Independence

Keystone 65 HMO

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

Annual Notice of Changes for 2022

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 Section 1 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, 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.

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2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 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 don't join another plan by December 7, 2021, you will be enrolled 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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Keystone 65 Preferred Medical-Only.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Help Team number at 1-800-645-3965 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
- 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 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.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Keystone 65 Preferred Medical-Only in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.ibxmedicare.com/EOC. You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage.*

Cost	2021 (this year)	2022 (next year)
Monthly plan premium (See Section 1.1 for details.)	$194	$187
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$4,000	$3,800
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $40 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $40 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.	$225 copayment per day for days 1-6 per admission $1,350 maximum per admission	$225 copayment per day for days 1-6 per admission $1,350 maximum per admission

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$194	$187

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	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$4,000	$3,800 Once you have paid $3,800 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 2022. An updated *Provider/Pharmacy Directory* is located on our website at 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 to manage 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 *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Hearing services	WE COVER • Fitting and evaluation for hearing aids, covered three times every year • 45-day trial period • 48 batteries per aid for non-rechargeable models WHAT YOU PAY • You pay a $10 copay per visit with a TruHearing provider for each routine hearing exam	WE COVER • Unlimited fittings and evaluations for hearing aids • 60-day trial period • 80 batteries per aid for non-rechargeable models WHAT YOU PAY • You pay a $0 copay per visit with a TruHearing provider for each routine hearing exam
Outpatient mental health care	Prior authorization is **not** required for Transcranial Magnetic Stimulation	Prior authorization is required for Transcranial Magnetic Stimulation
Screening for lung cancer with low dose computed tomography (LDCT)	Prior authorization is **not** required	Prior authorization is required
Skilled Nursing Facility (SNF) care	You pay a $170 copay per day for days 21-100	You pay a $188 copay per day for days 21-100
Special Supplemental Benefits for the Chronically Ill – Grocery benefit	Grocery benefit is **not** covered.	Grocery boxes will be provided for a maximum of 4 weeks per year, per member. Members must be diagnosed with both of the following conditions to be eligible to receive the grocery benefit: • Diabetes • Depression

Cost	2021 (this year)	2022 (next year)
Special Supplemental Benefits for the Chronically Ill – Meals program	Members must participate in the medical management - Transitions of Care Program, who will help connect you to our approved provider. Members **must have both** of the following conditions to receive meals: • Diabetes • Congestive heart failure	Participation in the medical management – Transitions of Care Program is no longer required to receive meals. In order to receive meals, members must: • Receive a new diagnosis for **one** of the following conditions: o Colorectal Cancer o Endometrial Cancer o Male or Female Breast Cancer o Lung Cancer o Prostate Cancer **OR** • Receive a diagnosis for **both** of the following conditions: o Diabetes o Congestive heart failure (CHF) For members who have been diagnosed with **both** diabetes and congestive heart failure (CHF), meals will be provided after discharge to the home following an inpatient acute hospital, skilled nursing facility, long-term acute care facility, acute rehabilitation facility, or rehabilitation facility stay.

Cost	2021 (this year)	2022 (next year)
Telemedicine visits through MDLIVE	You pay a $5 copay for behavioral health visits through MDLIVE *(focused on therapy and counseling services)*	You pay a $0 copay for behavioral health visits through MDLIVE *(focused on therapy and counseling services)*
Uniform flexibility – Radiation therapy for breast cancer	Radiation therapy for breast cancer covered under therapeutic radiological services with a $60 copay.	$0 copay for radiation therapy with a diagnosis of breast cancer
Uniform flexibility – Transportation	Transportation is **not** covered.	Members must be diagnosed with both of the following conditions to be eligible to receive the transportation benefit: • Diabetes • Congestive Heart Failure (CHF) The transportation benefit includes 12 one-way trips per year to plan-approved medical facilities. Modes of transportation include taxi, rideshare services, van, and medical transport.
Vision care	• You pay a $10 copay for one routine eye exam per year • If you purchase glasses (frames and lenses) from Visionworks, you are covered up to $200.	• You pay a $0 copay for one routine eye exam per year • If you purchase glasses (frames and lenses) from Visionworks, you are covered up to $250.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – 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 be enrolled in our Keystone 65 Preferred Medical-Only.

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 2022 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, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (SHIP) (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 www.medicare.gov/plan-compare. **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 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, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. 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, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 8, 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 Pennsylvania Medicare Education and Decision Insight (PA MEDI).

PA MEDI 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. PA MEDI 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 PA MEDI at 1-800-783-7067. You can learn more about PA MEDI by visiting their website (www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx).

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).
- **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 6 Questions?

Section 6.1 – 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: 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 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for 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 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 www.ibxmedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*).

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 (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read Medicare & You 2022

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.