



Keystone 65 HMO

**Keystone 65 Preferred Medical-Only (HMO) offered by  
Keystone Health Plan East, Inc.**

## Annual Notice of Changes for 2019

You are currently enrolled as a member of Keystone 65 Preferred Medical-Only. 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 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 Preferred Medical-Only, you don't need to do anything. You will stay in Keystone 65 Preferred Medical-Only.
- 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 Preferred Medical-Only.
- 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 Preferred Medical-Only**

- 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 Preferred Medical-Only.
- This information is not a complete description of benefits. Call 1-800-645-3965 (TTY/TDD: 711) for more information.

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## Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Keystone 65 Preferred Medical-Only 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)                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium</b><br>(See Section 1.1 for details.)                                                                                                                                                                                                                                                                         | \$224                                                                                                 | \$224                                                                                                                                                                                                                                                       |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services.<br>(See Section 1.2 for details.)                                                                                                                                                              | \$4,000                                                                                               | \$4,000                                                                                                                                                                                                                                                     |
| <b>Doctor office visits</b>                                                                                                                                                                                                                                                                                                           | Primary care visits:<br>\$5 copayment per visit<br><br>Specialist visits:<br>\$40 copayment per visit | Primary care visits: <ul style="list-style-type: none"> <li>• \$0 copayment per visit for preferred primary care physician</li> <li>• \$5 copayment per visit for standard primary care physician</li> </ul> Specialist visits:<br>\$40 copayment per visit |
| <b>Inpatient hospital stays</b><br>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. | \$250 copayment per day for days 1-6 per admission<br><br>\$1,500 maximum per admission               | \$250 copayment per day for days 1-6 per admission<br><br>\$1,500 maximum per admission                                                                                                                                                                     |

***Annual Notice of Changes for 2019***  
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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) |
|-----------------------------------------------------------------------------------------|------------------|------------------|
| <b>Monthly premium</b><br>(You must also continue to pay your Medicare Part B premium.) | \$224            | \$224            |

### 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)                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amount</b><br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount. | \$4,000          | \$4,000<br><br>Once you have paid \$4,000 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 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)                                                                                                                               |
|---------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ambulance services</b> | You pay a \$150 copayment per one-way trip by ground ambulance.                                                      | You pay a \$150 copayment per one-way trip by ground or air ambulance.                                                                         |
| <b>Dental services</b>    | You pay a \$20 copayment per visit for one exam and cleaning every six months.<br><br>Dental X-rays are not covered. | You pay a \$10 copayment per visit for one exam and cleaning every six months.<br><br>You pay a \$0 copayment for one dental X-ray every year. |

| Cost                                                                            | 2018 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                 | 2019 (next year)                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Diabetes self-management training, diabetic services and supplies</b></p> | <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.</p> <p>You pay a \$0 copayment for diabetic test strips and monitors.</p> <p>You pay a \$0 copayment for lancets and solutions.</p> <p>You pay a 20% coinsurance for custom-molded shoes and inserts.</p> <p>You pay a 20% coinsurance for insulin pumps and related supplies.</p> | <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.</p> <p>You pay a \$0 copayment for diabetic test strips and monitors.</p> <p>You pay a \$0 copayment for lancets and solutions.</p> <p>You pay a \$0 copayment for custom-molded shoes and inserts.</p> <p>You pay a \$0 copayment for insulin pumps and related supplies.</p> |
| <p><b>Diagnostic colonoscopy</b></p>                                            | <p>You pay a \$125 copayment for a diagnostic colonoscopy performed in an ambulatory surgical center.</p> <p>You pay a \$400 copayment for a diagnostic colonoscopy performed in an outpatient hospital facility.</p>                                                                                                                                                                                                            | <p>You pay a \$125 copayment for a diagnostic colonoscopy performed in an ambulatory surgical center.</p> <p>You pay a \$400 copayment for a diagnostic colonoscopy performed in an outpatient hospital facility.</p> <p>A copayment will not apply for a preventive colonoscopy that becomes diagnostic received in an ambulatory surgical center or outpatient hospital.</p>                                               |
| <p><b>Emergency care</b></p>                                                    | <p>You pay an \$80 copayment for emergency care.</p>                                                                                                                                                                                                                                                                                                                                                                             | <p>You pay a \$90 copayment for emergency care.</p>                                                                                                                                                                                                                                                                                                                                                                          |

| Cost                    | 2018 (this year)                                                                                                                                                                                                                                                                                                                                                                                                  | 2019 (next year)                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing services</b> | <p>You pay a \$40 copayment per visit with a TruHearing provider for one routine hearing exam per year.</p> <p>You pay a \$0 copayment for fitting and evaluation for hearing aids, covered 2 times every year.</p> <p>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.</p> | <p>You pay a \$10 copayment per visit with a TruHearing provider for one routine hearing exam per year.</p> <p>You pay a \$0 copayment for fitting and evaluation for hearing aids, covered 3 times every year.</p> <p>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.</p> |

| Cost                                                                                                                                                   | 2018 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2019 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Medical nutrition therapy</b></p>                                                                                                                | <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>We cover:</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> | <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>We cover:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Up to four additional visits for Medicare-covered medical nutrition therapy visits.</li> <li>• Up to four medical nutritional therapy visits for routine medical conditions (non-Medicare), such as high blood pressure, high cholesterol and gluten intolerance.</li> </ul> |
| <p><b>Outpatient rehabilitation services</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> | <p>You pay a \$40 copayment per provider, per date of service.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>You pay a \$20 copayment per provider, per date of service.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Cost                                                                     | 2018 (this year)                                                                                                                                                                                                                                                                                                                            | 2019 (next year)                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Over-the-counter (OTC) items</b>                                      | Over-the-counter items are <b>not</b> covered.                                                                                                                                                                                                                                                                                              | You have a \$30 allowance per quarter for over-the-counter items when purchased through Convey.                                                                                                                                                                                                                                                                    |
| <b>Palliative care</b>                                                   | Home-based palliative care services are <b>not</b> offered.                                                                                                                                                                                                                                                                                 | You pay a \$0 copayment for home-based palliative care services.                                                                                                                                                                                                                                                                                                   |
| <b>Physician/practitioner services, including doctor's office visits</b> | <p>You pay a \$5 copayment per visit for primary care provider.</p> <p>You pay a \$40 copayment per visit for specialist.</p> <p>You pay a \$40 copayment for non-routine Medicare-covered dental services in a specialist office.</p> <p>You pay a \$40 copayment per visit, per provider type for each Medicare-covered hearing exam.</p> | <p>You pay a \$0 copayment for a preferred PCP, or a \$5 copayment for a standard PCP.</p> <p>You pay a \$40 copayment per visit for specialist.</p> <p>You pay a \$40 copayment for non-routine Medicare-covered dental services in a specialist office.</p> <p>You pay a \$40 copayment per visit, per provider type for each Medicare-covered hearing exam.</p> |
| <b>Podiatry services</b>                                                 | <p>You pay a \$40 copayment per visit for Medicare-covered care.</p> <p>You pay a \$40 copayment per visit for non-Medicare-covered routine care, up to six visits per year.</p>                                                                                                                                                            | <p>You pay a \$20 copayment per visit for Medicare-covered care.</p> <p>You pay a \$20 copayment per visit for non-Medicare-covered routine care, up to six visits per year.</p>                                                                                                                                                                                   |
| <b>Preventive visits and services</b>                                    | 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.                                                                                                                                                    |

| Cost                                       | 2018 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                | 2019 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Telemedicine visits</b>                 | Telemedicine visits are <b><u>not</u></b> covered.                                                                                                                                                                                                                                                                                                                                                                              | You pay a \$5 copayment per visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Uniform flexibility – Meals program</b> | Meals program is <b><u>not</u></b> covered.                                                                                                                                                                                                                                                                                                                                                                                     | <p>After an inpatient hospital stay, you can receive three meals per day, seven days per week, up to four weeks, twice per year.</p> <p>You <b>must have all</b> of the following conditions to receive meals:</p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Congestive Heart Failure</li> <li>• Chronic Kidney Disease, Stage 4 or Stage 5</li> </ul>                                                                                                                                                                                                                                                                                                 |
| <b>Vision care</b>                         | <p>You pay a \$40 copayment for one routine eye exam every two years.</p> <p>If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames and lenses are covered in full (some restrictions may apply).</p> <p>If you purchase glasses (frames and lenses) outside of the Davis Vision Collection but at a Davis Vision provider, you are covered up to \$100 (some restrictions may apply).</p> | <p>You pay a \$10 copayment for one routine eye exam every year.</p> <p>If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames and lenses are covered in full (some restrictions may apply).</p> <p>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).</p> <p>If you purchase glasses (frames and lenses) from Visionworks, you are covered up to \$200 (some restrictions may apply).</p> <p>You are covered up to \$150 per year for contact lenses in lieu of routine eyewear (frames and lenses).</p> |

| <b>Cost</b>                     | <b>2018 (this year)</b>                                 | <b>2019 (next year)</b>                                |
|---------------------------------|---------------------------------------------------------|--------------------------------------------------------|
| <b>Worldwide emergency care</b> | You pay an \$80 copayment for worldwide emergency care. | You pay a \$90 copayment for worldwide emergency care. |

## SECTION 2 Administrative Changes

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

| <b>Cost</b>                             | <b>2018 (this year)</b>                                                                                                                                                                                                             | <b>2019 (next year)</b>                                                                                                                                                                      |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Capitation (designated sites)</b>    | 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.                    |
| <b>Medicare-covered dental services</b> | 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.                                                                        |
| <b>Preventive dental services</b>       | You must use a participating Keystone DHMO provider.                                                                                                                                                                                | You must use a participating Concordia Choice Plus provider. Go to <a href="http://ibxmedicare.com/providerfinder">ibxmedicare.com/providerfinder</a> for a list of participating providers. |

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 – If you want to stay in Keystone 65 Preferred Medical-Only

**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 (SHIP) (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 "Review and Compare Your Coverage Options." **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 Preferred Medical-Only.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Keystone 65 Preferred Medical-Only.
- 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 8, Section 2.3 of the *Evidence of Coverage*.

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 8, 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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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). Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call the Pennsylvania Office of Medical Assistance Programs (OMAP) at 1-800-922-9384.

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 Preferred Medical-Only

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 Preferred Medical-Only. 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>.

#### **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*).

### 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 *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 Deutsch schwetztscht, kannscht du Hilf griegie 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. Hódíílnih kojí' 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:

ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ 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: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@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](https://ibxmedicare.com)

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## HOW TO FIND A NETWORK PROVIDER OR PHARMACY

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1. To find a provider, go to [ibxmedicare.com/providerfinder](https://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
  - Preferred PCP
  - Quality recognitions
  - Providers
  - Languages spoken
  - Admitting privileges
  - Facilities
  - Gender
  - Board certifications

1. To find a pharmacy, go to [ibxmedicare.com/pharmacyfinder](https://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
  - Open 24 hours
  - Drive-up services
  - Durable medical equipment

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## HOW TO FIND OUT IF A DRUG IS ON THE FORMULARY

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1. Go to [ibxmedicare.com/formulary](https://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.

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

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1. You can view or download a copy of your EOC at [ibxmedicare.com/EOC](https://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 65<sup>SM</sup> 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)