PRESBYTERIAN

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

Contract ID: H3204-013-005

# 2025
# 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 2025 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, 2024.

- **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, 2024.

## 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

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

# Annual Notice of Changes for 2025

## Contract ID: H3204-013-005

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 5 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 can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, 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, 2025.** This will end your enrollment with Presbyterian Dual Plus (HMO D-SNP).
- Look in section 4.2, page 15, to learn more about your choices.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

**Additional Resources**

- This document is available for free in Spanish.
- Please contact our Presbyterian Customer Service Center (customer service) number 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).

# *Annual Notice of Changes* for 2025
# Table of Contents

## Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 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.

*These are 2024 cost-sharing amounts and may change for 2025. Presbyterian Dual Plus (HMO D-SNP) will provide updated rates as soon as they are released.

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium may be higher or lower than this amount. See Section 2.1 for details. | $35.60 | $35.60* |
| **Deductible** | $226, except for insulin furnished through an item of durable medical equipment. <br> If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. | $226*, *e*xcept for insulin furnished through an item of durable medical equipment. <br> If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. |
| **Doctor office visits** | Primary care visits: 20% per visit <br> Specialist visits: 20% per visit <br> If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit. | Primary care visits: 20% per visit <br> Specialist visits: 20% per visit <br> If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit. |
| **Inpatient hospital stays** | **Per Original Medicare Benefit Period, you pay**: | **Per Original Medicare Benefit Period, you pay:** |

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| | $1,632 for each benefit period.<br><br>Days 1-60:<br>$0 copay<br><br>Days 61-90:<br>$408 copay<br><br>Days 91 and beyond:<br>$816 copayment<br><br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. | $1,632* for each benefit period.<br><br>Days 1-60:<br>$0 copay<br><br>Days 61-90:<br>$408* copay<br><br>Days 91 and beyond:<br>$816* copayment<br><br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. |
| **Part D prescription drug coverage**<br>(See Section 2.5 for details.) | Deductible: $545, except for covered insulin products and most adult Part D vaccines.<br><br>Copayment or Coinsurance during the Initial Coverage Stage:<br><br>• Drug Tier 1 - Preferred Generic Drugs:<br>$0 copay<br>• Drug Tier 2 – Generic Drugs:<br>$20 copay<br>• Drug Tier 3 – Preferred Brand Drugs:<br>18% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier. | Deductible: $590, except for covered insulin products and most adult Part D vaccines.<br><br>Copayment or coinsurance during the Initial Coverage Stage:<br><br>• Drug Tier 1 - Preferred Generic Drugs:<br>$0 copay<br>• Drug Tier 2 – Generic Drugs:<br>25% coinsurance<br>• Drug Tier 3 – Preferred Brand Drugs:<br>25% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier. |

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| | • Drug Tier 4 – Non-Preferred Drugs:<br>48% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 5 – Specialty Drugs:<br>25% coinsurance<br>Catastrophic Coverage:<br>• During this payment stage, the plan pays the full cost for your covered Part D drugs. | • Drug Tier 4 – Non-Preferred Drugs:<br>26% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 5 – Specialty Drugs:<br>25% coinsurance<br>Catastrophic Coverage:<br>• During this payment stage, you pay nothing for your covered Part D drugs. |
| **Maximum out-of-pocket amount**<br>This is the most you will pay out of pocket for your covered Part A and Part B services.<br>(See Section 2.2 for details.) | $8,850<br>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. | $9,350<br>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 2025

**If you do nothing in 2024, we will automatically enroll you in our Presbyterian Dual Plus (HMO D-SNP).** This means starting January 1, 2025, 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, 2025.

# SECTION 2 Changes to Benefits and Costs for Next Year

## Section 2.1 – Changes to the Monthly Premium

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.) | $35.60 | $35.60* |

## 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 | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>**Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.**<br>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.<br>Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount.<br>Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $8,850 | $9,350<br>Once you have paid $9,350 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

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are also 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 2025 *Provider Directory* www.phs.org/Medicare 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 2025 *Provider Directory* www.phs.org/Medicare 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), and pharmacies that are a 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 | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Emergency Services** | You pay 20% of the total cost up to $100 per visit.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. | You pay 20% of the total cost up to $110 per visit.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. |
| **Inpatient Hospital Services (medical and behavioral)** | Per Original Medicare Benefit Period, you pay a $1,632 deductible.<br>You pay $0 per day for days 1-60.<br>You pay $408 per day for days 61-90.<br>You pay $816 per day for days 91 and beyond.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. | Per Original Medicare Benefit Period, you pay a $1,632* deductible.<br>You pay $0 per day for days 1-60.<br>You pay $408* per day for days 61-90.<br>You pay $816* per day for days 91 and beyond.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. |
| **Prescription Hearing Aids – Non-Medicare** | You have up to a $1,500 allowance, every 3 years for both ears combined. | You have up to a $2,000 allowance, every 3 years for both ears combined. |

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Skilled Nursing Facility (SNF) Stay** | Per Original Medicare Benefit Period, you pay $0 per day for days 1-20.<br>You pay $204 per day for days 21-100.<br>You pay the total costs for days 101 and beyond.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. | Per Original Medicare Benefit Period, you pay $0 per day for days 1-20.<br>You pay $204* per day for days 21-100.<br>You pay the total costs for days 101 and beyond.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. |
| **Urgent Care** | You pay 20% of the total cost up to $55 per visit.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. | You pay 20% of the total cost up to $45 per visit.<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost. |

## 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. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling customer service (see the back cover) or visiting our website www.phs.org/Medicare.

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.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If

we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also 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.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact customer service or ask your health care provider, prescriber, or pharmacist for more information.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact customer service or ask your health care provider, prescriber, or pharmacist for more information.

## Changes to Prescription Drug Benefits and 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, 2024, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

### Changes to the Deductible Stage

| Stage | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage**<br>During this stage, **you pay the full cost** of your Part D 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 $545.<br>During this stage, you pay $0 cost sharing for drugs on Tier 1 – Preferred Generic and the full cost of drugs on Tiers 2, 3, 4 and 5 until you have reached the yearly deductible. | The deductible is $590.<br>During this stage, you pay $0 cost sharing for drugs on Tier 1 – Preferred Generic 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 2 – Generic, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

| Stage | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>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**.<br>For 2024 you paid a $20 copayment for drugs on Tier 2 – Generic Drugs. For 2025 you will pay 25% for drugs on this tier.<br>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.<br>Most adult Part D vaccines are covered at no cost to you. | Your cost for a one-month supply is:<br>**Tier 1 – Preferred Generic Drugs:**<br>You pay $0 per prescription.<br>**Tier 2 – Generic Drugs:**<br>You pay $20 per prescription.<br>**Tier 3 – Preferred Brand Drugs:**<br>You pay 18% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>**Tier 4 – Non-Preferred Drugs:**<br>You pay 48% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>**Tier 5 – Specialty Drugs:**<br>You pay 25% of the total cost.<br>_____<br>Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage). | Your cost for a one-month supply is:<br>**Tier 1 – Preferred Generic Drugs:**<br>You pay $0 per prescription.<br>**Tier 2 – Generic Drugs:**<br>You pay 25% of the total cost.<br>**Tier 3 – Preferred Brand Drugs:**<br>You pay 25% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>**Tier 4 – Non-Preferred Drugs:**<br>You pay 26% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>**Tier 5 – Specialty Drugs:**<br>You pay 25% of the total cost.<br>_____<br>Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). |

### Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

## SECTION 3 Administrative Changes

| Description | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Medicare Prescription Payment Plan** | Not applicable | The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).<br>To learn more about this payment option, please contact us at (505) 923-7675 or 1-855-465-7737. (TTY only, call 711.) or visit Medicare.gov. |

## SECTION 4 Deciding Which Plan to Choose

### Section 4.1 – 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 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

**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 Turquoise Care (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

## SECTION 6 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 (https://aging.nm.gov/).

For questions about your Turquoise Care (Medicaid) benefits, contact Turquoise 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 Turquoise Care (Medicaid) coverage.

## SECTION 7 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, yearly deductibles, and coinsurance. Because you qualify, you do not have a 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.
- **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. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. 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. Resources and Enrollment Locations can be found at https://nmhivguide.org. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you are currently enrolled how to continue receiving assistance, call the New Mexico Department of Health, AIDS Drugs Assistance Program at (505) 479-1573. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must

offer this payment option. To learn more about this payment option, please contact us at (505) 923-7675 or 1-855-465-7737. (TTY only, call 711.) or visit Medicare.gov.

# SECTION 8 Questions?

## Section 8.1 – 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 *2025 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 2025. For details, look in the *2025 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 Member Services 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 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

**Visit the Medicare Website**

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

**Read *Medicare & You 2025***

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Section 8.3 – Getting Help from Medicaid

To get information from Turquoise Care (Medicaid) you can call Turquoise 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

## 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。