



Keystone 65 HMO

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

Annual Notice of Changes for 2020

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.**
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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 Section 1 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 2020 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.

- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors, including specialists you see regularly, in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 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 2.2 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, 2019**.

- If you **don’t join another plan by December 7, 2019**, you will stay in Keystone 65 Basic Rx.
- If you **join another plan by December 7, 2019**, your new coverage will start on January 1, 2020.

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.

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Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Keystone 65 Basic Rx in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at <https://www.ibxmedicare.com/EOC>. You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	\$0	\$0
Deductible	\$0	\$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: <ul style="list-style-type: none"> \$0 copayment per visit for preferred primary care physician \$15 copayment per visit for standard primary care physician Specialist visits: \$45 copayment per visit	Primary care visits: <ul style="list-style-type: none"> \$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 \$1,800 maximum copayment per admission	\$250 copayment per day for days 1-7 per admission \$1,750 maximum copayment per admission

Cost	2019 (this year)	2020 (next year)
<p>Part D prescription drug coverage (See Section 1.6 for details.)</p>	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$9 • Drug Tier 2: \$20 • Drug Tier 3: \$47 • Drug Tier 4: \$100 • Drug Tier 5: 33% <p>Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$2 • Drug Tier 2: \$10 • Drug Tier 3: \$47 • Drug Tier 4: \$100 • Drug Tier 5: 33% 	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$9 • Drug Tier 2: \$20 • Drug Tier 3: \$47 • Drug Tier 4: \$100 • Drug Tier 5: 33% <p>Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$2 • Drug Tier 2: \$10 • Drug Tier 3: \$47 • Drug Tier 4: \$100 • Drug Tier 5: 33%

Annual Notice of Changes for 2020

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (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.)	\$7	\$12
Choice Plus Program – Optional Supplemental Benefits (For an additional monthly premium, you receive dental, hearing, and vision coverage.)	\$20	\$25

- 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	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount	\$6,700	\$6,700
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.	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.	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 2020. 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, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good-faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider 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 2020 *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 *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Diabetic supplies	Prior authorization is not required for select diabetic supplies.	Prior authorization is required for select diabetic supplies.
Inpatient hospital stays	\$300 copayment per day for days 1-6 per admission \$1,800 maximum copayment per admission	\$250 copayment per day for days 1-7 per admission \$1,750 maximum copayment per admission
Inpatient mental health care	\$270 copayment per day for days 1-6 per admission \$1,620 maximum copayment per admission	\$250 copayment per day for days 1-7 per admission \$1,750 maximum copayment per admission
Meals program	Members must have all of the following conditions to receive meals: <ul style="list-style-type: none"> • Diabetes • Congestive Heart Failure • Chronic Kidney Disease, Stage 4 or Stage 5 	Members must have both of the following conditions to receive meals: <ul style="list-style-type: none"> • Diabetes • Congestive Heart Failure

Cost	2019 (this year)	2020 (next year)
Medicare Part B prescription drugs	Covered Part B prescription drugs are not subject to step therapy.	Some covered Part B prescription drugs may be subject to step therapy.
Outpatient diagnostic radiology services	\$250 copayment for complex radiology services (e.g., CT scans, MRI, MRA, Nuclear Cardiology Studies)	\$200 copayment for complex radiology services (e.g., CT scans, MRI, MRA, Nuclear Cardiology Studies)
Outpatient rehabilitation services	Outpatient rehabilitation services (physical therapy, occupational therapy, and speech language therapy) do not require prior authorization.	Outpatient rehabilitation services (physical therapy, occupational therapy, and speech language therapy) require prior authorization.

Cost	2019 (this year)	2020 (next year)
Dental services	<p>Routine dental care is covered under the Choice Program for an additional premium:</p> <ul style="list-style-type: none"> • \$10 copayment per visit • \$0 copayment for dental X-rays (bitewing X-rays) 	<p>Routine dental care is covered under the Choice Program for an additional premium:</p> <ul style="list-style-type: none"> • \$10 copayment per visit • \$0 copayment for dental X-rays (bitewing X-rays) • 50% coinsurance up to a combined \$500 allowance for restorative services, endodontics, periodontics, and extractions • Prosthodontics, other oral/maxillofacial surgery are not covered.
	<p>Routine dental care is covered under the Choice Plus Program for an additional premium:</p> <ul style="list-style-type: none"> • \$0 copayment per visit • \$0 copayment for dental X-rays (bitewing X-rays) • \$500 plan allowance per calendar year for restorative dental services • \$0 copayment for restorative dental services 	<p>Routine dental care is covered under the Choice Plus Program for an additional premium:</p> <ul style="list-style-type: none"> • \$0 copayment per visit • \$0 copayment for dental X-rays (bitewing X-rays) • 50% coinsurance up to a combined \$1,500 allowance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery. • \$0 copayment for restorative dental services

Cost	2019 (this year)	2020 (next year)
Hearing services	<p>Routine hearing care is covered under the Choice Program for an additional premium:</p> <p>\$40 copayment per visit with a TruHearing provider for each routine hearing exam</p>	<p>Routine hearing care is covered under the Choice Program for an additional premium:</p> <p>\$10 copayment per visit with a TruHearing provider for each routine hearing exam</p>
Vision care	<p>Routine eye examinations and eyeglasses are covered under the Choice Program for an additional premium:</p> <ul style="list-style-type: none"> • \$10 copayment for routine eye exam every two years • 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 \$100 every two years (some restrictions may apply). • You are covered up to \$100 every two years for contact lenses in lieu of routine eyewear (frames and lenses). 	<p>Routine eye examinations and eyeglasses are covered under the Choice Program for an additional premium:</p> <ul style="list-style-type: none"> • \$10 copayment for 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 eyewear (glasses and lenses) from Visionworks, you are covered up to \$200 per year. • 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 per year (some restrictions may apply). • You are covered up to \$150 per year for contact lenses in lieu of routine eyewear (frames and lenses).

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. (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 2019 will expire on December 31, 2019. To continue to receive a non-formulary drug in 2020, 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 6.1 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.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by September 30, 2019, please call our Member Help Team and ask for the “LIS Rider.” Phone numbers for our Member Help Team are in Section 6.1 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*, which is located on our website at <https://www.ibxmedicare.com/EOC>.) You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage*.

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

	2019 (this year)	2020 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>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 <i>Evidence of Coverage</i>.</p> <p>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.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p>Preferred Generic Tier (Tier 1):</p> <p><i>Standard cost-sharing:</i> You pay \$9 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$2 per prescription.</p> <p>Generic Tier (Tier 2):</p> <p><i>Standard cost-sharing:</i> You pay \$20 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$10 per prescription.</p> <p>Preferred Brand Tier (Tier 3):</p> <p><i>Standard cost-sharing:</i> You pay \$47 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$47 per prescription.</p> <p>Non-Preferred Drug Tier (Tier 4):</p> <p><i>Standard cost-sharing:</i> You pay \$100 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$100 per prescription.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p>Preferred Generic Tier (Tier 1):</p> <p><i>Standard cost-sharing:</i> You pay \$9 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$2 per prescription.</p> <p>Generic Tier (Tier 2):</p> <p><i>Standard cost-sharing:</i> You pay \$20 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$10 per prescription.</p> <p>Preferred Brand Tier (Tier 3):</p> <p><i>Standard cost-sharing:</i> You pay \$47 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$47 per prescription.</p> <p>Non-Preferred Drug Tier (Tier 4):</p> <p><i>Standard cost-sharing:</i> You pay \$100 per prescription.</p> <p><i>Preferred cost-sharing:</i> You pay \$100 per prescription.</p>

	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage	<p>Specialty Tier (Tier 5):</p> <p><i>Standard cost-sharing:</i> You pay 33% of the total cost.</p> <p><i>Preferred cost-sharing:</i> You pay 33% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$3,820, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Specialty Tier (Tier 5):</p> <p><i>Standard cost-sharing:</i> You pay 33% of the total cost.</p> <p><i>Preferred cost-sharing:</i> You pay 33% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$4,020, you will move to the next stage (the Coverage Gap Stage).</p>

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 Deciding Which Plan to Choose

Section 2.1 – 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 2020.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely.
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 6.1 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 3 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, 2020.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 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 5 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 a.m. and 7 p.m., 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 4 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/underinsured 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 6 Questions?

Section 6.1 – 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: 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 2020 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 2020. For details, look in the 2020 *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>. You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage*.

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 6.2 – 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 2020*

You can read the *Medicare & You 2020* 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.

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