Independence
Keystone 65 HMO

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

Annual Notice of Changes for 2023

You are currently enrolled as a member of Keystone 65 Preferred Rx. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which 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*.

- **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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Keystone 65 Preferred Rx.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Keystone 65 Preferred Rx.
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

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 Rx

- Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal.
- When this document says "we," "us," or "our," it means Keystone Health Plan East, Inc. When it says "plan" or "our plan," it means Keystone 65 Preferred Rx.

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Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Keystone 65 Preferred Rx in several important areas. **Please note this is only a summary of changes**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$258	$241
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.)	$3,800	$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	$225 copayment per day for days 1-6 per admission $1,350 maximum copayment per admission	$225 copayment per day for days 1-6 per admission $1,350 maximum copayment per admission

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $20 • Drug Tier 3: $47 Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 33% Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $9 • Drug Tier 3: $47 Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 33%	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $20 • Drug Tier 3: $47 Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 33% Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $7 • Drug Tier 3: $47 Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 33%

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$258	$241

- 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. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (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 and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$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.	$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 and Pharmacy Networks

Updated *Provider/Pharmacy Directories* are located on our website at www.ibxmedicare.com. You may also call our Member Help Team for updated provider and/or pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory.*

There are changes to our network of providers for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact our Member Help Team so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Emergency care	You pay a $90 copay per visit.	You pay a $95 copay per visit.
Fitness benefit	Members receive: • A basic fitness membership to participating SilverSneakers facilities • Access to basic gym amenities and SilverSneakers fitness classes if available at those facilities, with the goal of improving general member health In addition, members may choose to receive: • One in-home SilverSneakers Steps exercise kit per year. Members must use a SilverSneakers network gym/fitness center and enroll in the SilverSneakers program. No payment can be made for membership fees/dues prior to a member enrolling in our plan and enrolling in the SilverSneakers program. Gym memberships and services received from non-SilverSneakers fitness centers will be denied.	Members receive: • A physical and cognitive fitness membership through a plan-specific vendor to help improve general health and well-being • Access to a participating gym network, on-demand and livestreamed digital content, cognitive fitness program, home kits, and curated health and wellness events Members must use a One Pass network gym/fitness center and enroll in the One Pass program. No payment can be made for membership fees/dues prior to a member enrolling in our plan and enrolling in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.
Hearing services	Premium hearing aids are available in rechargeable style options.	**Both** Advanced and Premium hearing aids are available in rechargeable style options.

Cost	2022 (this year)	2023 (next year)
Outpatient mental health care	You pay a $40 copay for each individual/group therapy session.	You pay a $30 copay for each individual therapy session. You pay a $20 copay for each group therapy session. Includes Medicare-covered telehealth. See the "Physician/Practitioner services, including doctor's office visits" row of the Medical Benefits Chart in Chapter 4 of your 2023 *Evidence of Coverage* for further detail. This benefit does **not** include Telemedicine services from MDLIVE.
Outpatient substance abuse services	You pay a $40 copay for each individual/group therapy session.	You pay a $30 copay for each individual therapy session. You pay a $20 copay for each group therapy session. Includes Medicare-covered telehealth. See the "Physician/Practitioner services, including doctor's office visits" row of the Medical Benefits Chart in Chapter 4 of your 2023 *Evidence of Coverage* for further detail. This benefit does **not** include Telemedicine services from MDLIVE.
Partial hospitalization	You pay a $40 copay per day.	You pay a $30 copay per day.

Cost	2022 (this year)	2023 (next year)
Skilled Nursing Facility (SNF) care	You pay a $188 copay per day for days 21-100.	You pay a $196 copay per day for days 21-100.
Special Supplemental Benefits for the Chronically Ill – Grocery benefit	Members must have **both** diabetes and depression to be eligible.	Members must have **both** diabetes and depression or diabetes and a depressive disorder to be eligible.
Special Supplemental Benefits for the Chronically Ill – Meals program	Participation in the medical management Transitions of Care Program is **not** required. **Two groups of members are eligible:** Group 1 members must have a new diagnosis of one of the following conditions: • Colorectal cancer • Endometrial cancer • Male or female breast cancer • Lung cancer • Prostate cancer Group 2 members must have **both** of the following conditions: • Diabetes • Congestive heart failure (CHF) **For members in Group 2:** 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	Participation in the medical management Transitions of Care Program is required. **Two groups of members are eligible:** Group 1 members must have a new diagnosis of one of the following conditions: • Colorectal cancer • Endometrial cancer • Male or female breast cancer • Lung cancer • Prostate cancer Group 2 members must have **both** of the following conditions: • Diabetes • Congestive heart failure (CHF) **For members in both groups:** 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	2022 (this year)	2023 (next year)
Telehealth services	Telehealth for the following services is **not** covered: Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: • You have an in-person visit within 6 months prior to your first telehealth visit. • You have an in-person visit every 12 months while receiving these telehealth services. • Exceptions can be made to the above for certain circumstances. • Telehealth services for PCP visits • Telehealth services for specialist and other health care professional visits • Telehealth services for physical therapy, occupational therapy, and speech therapy visits • Telehealth services for individual and group therapy sessions focused on mental health and substance abuse	Telehealth for the following services is covered: Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: • You have an in-person visit within 6 months prior to your first telehealth visit. • You have an in-person visit every 12 months while receiving these telehealth services. • Exceptions can be made to the above for certain circumstances. You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • You pay a $0 copay for telehealth services for PCP visits • You pay a $40 copay for telehealth services for specialist and other health care professional visits • You pay a $20 copay for telehealth services for physical therapy, occupational therapy, and speech therapy visits

(continued)

Cost	2022 (this year)	2023 (next year)
Telehealth services (continued)		• You pay a $30 copay for telehealth services for each individual therapy session and a $20 copay for each group therapy session focused on mental health and substance abuse Prior authorization is required for select services. This benefit does **not** include Telemedicine services from MDLIVE.
Telemedicine visits through MDLIVE	Dermatology services are **not** available.	You pay a $0 copay for dermatology visits through MDLIVE *(treating and diagnosing skin, hair, and nail conditions)*. You must use MDLIVE to receive this service at no cost. Additional telehealth services received from other in-network providers will include an in-office copay. Not all services can be provided as a telehealth visit. See the "Physician/Practitioner services, including doctor's office visits" row of the Medical Benefits Chart in Chapter 4 of your 2023 *Evidence of Coverage* for further detail.

Cost	2022 (this year)	2023 (next year)
Uniform flexibility – Transportation	12 one-way trips per year to plan-approved medical facilities Mode of transportation includes taxi, rideshare services, van, medical transport.	24 one-way trips per year to plan-approved medical facilities Mode of transportation includes taxi, rideshare services, van, medical sedan, and wheelchair van. Limit of 80 miles per one-way trip.
Worldwide emergency/urgent coverage	You pay a $90 copay per visit for worldwide emergency/urgent coverage.	You pay a $95 copay per visit for worldwide emergency/urgent coverage.

Section 1.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact our Member Help Team for more information.

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 you haven’t received this insert by September 30, 2022, please call our Member Help Team and ask for the “LIS Rider.”

There are four “drug payment stages.” The information below shows the changes 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.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Preferred Generic Tier (Tier 1):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Generic Tier (Tier 2):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $9 per prescription.	Your cost for a one-month supply at a network pharmacy: **Preferred Generic Tier (Tier 1):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Generic Tier (Tier 2):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $7 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Preferred Brand Tier (Tier 3):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $47 per prescription. *Select Insulins cost-sharing:* You pay $35 for Select Insulins. **Non-Preferred Drug Tier (Tier 4):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $100 per prescription. **Specialty Tier (Tier 5):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Preferred Brand Tier (Tier 3):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $47 per prescription. *Select Insulins cost-sharing:* You pay $35 for Select Insulins. **Non-Preferred Drug Tier (Tier 4):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $100 per prescription. **Specialty Tier (Tier 5):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call our Member Help Team for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Getting help from Medicare – If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Member Help Team number at 1-800-645-3965 (TTY users should call 711). Hours are 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.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Keystone 65 Preferred 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 be enrolled in our Keystone 65 Preferred Rx.

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 plans for 2023 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. 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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 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 Preferred 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 so.
  - – *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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

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. 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; 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.

- **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 Preferred 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 2023 *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 2023. For details, look in the 2023 *Evidence of Coverage* for Keystone 65 Preferred 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 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*) 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you

can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.