Keystone 65 HMO

Keystone 65 Basic Rx (HMO) offered by Keystone Health Plan East, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of Keystone 65 Basic Rx. 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 1 and 2 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 2019 Drug List and look in Section 1.6 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 https://go.medicare.gov/drugprices. 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.

OMB Approval 0938-1051 (Pending OMB Approval)

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider/Pharmacy 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 https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You 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 want to **keep** Keystone 65 Basic Rx, you don't need to do anything. You will stay in Keystone 65 Basic Rx.
- 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, 2018.**

- If you **don't join another plan by December 7, 2018**, you will stay in Keystone 65 Basic Rx.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- To receive this document in an alternate format such as Braille, large print or audio, please contact our Member Help Team.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Keystone 65 Basic Rx

- Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Keystone Health Plan East, Inc. When it says “plan” or “our plan,” it means Keystone 65 Basic Rx.
- This information is not a complete description of benefits. Call 1-800-645-3965 (TTY/TDD: 711) for more information.

Y0041_H3952_KS_M_19_67088 accepted 8/24/2018

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Keystone 65 Basic Rx in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* located on our website at https://www.ibxmedicare.com to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$475	$0
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $15 copayment per visit Specialist visits: $50 copayment per visit	Primary care visits: • $0 copayment per visit for preferred primary care physician • $15 copayment per visit for standard primary care physician Specialist visits: $45 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.	$300 copayment per day for days 1-6 per admission after deductible is met	$300 copayment per day for days 1-6 per admission $1,800 maximum copayment per admission

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $300 (Tiers 3-5) Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $18 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 27% Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $3 • Drug Tier 2: $12 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 27%	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33% Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $2 • Drug Tier 2: $10 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33%

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Choice Program – Optional Supplemental Benefits (For an additional monthly premium, you receive dental, hearing and vision coverage.)	$6	$7
Choice Plus Program – Optional Supplemental Benefits (For an additional monthly premium, you receive dental, hearing and vision coverage.)	Not covered	$20

- 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.

Section 1.2 – 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	2018 (this year)	2019 (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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 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 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2019. An updated *Provider/Pharmacy Directory* is located on our website at https://www.ibxmedicare.com. You may also call our Member Help Team for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory.* **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still 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, Medicare requires that we 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 and managing your care.

Section 1.4 – 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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at https://www.ibxmedicare.com. You may also call our Member Help Team for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2019 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – 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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Ambulance services	You pay a $300 copayment per one-way trip by ground ambulance.	You pay a $300 copayment per one-way trip by ground or air ambulance.

Cost	2018 (this year)	2019 (next year)
Dental services	You pay a $50 copayment for Medicare-covered dental services.	You pay a $45 copayment for Medicare-covered dental services.
	Routine dental care is covered under the **Choice Program** for an additional premium: • You pay a $10 copayment per visit for one exam and cleaning every six months. • Dental X-rays are **<u>not</u>** covered.	Routine dental care is covered under the **Choice Program** for an additional premium: • You pay a $10 copayment per visit for one exam and cleaning every six months. • You pay a $0 copayment for one dental X-ray every year.
	Enhanced optional supplemental benefits are **<u>not</u>** covered.	Routine dental exams, cleanings, X-rays, and restorative services are covered under the **Choice Plus Program** for an additional premium: • You pay a $0 copayment per visit for one exam and cleaning every six months. • You pay a $0 copayment for one dental X-ray every year. • You pay a $0 copayment for restorative dental services. • You have a $500 allowance per year for restorative dental services.

Cost	2018 (this year)	2019 (next year)
Diabetes self-management training, diabetic services and supplies	There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. You pay a $0 copayment for diabetic test strips and monitors. You pay a $0 copayment for lancets and solutions. You pay a 20% coinsurance for custom-molded shoes and inserts. You pay a 20% coinsurance for insulin pumps and related supplies.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. You pay a $0 copayment for diabetic test strips and monitors. You pay a $0 copayment for lancets and solutions. You pay a $0 copayment for custom-molded shoes and inserts. You pay a $0 copayment for insulin pumps and related supplies.
Diagnostic colonoscopy	You pay a $200 copayment for a diagnostic colonoscopy performed in an ambulatory surgical center. You pay a $350 copayment for a diagnostic colonoscopy performed in an outpatient hospital facility.	You pay a $200 copayment for a diagnostic colonoscopy performed in an ambulatory surgical center. You pay a $350 copayment for a diagnostic colonoscopy performed in an outpatient hospital facility. A copayment will not apply for a preventive colonoscopy that becomes diagnostic received in an ambulatory surgical center or outpatient hospital.
Emergency care	You pay an $80 copayment for emergency care.	You pay a $90 copayment for emergency care.

Hearing services	You pay a $50 copayment for a Medicare-covered hearing exam.	You pay a $45 copayment for a Medicare-covered hearing exam.
	Routine hearing care is covered under the **Choice Program** for an additional premium: • You pay a $40 copayment per visit with a TruHearing provider for one routine hearing exam per year. • You pay a $0 copayment for fitting and evaluation for hearing aids, covered 2 times every year. • You pay a $699 copayment per year, per ear for standard digital hearing aid; or, $999 copayment per year, per ear for premium digital hearing aid when purchased through TruHearing.	Routine hearing care is covered under the **Choice Program** for an additional premium: • You pay a $40 copayment per visit with a TruHearing provider for one routine hearing exam per year. • You pay a $0 copayment for fitting and evaluation for hearing aids, covered 3 times every year. • You pay a $699 copayment per year, per ear for standard digital hearing aid; or, $999 copayment per year, per ear for premium digital hearing aid when purchased through TruHearing.
	Enhanced optional supplemental benefits are **<u>not</u>** covered.	Routine hearing care is covered under the **Choice Plus Program** for an additional premium: • You pay a $10 copayment per visit with a TruHearing provider for one routine hearing exam per year. • You pay a $0 copayment for fitting and evaluation for hearing aids, covered 3 times every year. • You pay a $499 copayment per year, per ear for standard digital hearing aid; or, $799 copayment per year, per ear for premium digital hearing aid when purchased through TruHearing.

Cost	2018 (this year)	2019 (next year)
Hospice care	You pay a $15 copayment for a one-time hospice consultation with your primary care provider. You pay a $50 copayment for a one-time hospice consultation with a specialist.	You pay a $0 copayment at a preferred PCP or a $15 copayment at a standard PCP for a one-time hospice consultation with your primary care provider. You pay a $45 copayment for a one-time hospice consultation with a specialist.
Inpatient hospital stays	You pay a $300 copayment per day for days 1-6 per admission after deductible is met.	You pay a $300 copayment per day for days 1-6 per admission. You pay a $1,800 maximum copayment per admission.
Inpatient mental health care stays	You pay a $270 copayment per day for days 1-6 per admission after deductible is met.	You pay a $270 copayment per day for days 1-6 per admission. You pay a $1,620 maximum copayment per admission.

Cost	2018 (this year)	2019 (next year)
Medical nutrition therapy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. We cover: • Three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. We cover: ▪ Three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. ▪ Up to four additional visits for Medicare-covered medical nutrition therapy visits. ▪ Up to four medical nutritional therapy visits for routine medical conditions (non-Medicare), such as high blood pressure, high cholesterol and gluten intolerance.
Other health care professional Medicare-covered benefits	You pay a $0 copayment for provider visits received in a home setting. You pay a $50 copayment for provider visits received in an office, clinic, or outpatient setting.	You pay a $0 copayment for provider visits received in a home setting. You pay a $45 copayment for provider visits received in an office, clinic, or outpatient setting.

Cost	2018 (this year)	2019 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	*EKG Screening:* There is no coinsurance, copayment, or deductible. *Laboratory Tests:* There is no coinsurance, copayment, or deductible. *Radiation Therapy:* You pay a $60 copayment per provider, per date of service. *Routine Radiology (X-ray, radiology, diagnostic services, ultrasounds):* You pay a $75 copayment per provider, per date of service. *Complex Radiology (MRI/MRA, CT scans, nuclear cardiology studies):* You pay a $250 copayment per provider, per date of service. If services are performed at a freestanding ambulatory surgical center (ASC) or an outpatient hospital facility (OHF), you may be responsible for a $200 copayment (ASC) or $350 copayment (OHF) per visit.	*EKG Screening:* There is no coinsurance, copayment, or deductible. *Laboratory Tests:* There is no coinsurance, copayment, or deductible. *Radiation Therapy:* You pay a $60 copayment per provider, per date of service. *Routine Radiology (X-ray, radiology, diagnostic services, ultrasounds):* You pay a $45 copayment per provider, per date of service. *Complex Radiology (MRI/MRA, CT scans, nuclear cardiology studies):* You pay a $250 copayment per provider, per date of service. If services are performed at a freestanding ambulatory surgical center (ASC) or an outpatient hospital facility (OHF), you may be responsible for a $200 copayment (ASC) or $350 copayment (OHF) per visit.
Outpatient hospital observation stays	You pay a $350 copayment per stay after deductible is met.	You pay a $350 copayment per stay.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy.	You pay a $40 copayment per provider, per date of service.	You pay a $25 copayment per provider, per date of service.
Over-the-counter (OTC) items	Over-the-counter items are **not** covered.	You have a $30 allowance per quarter for over-the-counter items when purchased through Convey.

Cost	2018 (this year)	2019 (next year)
Palliative care	Home-based palliative care services are **not** offered.	You pay a $0 copayment for home-based palliative care services.
Physician/practitioner services, including doctor's office visits	You pay a $15 copayment per visit for primary care provider. You pay a $50 copayment per visit for specialist. You pay a $50 copayment for non-routine Medicare-covered dental services in a specialist office. You pay a $50 copayment per visit, per provider type for each Medicare-covered hearing exam.	You pay a $0 copayment for a preferred PCP, or a $15 copayment for a standard PCP. You pay a $45 copayment per visit for specialist. You pay a $45 copayment for non-routine Medicare-covered dental services in a specialist office. You pay a $45 copayment per visit, per provider type for each Medicare-covered hearing exam.
Podiatry services	You pay a $50 copayment per visit for Medicare-covered non-routine care. You pay a $50 copayment per visit for Medicare-covered routine care, up to six visits per year.	You pay a $25 copayment per visit for Medicare-covered non-routine care. You pay a $25 copayment per visit for Medicare-covered routine care, up to six visits per year.
Preventive visits and services	If you receive a preventive test that turns into a diagnostic test or service during a breast cancer screening (mammograms) or colorectal cancer screening, you will be charged a copayment or coinsurance. The amount depends on place of service.	If you receive a preventive test that turns into a diagnostic test or service during a breast cancer screening (mammograms) or colorectal cancer screening, the copayment for that diagnostic test will be $0.
Telemedicine visits	Telemedicine visits are **not** covered.	You pay a $5 copayment per visit.

Cost	2018 (this year)	2019 (next year)
Uniform flexibility – Meals program	Meals program is **not** covered.	After an inpatient hospital stay, you can receive three meals per day, seven days per week, up to four weeks, twice per year. You **must have all** of the following conditions to receive meals: ▪ Diabetes ▪ Congestive Heart Failure ▪ Chronic Kidney Disease, Stage 4 or Stage 5
Urgently needed services	You pay a $15 copayment for a retail clinic. You pay a $40 copayment for an urgent care center. You pay an $80 copayment for urgently needed services received outside the U.S.	You pay a $15 copayment for a retail clinic. You pay a $40 copayment for an urgent care center. You pay a $90 copayment for urgently needed services received outside the U.S.

Cost	2018 (this year)	2019 (next year)
Vision care	You pay a $50 copayment for each Medicare-covered eye exam. Enhanced optional supplemental benefits are **not** covered.	You pay a $45 copayment for each Medicare-covered eye exam. Routine eye examinations and eyeglasses are covered under the **Choice Plus Program** for an additional premium: • You pay a $10 copayment for one routine eye exam every year. • If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames and lenses are covered in full (some restrictions may apply). • If you purchase glasses (frames and lenses) outside of the Davis Vision Collection but at a Davis Vision provider, you are covered up to $150 (some restrictions may apply). • If you purchase glasses (frames and lenses) from Visionworks, you are covered up to $200 (some restrictions may apply). • You are covered up to $150 per year for contact lenses in lieu of routine eyewear (frames and lenses).
Worldwide emergency care	You pay an $80 copayment for worldwide emergency care.	You pay a $90 copayment for worldwide emergency care.

Section 1.6 – 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.
    - 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 our Member Help Team.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call our Member Help Team 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. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 30 days of medication rather than the amount provided in 2018 (90 days of medication). (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.

Formulary exceptions for 2018 will expire on December 31, 2018. To continue to receive a non-formulary drug in 2019, you must submit a new formulary exception request. Please see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call our Member Help Team (phone numbers are in Section 7.1 of this booklet).

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.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may 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. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with

notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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 the 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. If you receive "Extra Help" and haven't received this insert by September 30, 2018, please call our Member Help Team and ask for the "LIS Rider." Phone numbers for our Member Help Team are in Section 7.1 of this booklet.

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*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your preferred brand drugs, non-preferred drugs, and specialty drugs until you have reached the yearly deductible.	The deductible is $300 (Tiers 3-5). During this stage, you pay $0 cost-sharing for drugs on the preferred generic and generic tiers and the full cost of drugs on preferred brand, non-preferred drug, and specialty tiers until you have reached the yearly deductible.	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*.

	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or 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 at a network pharmacy: **Preferred Generic Tier (Tier 1):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Generic Tier (Tier 2):** *Standard cost-sharing:* You pay $18 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Preferred Brand Tier (Tier 3):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $47 per prescription. **Non-Preferred Drugs Tier (Tier 4):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $100 per prescription.	Your cost for a one-month supply at a network pharmacy: **Preferred Generic Tier (Tier 1):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $2 per prescription. **Generic Tier (Tier 2):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Preferred Brand Tier (Tier 3):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $47 per prescription. **Non-Preferred Drugs Tier (Tier 4):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $100 per prescription.

	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage	**Specialty Tier (Tier 5):** *Standard cost-sharing:* You pay 27% of the total cost. *Preferred cost-sharing:* You pay 27% of the total cost. ______________ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	**Specialty Tier (Tier 5):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. ______________ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

We are changing our requirements for capitation for certain services, and the cost-sharing for Medicare-covered dental services. The information below describes these changes.

Cost	2018 (this year)	2019 (next year)
Capitation (designated sites)	PCPs are required to select a designated site that you must use for routine X-ray, laboratory, physical therapy and occupational therapy services. You must use your PCP's designated site in order to receive in-network coverage.	PCPs are required to select a designated site that you must use for laboratory services. You must use your PCP's designated site in order to receive in-network coverage.
Medicare-covered dental services	Medicare-covered dental services provided in an inpatient setting is a $0 copayment.	Medicare-covered dental services provided in an inpatient setting are covered under the inpatient hospital copayment.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Keystone 65 Basic Rx

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 stay enrolled as a member of our plan for 2019.

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 2019 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, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), 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 https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Keystone Health Plan East, 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 Keystone 65 Basic Rx.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Keystone 65 Basic Rx.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact our Member Help Team 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, 2019.

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.*

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. 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 Pennsylvania, the SHIP is called APPRISE.

APPRISE 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. APPRISE 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 APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (http://www.aging.pa.gov/aging-services/insurance/).

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** 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 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance

Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **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 Pennsylvania Office of Medical Assistance Programs (OMAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Pennsylvania Office of Medical Assistance Programs (OMAP) at 1-800-922-9384.

SECTION 7 Questions?

Section 7.1 – Getting Help from Keystone 65 Basic Rx

Questions? We're here to help. Please call our Member Help Team at 1-800-645-3965. (TTY/TDD, call 711). We are available for phone calls seven days a week from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Calls to these numbers are free.

Read your 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Keystone 65 Basic Rx. 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 https://www.ibxmedicare.com/EOC.

Visit our Website

You can also visit our website at https://www.ibxmedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy 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 (https://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 https://www.medicare.gov and click on “Find health & drug plans”).

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* 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 (https://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.

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

The Independence Blue Cross OTC benefit is underwritten by Keystone Health Plan East and is administered by Convey Health Solutions, Inc., an independent company.

TruHearing® is a registered trademark of TruHearing, Inc., an independent company.

Vision benefits are underwritten by Keystone Health Plan East and administered by Davis Vision, an independent company.

An affiliate of Independence Blue Cross has a financial interest in Visionworks, an independent company.

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 Deitsch schwetzscht, kannscht du Hilf griege 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'dę́ę́', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: 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៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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. 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*.

Point, Click, Discover

Need to find a doctor or check the cost of a drug?
It's simple and fast at **ibxmedicare.com**

HOW TO FIND A NETWORK PROVIDER OR PHARMACY

1. To find a provider, go to ibxmedicare.com/providerfinder.
2. You can choose to log in to have your plan information preloaded. Or, you can simply search for a health plan by clicking the drop-down box under Choose a Health Plan and selecting Medical.
3. Select the health plan network you would like to search. You can narrow your search by typing in a location (i.e. city or ZIP code) as well as search for a specific doctor, hospital, specialty, or condition. You can easily sort and refine your results by:
   - Specialty
   - Providers
   - Facilities
   - Preferred PCP
   - Languages spoken
   - Gender
   - Quality recognitions
   - Admitting privileges
   - Board certifications

1. To find a pharmacy, go to ibxmedicare.com/pharmacyfinder.
2. Enter terms to search for providers or specialties. You can narrow your search by entering your city, state, or ZIP code.
3. Each pharmacy result is listed as a Preferred or Standard pharmacy. You can sort and refine your results by:
   - Prescription compound services
   - Prescription delivery
   - Drive-up services
   - Open 24 hours
   - Durable medical equipment

HOW TO FIND OUT IF A DRUG IS ON THE FORMULARY

1. Go to ibxmedicare.com/formulary.
2. Scroll down the Health Plans page and click on your type of health coverage (i.e. individual or group), and then select your plan's name.
3. Once the drug search tool opens, you can search the formulary alphabetically by drug name or by therapeutic class.

HOW TO FIND THE EVIDENCE OF COVERAGE (EOC) AND OTHER PLAN DOCUMENTS

1. You can view or download a copy of your EOC at **ibxmedicare.com/EOC**.
2. Hover over the For Members button on the right side of the screen, and select Plan Documents from the drop-down menu.
3. Choose the EOC for your plan. Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
4. The Plan Documents page also includes other useful information about your plan, such as forms for paying your bills electronically, requesting reimbursements for claims, and making plan changes.

If you would like a printed copy of the *Provider/Pharmacy Directory*, *Formulary* or *Evidence of Coverage*, please call the Member Help Team. Keystone 65 members call 1-800-645-3965; Personal Choice 65SM members call 1-888-718-3333 (TTY/TDD: 711). Representatives are available to assist you 7 days a week, from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.

Independence Blue Cross offers Medicare Advantage plans with a Medicare contract. Enrollment in Independence Medicare Advantage plans depends on contract renewal.
Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.
Independence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-800-275-2583 (TTY/TDD: 711)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-275-2583 (TTY/TDD: 711)

Independence

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