

# 2018

## Summary of Benefits

Effective January 1, 2018 through December 31, 2018

- Keystone 65 Preferred Medical-Only HMO
- Keystone 65 Preferred Rx HMO

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This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the ***Evidence of Coverage***.

This *Summary of Benefits* booklet gives you a summary of what Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO cover and what you pay.

Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO are Medicare Advantage HMO (Health Maintenance Organization) plans. With an HMO plan, members choose a family doctor, called a primary care physician (PCP), who provides the services they need. When they need specialized care, PCPs refer members to other doctors or health care providers within the HMO provider network.

If you want to compare our plans with other available Medicare health plans, ask the other plan(s) for their *Summary of Benefits* booklet. Or, use the Medicare Plan Finder at [www.medicare.gov](http://www.medicare.gov).

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy 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.

## **Sections of this booklet**

- Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Keystone 65 Preferred Rx HMO

## **Who can join?**

To join Keystone 65 Preferred Medical-Only HMO or Keystone 65 Preferred Rx HMO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

## **Which doctors, hospitals, and pharmacies can I use?**

Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, we may not pay for these services. Keystone 65 Preferred Rx HMO also has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our list of network providers and pharmacies (*Provider/Pharmacy Directory*), please visit [www.ibxmedicare.com](http://www.ibxmedicare.com).

Keystone 65 Preferred Rx HMO covers Part D drugs. In addition, the plan covers Part B drugs such as chemotherapy and some other drugs administered by your provider. You can see our complete plan *Formulary (List of Covered Drugs)* and any restrictions on our website, [www.ibxmedicare.com](http://www.ibxmedicare.com).

Keystone 65 Preferred Medical-Only HMO covers Part B drugs, including chemotherapy and some other drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

## Monthly Plan Premium

### Keystone 65 Preferred HMO

If You Live In...	And You Have...	
	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
	You Pay...	
<b>Chester, Delaware, or Montgomery County</b>	\$224	\$289
<b>Bucks or Philadelphia County</b>	\$178	\$229
You must continue to pay your Medicare Part B premium.		

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Deductible</b>	This plan does not have a deductible for covered medical services.	This plan does not have a deductible for covered medical services.  This plan does not have a deductible for Part D prescription drugs.
<b>Maximum Out-of-Pocket</b> (the amounts you pay for your premium, Part D prescription drugs and some medical services do not count toward your maximum out-of-pocket)	\$4,000 each year  Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	\$4,000 each year  Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.
<b>Covered Medical and Hospital Benefits</b>		
<b>Inpatient Hospital Coverage (1)</b>	\$250 copayment per day for days 1 through 6 per admission  You pay nothing per day for days 7 and beyond per admission  \$1,500 maximum copayment per admission  Unlimited days per benefit period	\$250 copayment per day for days 1 through 6 per admission  You pay nothing per day for days 7 and beyond per admission  \$1,500 maximum copayment per admission  Unlimited days per benefit period
<b>Outpatient Hospital Coverage</b> • <b>Ambulatory Surgical Center(1)</b> • <b>Outpatient Hospital Facility (1)</b> • <b>Observation Services</b>	\$125 copayment  \$400 copayment  \$400 copayment per stay	\$125 copayment  \$400 copayment  \$400 copayment per stay
<b>Doctor's Office Visits</b> • <b>Primary Care Physician</b> • <b>Specialist</b>	\$5 copayment  \$40 copayment	\$5 copayment  \$40 copayment

Services with a (1) may require prior authorization.

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)	You pay nothing Please refer to the <i>Evidence of Coverage</i> for a complete listing of services. Any additional preventive services approved by Medicare during the contract year will be covered at the appropriate cost-share.	You pay nothing Please refer to the <i>Evidence of Coverage</i> for a complete listing of services. Any additional preventive services approved by Medicare during the contract year will be covered at the appropriate cost-share.
<b>Emergency Care</b> — covered worldwide	\$80 copayment Not waived if admitted	\$80 copayment Not waived if admitted
<b>Urgently Needed Services</b> — covered worldwide	\$5 copayment in a retail clinic Not waived if admitted  \$40 copayment in an urgent care center Not waived if admitted  \$80 copayment per visit outside of U.S. Not waived if admitted	\$5 copayment in a retail clinic Not waived if admitted  \$40 copayment in an urgent care center Not waived if admitted  \$80 copayment per visit outside of U.S. Not waived if admitted
<b>Diagnostic Services(1), Lab and Radiology Services (1), and X-rays (1)</b>		
• <b>Diagnostic Radiology Services</b>	\$40 or \$150 copayment depending on service	\$40 or \$150 copayment depending on service
• <b>Lab Services</b>	You pay nothing	You pay nothing
• <b>Diagnostic Tests and Procedures</b>	You pay nothing	You pay nothing
• <b>Outpatient X-rays</b>	\$40 copayment for routine radiology services	\$40 copayment for routine radiology services
<b>Hearing Services</b>		
• <b>Hearing Exam</b>	\$40 copayment for Medicare-covered hearing exams \$40 copayment for routine non-Medicare-covered hearing exams once every year	\$40 copayment for Medicare-covered hearing exams \$40 copayment for routine non-Medicare-covered hearing exams once every year
• <b>Hearing Aid</b>	\$699 or \$999 copayment per year, per ear when purchased through TruHearing	\$699 or \$999 copayment per year, per ear when purchased through TruHearing

Services with a (1) may require prior authorization.

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Dental Services</b>	<p>\$40 copayment for non-routine Medicare-covered dental services in a specialist office</p> <p>\$0 copayment for non-routine Medicare-covered dental services in an inpatient facility</p> <p>\$20 copayment for routine dental care (1 visit every 6 months)</p>	<p>\$40 copayment for non-routine Medicare-covered dental services in a specialist office</p> <p>\$0 copayment for non-routine Medicare-covered dental services in an inpatient facility</p> <p>\$20 copayment for routine dental care (1 visit every 6 months)</p>
<b>Vision Services</b>	<p>\$40 copayment for Medicare-covered eye exams to diagnose and treat diseases of the eye</p> <p>\$0 copayment for diabetic retinal exam</p> <p>\$0 copayment for glaucoma screening</p> <p>\$0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery</p> <p>\$40 copayment for non-Medicare-covered routine eye exams (1 exam every 2 years) You must use a participating provider.</p> <p>Covered up to \$100 every 2 years for non-Medicare-covered eyewear</p> <p>Coverage for a pair of eyeglasses will include the allowance for a standard frame and lenses. A deluxe frame and/or progressive lens will be paid up to the allowance for the standard frame and/or lens.</p>	<p>\$40 copayment for Medicare-covered eye exams to diagnose and treat diseases of the eye</p> <p>\$0 copayment for diabetic retinal exam</p> <p>\$0 copayment for glaucoma screening</p> <p>\$0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery</p> <p>\$40 copayment for non-Medicare-covered routine eye exams (1 exam every 2 years) You must use a participating provider.</p> <p>Covered up to \$100 every 2 years for non-Medicare-covered eyewear</p> <p>Coverage for a pair of eyeglasses will include the allowance for a standard frame and lenses. A deluxe frame and/or progressive lens will be paid up to the allowance for the standard frame and/or lens.</p>

Services with a (1) may require prior authorization.

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Mental Health Services</b>		
• <b>Inpatient Mental Health Care(1)</b>	\$200 copayment per day for days 1 through 7  You pay nothing per day for days 8 and beyond  \$1,400 maximum copayment per admission  190-day lifetime maximum in a mental health facility	\$200 copayment per day for days 1 through 7  You pay nothing per day for days 8 and beyond  \$1,400 maximum copayment per admission  190-day lifetime maximum in a mental health facility
• <b>Outpatient Therapy (Group and Individual)</b>	\$40 copayment	\$40 copayment
• <b>Outpatient Substance Abuse Services (Group and Individual)</b>	\$40 copayment	\$40 copayment
• <b>Partial Hospitalization (1)</b>	\$40 copayment	\$40 copayment
<b>Skilled Nursing Facility(1)</b>	You pay nothing per day for days 1 through 20 per admission  \$150 copayment per day for days 21 through 100 per admission  100 days per benefit period	You pay nothing per day for days 1 through 20 per admission  \$150 copayment per day for days 21 through 100 per admission  100 days per benefit period
<b>Physical Therapy</b>	\$40 copayment	\$40 copayment
<b>Ambulance(1)</b>	\$150 copayment for a one-way trip Not waived if admitted  Non-emergency ambulance services require prior authorization	\$150 copayment for a one-way trip Not waived if admitted  Non-emergency ambulance services require prior authorization
<b>Transportation</b>	Not covered	Not covered
<b>Medicare Part B Drugs(1)</b>	20% coinsurance for Part B drugs such as chemotherapy drugs  For a description of the types of drugs available under Part B, see your <i>Evidence of Coverage</i>	20% coinsurance for Part B drugs such as chemotherapy drugs  For a description of the types of drugs available under Part B, see your <i>Evidence of Coverage</i>

Services with a (1) may require prior authorization.



## Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Keystone 65 Preferred Rx HMO. This benefit is not available for members of Keystone 65 Preferred Medical-Only HMO.

	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<p><b>Initial Coverage Stage</b></p>	<p>Part D prescription drugs are not available with this plan.</p>	<p>You pay the following until your total yearly drug costs reach \$3,750. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail-order pharmacies.</p> <p>Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. You may fill your prescriptions at either a preferred or standard pharmacy. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies.</p> <p>For information, please review the Keystone 65 Rx HMO <i>Evidence of Coverage</i>.</p>

**Keystone 65  
Preferred  
Medical-Only HMO**

**Keystone 65  
Preferred  
Rx HMO**

**Retail Cost-sharing**  
(what you pay at a  
pharmacy location)

<b>Tier</b>		One- Month Supply	Two- Month Supply	Three- Month Supply
<b>Tier 1</b> (Preferred Generic Drugs)	Part D prescription drugs are not available with this plan.			
<b>Preferred Pharmacy</b>		\$2 copayment	\$4 copayment	\$6 copayment
<b>Standard Pharmacy</b>		\$7 copayment	\$14 copayment	\$21 copayment
<b>Tier 2</b> (Generic Drugs)				
<b>Preferred Pharmacy</b>		\$10 copayment	\$20 copayment	\$30 copayment
<b>Standard Pharmacy</b>		\$16 copayment	\$32 copayment	\$48 copayment
<b>Tier 3</b> (Preferred Brand Drugs)				
<b>Preferred Pharmacy</b>		\$47 copayment	\$94 copayment	\$141 copayment
<b>Standard Pharmacy</b>		\$47 copayment	\$94 copayment	\$141 copayment
<b>Tier 4</b> (Non-Preferred Drugs)				
<b>Preferred Pharmacy</b>		\$100 copayment	\$200 copayment	\$300 copayment
<b>Standard Pharmacy</b>		\$100 copayment	\$200 copayment	\$300 copayment
<b>Tier 5</b> (Specialty Drugs)				
<b>Preferred Pharmacy</b>	33% coinsurance	33% coinsurance	33% coinsurance	
<b>Standard Pharmacy</b>	33% coinsurance	33% coinsurance	33% coinsurance	

**Keystone 65  
Preferred  
Medical-Only  
HMO**

**Keystone 65  
Preferred  
Rx HMO**

**Mail-Order Cost-sharing**  
(what you pay when you order a  
prescription by mail)

<b>Tier</b>		One- Month Supply	Two- Month Supply	Three- Month Supply
<b>Tier 1</b> (Preferred Generic Drugs)	Part D prescription drugs are not available with this plan.	\$2 copayment	\$4 copayment	\$4 copayment
<b>Tier 2</b> (Generic Drugs)		\$10 copayment	\$20 copayment	\$20 copayment
<b>Tier 3</b> (Preferred Brand Drugs)		\$47 copayment	\$94 copayment	\$94 copayment
<b>Tier 4</b> (Non-Preferred Drugs)		\$100 copayment	\$200 copayment	\$200 copayment
<b>Tier 5</b> (Specialty Drugs)		33% coinsurance	33% coinsurance	33% coinsurance

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Initial Coverage Stage</b>	Part D prescription drugs are not available with this plan.	<p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy. This plan has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy used.</p> <p>You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.</p>
<b>Coverage Gap Stage</b>	Part D prescription drugs are not available with this plan.	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,750.</p> <p>After you enter the coverage gap, you pay 35% of the plan’s cost for covered brand-name drugs and 44% of the plan’s cost for covered generic drugs until your costs total \$5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>
<b>Catastrophic Coverage Stage</b>	Part D prescription drugs are not available with this plan.	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,000, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the costs, or;</li> <li>• \$3.35 copayment for generic (including brand drugs tested as generic) and an \$8.35 copayment for all other drugs</li> </ul>

## Other Medical Benefits

	<b>Keystone 65 Preferred Medical-Only HMO</b>	<b>Keystone 65 Preferred Rx HMO</b>
<b>Podiatry Services</b> <ul style="list-style-type: none"> <li>• <b>Medical Condition</b></li> <li>• <b>Routine Foot Care (Medicare-covered)</b></li> <li>• <b>Routine Foot Care (non-Medicare-covered)</b></li> </ul>	<p>\$40 copayment per visit for condition treatment</p> <p>\$40 copayment per visit for Medicare-covered routine care</p> <p>\$40 copayment per visit for non-Medicare-covered routine foot care (up to 6 visits each year)</p>	<p>\$40 copayment per visit for condition treatment</p> <p>\$40 copayment per visit for Medicare-covered routine care</p> <p>\$40 copayment per visit for non-Medicare-covered routine foot care (up to 6 visits each year)</p>
<b>Durable Medical Equipment (1) and Prosthetic Devices and Related Supplies (1)</b>	<p>0-20% coinsurance</p>	<p>0-20% coinsurance</p>
<b>Wellness Programs</b>	<p>SilverSneakers® included at no additional cost</p> <p>A toll-free hotline with nurses available 24 hours a day, 7 days a week</p> <p>Disease Management included at no additional cost</p> <p>Access to a health coach included at no additional cost</p>	<p>SilverSneakers® included at no additional cost</p> <p>A toll-free hotline with nurses available 24 hours a day, 7 days a week</p> <p>Disease Management included at no additional cost</p> <p>Access to a health coach included at no additional cost</p>
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>• <b>Medical Condition</b></li> <li>• <b>Routine Care (non-Medicare-covered)</b></li> </ul>	<p>\$20 copayment per visit for spinal manipulations</p> <p>\$20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year)</p>	<p>\$20 copayment per visit for spinal manipulations</p> <p>\$20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year)</p>

Services with a (1) may require prior authorization.

## Language Assistance Services

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deutsch schwetzsch, kannscht du Hilf grieg in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

### Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

### Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

**Mon-Khmer, Cambodian:** សូមមេត្តាចាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ ។ ទូរសព្ទទៅលេខ 1-800-275-2583 ។

## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: [civilrightscoordinator@1901market.com](mailto:civilrightscoordinator@1901market.com). If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Keystone 65 HMO

PO Box 13713

Philadelphia, PA 19101-3713

[www.ibxmedicare.com](http://www.ibxmedicare.com)

### For more information

For updated information regarding plan providers, visit our website at [www.ibxmedicare.com](http://www.ibxmedicare.com), or call the Member Help Team at 1-800-645-3965 (TTY/TDD: 711), seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from February 15 through September 30, your call may be sent to voicemail.

If you are not yet a member and have questions, please call 1-877-393-6733 or TTY/TDD: 711, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from February 15 through September 30, your call may be sent to voicemail. By calling this number you will be directed to a licensed sales agent.

Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal.

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To receive this document in an alternate format such as Braille, large print, or audio, please call 1-877-393-6733 (non-members) (by calling this number you will be directed to a licensed sales agent) or 1-800-645-3965 (members) (TTY/TDD: 711).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.