PRESBYTERIAN

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

Contract ID: H3204-013-005

2022
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 2022 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, 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) 923-7675
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)

PRESBYTERIAN

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

Annual Notice of Changes for 2022

Contract ID: H3204-013-005

You are currently enrolled as a member of Presbyterian Dual Plus (HMO D-SNP*)*. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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 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

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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 Dual Plus (HMO D-SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 3.2 (page 13) to learn more about your choices.

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 Dual Plus (HMO D-SNP).
- If you join another plan between **October 15** and **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) 923-7675 or 1-855-465-7737 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**, customer service hours will be 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 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.
- When this booklet 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).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Presbyterian Dual Plus (HMO D-SNP) 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*.

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	2021 (this year)	2022 (next year)
Monthly plan premium*	$28.20	$28.40
*Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	Based on your level of Low Income Subsidy, your plan premium could be paid by Medicare.	Based on your level of Low Income Subsidy, your plan premium could be paid by Medicare.
Deductible	Your deductible for 2021 was $203. (Depending on your level of assistance through the New Mexico Human Services Department.)	Your deductible for 2022 is $203. You will be notified if Medicare changes this amount for 2022. $0 if you are enrolled in Medicaid as a Qualified Medicare Beneficiary (QMB) or if you are enrolled in Medicaid with full benefits (non-QMB). Out-of-pocket will depend on your level of assistance through the New Mexico Human Services Department.
Doctor office visits	**Primary care visits:** You pay $0-20% per visit **Specialist visits:** You pay $0-20% per visit	**Primary care visits:** You pay $0-20% per visit **Specialist visits:** You pay $0-20% per visit

Cost	2021 (this year)	2022 (next year)
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:** $1,484 for each benefit period. Days 1-60: $0 copayment Days 61-90: $371 copayment Days 91 and beyond: $742 copayment (Depending on your level of assistance through the New Mexico Human Services Department.)	**Per admission, you pay:** $1,484 for each benefit period. Days 1-60: $0 copayment Days 61-90: $371 copayment Days 91 and beyond: $742 copayment (Depending on your level of assistance through the New Mexico Human Services Department.) You will be notified if Medicare changes this amount for 2022.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible and cost-sharing are based on your level of "Extra Help." Please review your "LIS Rider" for information about your specific cost-share. If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs **Deductible:** • $0 or • $92 **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.30 copay; • Or $3.70 copay; • Or 15% coinsurance **For all other covered drugs:** • $0 copay; • Or $4.00; • Or $9.20; • Or 15% coinsurance **If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs**	Deductible and cost-sharing are based on your level of "Extra Help." Please review your "LIS Rider" for information about your specific cost-share. If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs **Deductible:** • $0 or • $99 **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.35 copay; • Or $3.95 copay; • Or 15% coinsurance **For all other covered drugs:** • $0 copay; • Or $4.00; • Or $9.85; • Or 15% coinsurance **If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs**

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (continued)	**Deductible:** $445 You pay 25% of the total cost of your medications.	**Deductible:** $480 • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: 45% coinsurance • Drug Tier 5: 25% coinsurance
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.)	$7,550 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. 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.	$7,550 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. 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.

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Presbyterian Dual Plus (HMO D-SNP) in 2022

If you do nothing to change your Medicare coverage in 2021, we will automatically enroll you in our Presbyterian Dual Plus (HMO D-SNP). This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through Presbyterian Dual Plus (HMO D-SNP). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you want to change, you can do so between now and December 7. The change will take effect on January 1, 2022.

The information in this document tells you about the differences between your current benefits in Presbyterian Dual Plus (HMO D-SNP) and the benefits you will have on January 1, 2022 as a member of Presbyterian Dual Plus (HMO D-SNP).

SECTION 2 Changes to Benefits and Costs 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 unless it is paid for you by Medicaid.	$28.20 Based on your level of Low Income Subsidy, your plan premium could be paid by Medicare.	$28.40 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

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 **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** 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. 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.	$7,550 Once you have paid $7,550 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.	$7,550 Once you have paid $7,550 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 – There are No Changes to your Benefits or Amounts you Pay for Medical Services

Our benefits and what you pay for these covered medical services will be exactly the same in 2022 as they are in 2021.

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 will send 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage.*)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	Your deductible amount is either $0, $92, or $445, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	Your deductible amount is either $0, $99, or $480, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

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 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.**	Cost-sharing is based on your level of "Extra Help." Please review your "LIS Rider" for information about your specific cost-share. **If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs** **Deductible:** • $0 or • $92 **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.30 copay; • Or $3.70 copay; • Or 15% coinsurance **For all other covered drugs:** • $0 copay; • Or $4.00; • Or $9.20; • Or 15% coinsurance	Cost-sharing is based on your level of "Extra Help." Please review your "LIS Rider" for information about your specific cost-share. **If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs** **Deductible:** • $0 or • $99 **For generic drugs (including brand drugs treated as generic):** • $0 copay; • Or $1.35 copay; • Or $3.95 copay; • Or 15% coinsurance **For all other covered drugs:** • $0 copay; • Or $4.00; • Or $9.85; • Or 15% coinsurance

Stage	2021 (this year)	2022 (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.	**If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs** **Deductible:** $445 You pay 25% of the total cost of your medications. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs** **Deductible:** $480 • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $45 • Drug Tier 4: 45% coinsurance • Drug Tier 5: 25% coinsurance _____ 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 Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or 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, you will automatically be enrolled in our 2022 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 2022 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.

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, 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 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 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.

  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, 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.

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 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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/).

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.

- **"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 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. 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 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 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 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

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.

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.