNP). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through Presbyterian Dual Plus (HMO D-SNP). If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan, you must do so between October 15 and December 7. The change will take effect on January 1, 2024.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$36.40 Based on your level of Low-Income Subsidy, your plan premium could be paid by Medicare	$35.60 Based on your level of Low-Income Subsidy, your plan premium could be paid by 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. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,300	$8,850 Once you have paid $8,850 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services 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, which we will mail within three business days.

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.**

There are changes to our network of pharmacies for next year. **Please review the 2024 *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

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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

Cost	2023 (this year)	2024 (next year)
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances. For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You pay 20% coinsurance	You pay 20% coinsurance
• Routine visits, up to three (3) visits per year	No Charge	Not Covered

Cost	2023 (this year)	2024 (next year)
Diabetes self-management		
Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions* for checking the accuracy of test strips and monitors	Standard test strips and lancets are limited to a quantity limit of 100 per 30 days for non-insulin dependent members and 200 per 30 days for insulin dependent members	Standard test strips and lancets are limited to a quantity limit of 100 per 90 days for non-insulin dependent members and 300 per 90 days for insulin dependent members
Blood glucose monitors, test strips, and lancets	**In-network:** No Charge * Coverage is limited to AccuChek branded products	**In-network:** No Charge * Coverage is limited to AccuChek branded products
*Continuous Glucose Monitors (CGM) and Supplies are covered under Durable Medical Equipment (DME) services. Authorization rules apply.	**In-network:** You pay a 20% coinsurance	**In-network:** You pay a 20% coinsurance * Coverage is limited to FreeStyle Libre products

Cost	2023 (this year)	2024 (next year)
Emergency care	You pay a 0-20% coinsurance up to $95 (waived if admitted) 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 for your care to continue to be covered *or* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital.	You pay a 20% coinsurance up to $100 (waived if admitted) 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 for your care to continue to be covered *or* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital.
Our plan does not cover any services, including emergency or urgently needed services, if you receive the care outside of the United States or its territories.	You are responsible for 100% of the costs.	You are responsible for 100% of the costs.
Over-the-counter (OTC) items	• Quarterly you will receive $320 to spend on non-prescription medications and other health-related items.	• Quarterly you will receive $315 to spend on non-prescription medications and other health-related items.

Cost	2023 (this year)	2024 (next year)
Dental Services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:	$3,000 annual limit	$3,000 combined Basic and Comprehensive annual limit You are responsible for any amounts spent that exceed the annual allowance
• **Dentures**	No Limit	Dentures limited to every 5 years
Preventive (Basic): • Oral Exams • Cleaning • Fluoride treatment • Dental X-rays **Comprehensive:** • Restorative services • Extractions • Periodontic services • Prosthodontic oral surgery • Maxillofacial services • Periodic oral evaluation, extensive oral exams, re-evaluation-limited problem focused - Two every 12 months. • Limited oral exams - three per 12 months. • Comprehensive oral exam and comprehensive periodontal evaluation - One every 36 months per provider or location. • Palliative treatment. • Prophylaxis, scaling in presence of generalized moderate or severe gingival inflammation, full mouth – 2 every 12 months.		

Cost	2023 (this year)	2024 (next year)
Dental services (continued) • Periodontal maintenance procedures (following active therapy) – 4 every 12 months. • Bitewings (one, two three four images) or intraoral tomosynthesis-bitewing radiographic image-one every 12 months. • Intraoral complete series, vertical bitewings, panoramic radiographic image or intraoral tomosynthesis-comprehensive series of radiographic image-once every 36 months. • Intraoral periapical image or intraoral tomosynthesis-periapical radiographic image-one every 12 months. • Intraoral occlusal radiographic image - 2 every 24 months. Dental Implants are not covered.		
Urgently needed services	**In- and Out-of-network:** You pay a 0-20% coinsurance up to $65	**In- and Out-of-network:** You pay a 20% coinsurance up to $55

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," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

If you were granted a formulary exception in 2023, you will need to submit a new request for 2024.

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.

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, 2023, 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	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs on Tier 2, Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $505. During this stage, you pay the full cost of drugs until you have reached the yearly deductible. Your deductible amount is either $0 or $505, depending on the level of "Extra Help" you receive. (Refer to the separate insert, the LIS Rider, for your deductible amount.)	The deductible is $545. During this stage, you pay $0 cost sharing for drugs on Drug Tier 1: Preferred Generic's and the full cost of drugs on Tiers 2, 3, 4 and 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

For drugs on Tier 3, your cost sharing in the initial coverage stage is changing from a copayment to a coinsurance. Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (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.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: • **Drug Tier 1:** You pay $0 per prescription. • **Drug Tier 2:** You pay $11 per prescription. • **Drug Tier 3:** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier • **Drug Tier 4:** You pay 43% of the total cost. You pay $35 per month supply of each covered insulin product on this tier • **Drug Tier 5:** You pay 25% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: • **Drug Tier 1: Preferred Generic** You pay $0 per prescription. • **Drug Tier 2: Generic** You pay $20 per prescription. • **Drug Tier 3: Preferred Brand** You pay 18% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4: Non-Preferred Drug** You pay 48% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5: Specialty** You pay 25% of the total cost.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs 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."	Once your total drug costs have reached $4,660 you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030 you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Presbyterian Dual Plus (HMO D-SNP)

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 Presbyterian Dual Plus (HMO D-SNP).

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 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.

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 6), or call Medicare (see Section 7.2).

As a reminder, Presbyterian Health Plan, Inc. 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 Dual Plus (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Presbyterian Dual Plus (HMO D-SNP).
- 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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 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.

Because you have Centennial Care (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

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 5 Programs That Offer Free Counseling about Medicare and Medicaid

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/).

For questions about your New Mexico Centennial Care (Medicaid) benefits, contact New Mexico Centennial Care (Medicaid) at 1-888-997-2583 (TTY 711). Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. (closed on weekends and holidays). Ask how joining another plan or returning to Original Medicare affects how you get your New Mexico Centennial Care (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," 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 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. The New Mexico Department of Health AIDS Drug Assistance Program is located at:

  New Mexico Department of Health AIDS Drug Assistance Program (ADAP)
  1190 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 Drugs Assistance Program at (505) 827-2435.

SECTION 7 Questions?

Section 7.1 – Getting Help from Presbyterian Dual Plus (HMO D-SNP)

Questions? We're here to help. Please call customer service at (505) 923-7675 or 1-855-465-7737. (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**. 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 Presbyterian Dual Plus (HMO D-SNP). 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 2024*

Read the *Medicare & You 2024* handbook. Every year 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 (http://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.

Section 7.3 – Getting Help from Medicaid

To get information from New Mexico Centennial Care (Medicaid), you can call New Mexico Centennial Care (Medicaid) at 1-888-997-2583. TTY users should call 711.

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or **https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Address: U.S. Department of Health and Human Services200
Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

PRESBYTERIAN

PRESBYTERIAN

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

Form Approved
OMB# 0938-1421

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 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 किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-592-7737 (TTY:711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता 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。