PRESBYTERIAN

Presbyterian Senior Care Plan 3 with Rx (HMO)
offered by Presbyterian Health Plan, Inc.

2022
Annual Notice of Changes



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



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

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



info@phs.org

www.phs.org/Medicare

PRESBYTERIAN

Important Information for Presbyterian Senior Care (HMO/HMO-POS)

Thank you for allowing Presbyterian Senior Care to be your partner in health! This document outlines the changes you can expect for the 2022 plan year. We also want to make sure you have access to important information such as your health plan's Provider Directory, Formulary, and Evidence of Coverage (EOC). See below for details on where to find the most current list of providers, pharmacies, and covered prescription drugs in your network, 24/7.

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

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

- **Formulary**
  The Formulary lists generic and brand-name prescription drugs and the coverage amount or copayment you will need to pay for each prescription. Formularies will be available on October 15, 2021.

- **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, 2021.

Contact Us

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

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

info@phs.org

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

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

PRESBYTERIAN

Presbyterian Senior Care Plan 3 with Rx (HMO) offered by Presbyterian Health Plan, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Presbyterian Senior Care Plan 3 with Rx (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second

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

Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ 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, 2021, you will be enrolled in Presbyterian Senior Care Plan 3 with Rx (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Presbyterian Senior Care Plan 3 with Rx (HMO).
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Presbyterian Customer Service Center (customer service) at (505) 923-6060 or 1-800-797-5343 for additional information. (TTY users should call 711.) Hours are Sunday through Saturday, 8 a.m. to 8 p.m., 7 days a week. If you are calling from **April 1 through September 30**, our hours are 8 a.m. to 8 p.m., Monday through Friday (except holidays).
- Customer service has free language interpreter services available for non-English speakers.
- This information is available in other formats. Contact the plan for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Presbyterian Senior Care Plan 3 with Rx (HMO)

- Presbyterian Senior Care (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in Presbyterian Senior Care (HMO) depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Presbyterian Health Plan, Inc. When it says "plan" or "our plan," it means Presbyterian Senior Care Plan 3 with Rx (HMO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Presbyterian Senior Care Plan 3 with Rx (HMO) in several important areas. **Please note this is only a summary of changes.** 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*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	$120	$120
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.)	$3,000	$3,000
Doctor office visits	**Primary care visits:** You pay a $5 copayment per visit **Specialist visits:** You pay a $40 copayment per visit	**Primary care visits:** You pay a $5 copayment per visit **Specialist visits:** You pay a $40 copayment per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**Per admission, you pay:** $225 copayment per day for days 1-5. (No charge for the remainder of your stay)	**Per admission, you pay:** $225 copayment per day for days 1-5. (No charge for the remainder of your stay)

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call customer service (phone numbers for customer service are printed on the back cover of this booklet). (See Section 2.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: $95 • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: $95 • Drug Tier 5: 33% coinsurance

Annual Notice of Changes for 2022
Table of Contents

Summary of Important Costs for 2022 1

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Presbyterian Senior Care Plan 3 with Rx (HMO) in 2022 4

SECTION 2 Changes to Benefit and Cost for Next Year 4

Section 2.1 – Changes to the Monthly Premium 4
Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount 5
Section 2.3 – Changes to the Provider Network 5
Section 2.4 – Changes to the Pharmacy Network 6
Section 2.5 – Changes to Benefits and Costs for Medical Services 6
Section 2.6 – Changes to Part D Prescription Drug Coverage 8

SECTION 3 Deciding Which Plan to Choose 12

Section 3.1 – If you want to stay in Presbyterian Senior Care Plan 3 with Rx (HMO) 12
Section 3.2 – If you want to change plans 12

SECTION 4 Deadline for Changing Plans 13

SECTION 5 Programs That Offer Free Counseling about Medicare 13

SECTION 6 Programs That Help Pay for Prescription Drugs 13

SECTION 7 Questions? 14

Section 7.1 – Getting Help from Presbyterian Senior Care Plan 3 with Rx (HMO) 14
Section 7.2 – Getting Help from Medicare 15

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Presbyterian Senior Care Plan 3 with Rx (HMO) in 2022

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our Presbyterian Senior Care Plan 3 with Rx (HMO). This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through our plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Presbyterian Senior Care Plan 3 with Rx (HMO) and the benefits you will have on January 1, 2022 as a member of Presbyterian Senior Care Plan 3 with Rx (HMO).

SECTION 2 Changes to Benefit and Cost for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$120	$120
Optional Supplemental Dental Coverage This plan premium applies to you only if you enroll in our Comprehensive Dental Plan.	$19	$9

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.

- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) 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.	$3,000	$3,000 Once you have paid $3,000 out-of-pocket for covered 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 Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.phs.org/Medicare. You may also call customer service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) 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. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 2.4 – Changes to the Pharmacy Network

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.

There are changes to our network of pharmacies for next year. An updated *Provider Directory* is located on our website at www.phs.org/Medicare. You may also call customer service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see which pharmacies are in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2022 *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Comprehensive Dental Plan Our optional Comprehensive Dental Plan is in addition to the Basic Dental Plan to which you will be automatically enrolled. The Comprehensive Dental plan offers dental benefits that are not covered by Original Medicare.		

Cost	2021 (this year)	2022 (next year)
Comprehensive Dental Plan (continued)		
• The maximum calendar year benefit is not subject to the plan out-of-pocket maximum and is based on what you and your plan pay for dental services. • There is no deductible or waiting period.	$3,000	$4,000
• Fillings, extractions and denture adjustments/repairs.	You pay a 20-50% coinsurance.	You pay a 20-50% coinsurance.
• Major restoratives (for example, crowns, bridges, root canals, dentures, periodontics, implants, and anesthesia).	Coverage for implants	Implants are **not** covered
See the *Evidence of Coverage* (Chapter 4, Section 2.2) for details about the benefits, deductibles, and coinsurance amounts		
If you want these optional supplemental dental benefits, you must sign up for them and pay an additional monthly premium. We will send information to you by mail in October and you can also contact customer service. (Phone numbers are in Section 7.1 of this booklet). You can enroll in the Comprehensive Dental Plan anytime and your coverage will become effective the first day of the following month. If you disenroll from the comprehensive plan you cannot re-enroll until the following year.	Optional supplemental dental benefit monthly premium: $19	Optional supplemental dental benefit monthly premium: $9

Cost	2021 (this year)	2022 (next year)
Physician/Practitioner services including doctor's office visits • Individual and group sessions for mental health specialty, psychiatric, and outpatient substance use disorder services • Outpatient rehabilitation services, including physical, occupational, and speech language therapy • PCP/other health care professional services, specialist services • Urgently needed services You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	Cost-sharing for these types of telehealth service categories is the same as services rendered in person	No Charge
Vision Care Routine eyewear (frames, lenses, contacts, and contact lens fittings)	Not Covered	$250 allowance every year

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call customer service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call customer service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you were granted a formulary exception in 2021, you will need to submit a new request for 2022.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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. Because you receive "Extra Help," if you haven't received this insert by October 1, 2021, please call customer service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in 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.*)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1-Preferred Generic:** You pay $0 per prescription **Tier 2-Generic:** You pay $10 per prescription **Tier 3-Preferred Brand:** You pay $45 per prescription **Tier 4-Non-Preferred Drug:** You pay $95 per prescription **Specialty Tier:** You pay 33% of the total cost of the prescription You pay $35 for select insulins. Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage)	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1-Preferred Generic:** You pay $0 per prescription **Tier 2-Generic:** You pay $10 per prescription **Tier 3-Preferred Brand:** You pay $45 per prescription **Tier 4-Non-Preferred Drug:** You pay $95 per prescription **Specialty Tier:** You pay 33% of the total cost of the prescription You pay $35 for select insulins. Once your total drug costs have reached $4,430, 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. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $35. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For 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 Senior Care Plan 3 with Rx (HMO)

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 2022 Presbyterian Senior Care Plan 3 with Rx (HMO).

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 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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 Senior Care Plan 3 with Rx (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Presbyterian Senior Care Plan 3 with Rx (HMO).
- 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 this (phone numbers are in Section 7.1 of this booklet).

- – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

New Mexico Aging and Long-Term Services is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Mexico Aging and Long-Term Services counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call New Mexico Aging and Long-Term Services at 1-800-432-2080 or TTY (505) 476-4937. You can learn more about New Mexico Aging and Long-Term Services by visiting their website (www.nmaging.state.nm.us/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage

gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Mexico Department of Health AIDS Drug Assistance Program:

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

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

SECTION 7 Questions?

Section 7.1 – Getting Help from Presbyterian Senior Care Plan 3 with Rx (HMO)

Questions? We're here to help. Please call customer service at (505) 923-6060 or 1-800-797-5343. (TTY only, call 711). We are available for phone calls Sunday through Saturday, 8 a.m. to 8 p.m., 7 days a week. If you are calling from **April 1 through September 30**, customer service hours will be 8 a.m. to 8 p.m., Monday through Friday (except holidays). Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Presbyterian Senior Care Plan 3 with Rx (HMO). 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

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) 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.

Information regarding hospice

For more information about the coordination of your palliative care and hospice program, contact our Care Coordination Department at (505) 923-8858 or 1-866-672-1242 (TTY 711).