

**Independence** 

Keystone 65 HMO Preferred



2021

Keystone 65 Preferred Plan Information



# 2021

## Summary of Benefits

Effective January 1, 2021 through December 31, 2021



- Keystone 65 Preferred Medical-Only HMO
- Keystone 65 Preferred Rx HMO

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the ***Evidence of Coverage*** or go online at **[www.ibxmedicare.com](http://www.ibxmedicare.com)**.

This Summary of Benefits booklet gives you a summary of what Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO cover and what you pay.

Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO are Medicare Advantage HMO (Health Maintenance Organization) plans. With an HMO plan, members choose a family doctor, called a primary care physician (PCP), who provides the services they need. When they need specialized care, PCPs refer members to other doctors or health care providers within the HMO provider network.

If you want to compare our plans with other available Medicare health plans, ask the other plan(s) for their Summary of Benefits booklet. Or, use the Medicare Plan Finder at [www.medicare.gov](http://www.medicare.gov).

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy 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.

## **Sections of this booklet**

- Monthly Premium, Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Keystone 65 Preferred Rx HMO

## **Who can join?**

To join Keystone 65 Preferred Medical-Only HMO or Keystone 65 Preferred Rx HMO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

## Which doctors, hospitals, and pharmacies can I use?

Keystone 65 Preferred Medical-Only HMO and Keystone 65 Preferred Rx HMO have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, we may not pay for these services. Keystone 65 Preferred Rx HMO also has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our list of network providers and pharmacies (Provider/Pharmacy Directory), please visit [www.ibxmedicare.com](http://www.ibxmedicare.com).

Keystone 65 Preferred Rx HMO covers Part D drugs. In addition, the plan covers Part B drugs such as chemotherapy and some other drugs administered by your provider. You can see our complete plan Formulary (List of Covered Drugs) and any restrictions on our website, at [www.ibxmedicare.com](http://www.ibxmedicare.com).

Keystone 65 Preferred Medical-Only HMO covers Part B drugs, including chemotherapy and some other drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

## Monthly Plan Premium

Keystone 65 Preferred HMO		
If You Live In...	And You Have...	
	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
	You Pay...	
Chester, Delaware, or Montgomery County	\$194	\$258
Bucks or Philadelphia County	\$178	\$230

	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<b>Deductible</b>	This plan does not have a deductible for covered medical services.	This plan does not have a deductible for covered medical services. This plan does not have a deductible for Part D prescription drugs.
<b>Maximum Out-of-Pocket</b> (the amounts you pay for your premium, Part D prescription drugs and some medical services do not count toward your maximum out-of-pocket (MOOP) amount)	\$4,000 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	\$4,000 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.

## Covered Medical and Hospital Benefits

	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<b>Inpatient Hospital Coverage (1)</b>	\$225 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission. No copayment on day of discharge. \$1,350 maximum copayment per admission Unlimited days per benefit period	\$225 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission. No copayment on day of discharge. \$1,350 maximum copayment per admission Unlimited days per benefit period
<b>Inpatient Hospital Stay – Acute due to COVID-19 diagnosis (1)</b>	\$0 copayment	\$0 copayment
<b>Outpatient Hospital Coverage</b>		
• Ambulatory Surgical Center (1)	\$125 copayment	\$125 copayment
• Outpatient Hospital Facility (1)	\$350 copayment	\$350 copayment
• Observation Services	\$350 copayment per stay	\$350 copayment per stay
<b>Doctor's Office Visits</b>		
• Primary Care Physician	\$0 copayment per visit for a primary care physician	\$0 copayment per visit for a primary care physician
• Specialist	\$40 copayment	\$40 copayment

Services with a (1) may require prior authorization.

Covered Medical and Hospital Benefits (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<p><b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)</p>	<p>You pay nothing</p> <p>Please refer to the Evidence of Coverage for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.</p>	<p>You pay nothing</p> <p>Please refer to the Evidence of Coverage for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.</p>
<p><b>Emergency Care — covered worldwide</b></p> <p>Worldwide copayment outside the U.S. does not count towards the annual MOOP</p>	<p>\$90 copayment</p> <p>Not waived if admitted to inpatient hospital</p>	<p>\$90 copayment</p> <p>Not waived if admitted to inpatient hospital</p>
<p><b>Urgently Needed Services — covered worldwide</b></p> <p>Worldwide copayment outside the U.S. does not count towards the annual MOOP</p>	<p>\$5 copayment in a retail clinic Not waived if admitted</p> <p>\$40 copayment in an urgent care center Not waived if admitted</p> <p>\$90 copayment per visit outside of U.S. Not waived if admitted</p>	<p>\$5 copayment in a retail clinic Not waived if admitted</p> <p>\$40 copayment in an urgent care center Not waived if admitted</p> <p>\$90 copayment per visit outside of U.S. Not waived if admitted</p>
<p><b>Diagnostic Services (1), Lab and Radiology Services (1), and X-rays</b></p> <ul style="list-style-type: none"> <li>• <b>Diagnostic Radiology Services</b></li> <li>• <b>Lab Services</b></li> <li>• <b>Diagnostic Tests and Procedures</b></li> <li>• <b>Outpatient X-rays</b></li> <li>• <b>Therapeutic Radiology</b></li> </ul>	<p>\$0-150 copayment depending on service</p> <p>\$0 copayment applies to certain diagnostic tests (e.g. home- based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram).</p> <p>\$40 or \$150 copayment depending on service</p> <p>You pay nothing</p> <p>You pay nothing</p> <p>\$40 copayment for routine radiology services</p> <p>\$60 copayment</p>	<p>\$0-150 copayment depending on service</p> <p>\$0 copayment applies to certain diagnostic tests (e.g. home- based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram).</p> <p>\$40 or \$150 copayment depending on service</p> <p>You pay nothing</p> <p>You pay nothing</p> <p>\$40 copayment for routine radiology services</p> <p>\$60 copayment</p>

Services with a (1) may require prior authorization.





Covered Medical and Hospital Benefits (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<p><b>Dental Services</b></p>	<p>\$40 copayment for Medicare-covered dental services in a specialist office</p> <p>\$0 copayment for routine non-Medicare-covered exam and cleaning every six months;</p> <p>\$0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every three years</p> <p>Comprehensive dental services not covered. Routine dental services do not count toward the annual MOOP.</p>	<p>\$40 copayment for Medicare-covered dental services in a specialist office</p> <p>\$0 copayment for routine non-Medicare-covered exam and cleaning every six months;</p> <p>\$0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every three years</p> <p>Comprehensive dental services not covered. Routine dental services do not count toward the annual MOOP.</p>

Services with a (1) may require prior authorization.

Covered Medical and Hospital Benefits (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<p><b>Vision Services</b></p>	<p>\$40 copayment for Medicare-covered eye exams to diagnose and treat diseases of the eye; \$0 copayment for diabetic retinal exam; \$0 copayment for glaucoma screening; \$0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery</p> <p>\$10 copay for one routine eye exam every year; one pair of eyeglass frames and lenses or one pair of contact lenses are covered every year</p> <p>If eyewear is purchased from the Davis Vision Collection the eyeglass frames and lenses are covered in full. \$200 plan allowance every year on eyewear (glasses or lenses) purchased through Visionworks; \$150 plan allowance every year for all other eyewear (glasses, lenses or contacts) purchased through Davis Vision; \$150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses).</p> <p>Eyewear does not include lens options such as tints, progressives, transition lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.</p>	<p>\$40 copayment for Medicare-covered eye exams to diagnose and treat diseases of the eye; \$0 copayment for diabetic retinal exam; \$0 copayment for glaucoma screening; \$0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery</p> <p>\$10 copay for one routine eye exam every year; one pair of eyeglass frames and lenses or one pair of contact lenses are covered every year</p> <p>If eyewear is purchased from the Davis Vision Collection the eyeglass frames and lenses are covered in full. \$200 plan allowance every year on eyewear (glasses or lenses) purchased through Visionworks; \$150 plan allowance every year for all other eyewear (glasses, lenses or contacts) purchased through Davis Vision; \$150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses).</p> <p>Eyewear does not include lens options such as tints, progressives, transition lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.</p>

Covered Medical and Hospital Benefits (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>• Inpatient Mental Health Care (2)</li> <li>• Outpatient Therapy (Group and Individual)</li> <li>• Outpatient Substance Abuse Services (Group and Individual)</li> <li>• Partial Hospitalization (2)</li> </ul>	<p>\$225 copayment per day for days 1 through 6 You pay nothing per day for days 7 and beyond</p> <p>\$1,350 maximum copayment per admission</p> <p>190-day lifetime maximum in a mental health facility</p> <p>\$40 copayment</p> <p>\$40 copayment</p> <p>\$40 copayment</p>	<p>\$225 copayment per day for days 1 through 6 You pay nothing per day for days 7 and beyond</p> <p>\$1,350 maximum copayment per admission</p> <p>190-day lifetime maximum in a mental health facility</p> <p>\$40 copayment</p> <p>\$40 copayment</p> <p>\$40 copayment</p>
<b>Skilled Nursing Facility (1)</b>	<p>You pay nothing per day for days 1 through 20 per admission</p> <p>\$170 copayment per day for days 21 through 100 per admission</p> <p>100 days per benefit period</p>	<p>You pay nothing per day for days 1 through 20 per admission</p> <p>\$170 copayment per day for days 21 through 100 per admission</p> <p>100 days per benefit period</p>
<b>Physical Therapy (1)</b>	<p>\$20 copayment per visit</p>	<p>\$20 copayment per visit</p>
<b>Ambulance (1)</b>	<p>\$150 copayment for a one-way trip Not waived if admitted</p> <p>Non-emergency ambulance services require prior authorization</p>	<p>\$150 copayment for a one-way trip Not waived if admitted</p> <p>Non-emergency ambulance services require prior authorization</p>
<b>Transportation</b>	<p>Not covered</p>	<p>Not covered</p>
<b>Medicare Part B Drugs (1)</b>	<p>20% coinsurance for Part B drugs such as chemotherapy drugs</p> <p>For a description of the types of drugs available under Part B, see your Evidence of Coverage</p>	<p>20% coinsurance for Part B drugs such as chemotherapy drugs</p> <p>For a description of the types of drugs available under Part B, see your Evidence of Coverage</p>
<b>Ambulatory Surgical Center</b>	<p>\$125 copayment</p>	<p>\$125 copayment</p>

# Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Keystone 65 Preferred Rx HMO. This benefit is not available for members of Keystone 65 Preferred Medical-Only HMO.

Prescription Drug Benefits (Part D)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO			
<b>Retail Cost-sharing</b> (what you pay at a pharmacy location)	Part D prescription drugs are not available with this plan.	One-Month Supply	Two-Month Supply	Three-Month Supply	
Tier 1 (Preferred Generic Drugs)					
Preferred Pharmacy			\$1 copayment	\$2 copayment	\$2 copayment
Standard Pharmacy			\$9 copayment	\$18 copayment	\$27 copayment
Tier 2 (Generic Drugs)					
Preferred Pharmacy			\$9 copayment	\$18 copayment	\$18 copayment
Standard Pharmacy			\$20 copayment	\$40 copayment	\$60 copayment
Tier 3 (Preferred Brand Drugs)					
Preferred Pharmacy			\$47 copayment	\$94 copayment	\$141 copayment
Standard Pharmacy			\$47 copayment	\$94 copayment	\$141 copayment
Tier 4 (Non-Preferred Drugs)					
Preferred Pharmacy			\$100 copayment	\$200 copayment	\$300 copayment
Standard Pharmacy		\$100 copayment	\$200 copayment	\$300 copayment	
Tier 5 (Specialty Drugs)					
Preferred Pharmacy		33% coinsurance	33% coinsurance	33% coinsurance	
Standard Pharmacy		33% coinsurance	33% coinsurance	33% coinsurance	

Prescription Drug Benefits (Part D) (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
Initial Coverage Stage	Part D prescription drugs are not available with this plan.	<p>You pay the following until your total yearly drug costs reach \$4,130. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail-order pharmacies.</p> <p>Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. You may fill your prescriptions at either a preferred or standard pharmacy. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies.</p> <p>For information, please review the Keystone 65 Rx HMO Evidence of Coverage.</p>

Prescription Drug Benefits (Part D) (cont.)	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
Initial Coverage Stage	Part D prescription drugs are not available with this plan.	<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>You begin in this stage when you fill your first prescription of the year. You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan payments) total \$4,130. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. This plan has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy used.</p> <p>You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.</p>
Coverage Gap Stage	Part D prescription drugs are not available with this plan.	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130.</p> <p>After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand-name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>

## Other Medical Benefits

	Keystone 65 Preferred Medical-Only HMO	Keystone 65 Preferred Rx HMO
<b>Podiatry Services</b> <ul style="list-style-type: none"> <li>• Medical Condition</li> <li>• Routine Foot Care (Medicare-covered)</li> <li>• Routine Foot Care (non-Medicare-covered)</li> </ul>	<p>\$20 copayment per visit for condition treatment</p> <p>\$20 copayment per visit for Medicare-covered routine care</p> <p>\$20 copayment per visit for non-Medicare-covered routine foot care (up to 6 visits each year)</p>	<p>\$20 copayment per visit for condition treatment</p> <p>\$20 copayment per visit for Medicare-covered routine care</p> <p>\$20 copayment per visit for non-Medicare-covered routine foot care (up to 6 visits each year)</p>
<b>Over-the-Counter (OTC) Items</b>	<p>\$30 allowance for over-the-counter (OTC) items. OTC allowance is provided quarterly and does not carry forward to the next quarter if not used. You must use our OTC vendor to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC does not apply to MOOP. OTC items can also be ordered via website phone/catalog using our OTC Vendor.</p>	<p>\$30 allowance for over-the-counter (OTC) items. OTC allowance is provided quarterly and does not carry forward to the next quarter if not used. You must use our OTC vendor to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC does not apply to MOOP. OTC items can also be ordered via website phone/catalog using our OTC Vendor.</p>
<b>Telemedicine Visits</b>	<p>\$0 copayment for doctor visits focused on non-urgent medical conditions; \$5 copayment for behavioral health visits focused on therapy and counseling services. Telemedicine physicians are available 24/7, 365 days per year. MDLive must be used for telemedicine visits. MDLive doctors are state-licensed physicians. Telemedicine services rendered from other providers will not be covered.</p>	<p>\$0 copayment for doctor visits focused on non-urgent medical conditions; \$5 copayment for behavioral health visits focused on therapy and counseling services. Telemedicine physicians are available 24/7, 365 days per year. MDLive must be used for telemedicine visits. MDLive doctors are state-licensed physicians. Telemedicine services rendered from other providers will not be covered.</p>
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>• Medical Condition (Medicare-covered)</li> <li>• Routine Care (non-Medicare-covered)</li> </ul>	<p>\$20 copayment per visit for spinal manipulations</p> <p>\$20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year)</p>	<p>\$20 copayment per visit for spinal manipulations</p> <p>\$20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year); does not count toward MOOP</p>
<b>Acupuncture</b> <ul style="list-style-type: none"> <li>• Medical Condition (Medicare-covered)</li> <li>• Routine Care (non-Medicare-covered)</li> </ul>	<p>\$20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made</p> <p>\$20 copayment per visit (up to 6 visits each year)</p> <p>\$20 copayment (up to 6 visits per year)</p>	<p>\$20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made</p> <p>\$20 copayment per visit (up to 6 visits each year)</p> <p>\$20 copayment (up to 6 visits per year)</p>

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Help Team representative at 1-800-645-3965 (TTY/TDD: 711).

### Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit [www.ibxmedicare.com](http://www.ibxmedicare.com) or call 1-800-645-3965 (TTY/TDD: 711) to view a copy of the EOC.
  
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
  
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
  
- Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2022.
  
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).



## 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:** सूचना: જો તમે ગુજરાતી બોલતા હો, તો બિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

### Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh. Hódíílnih koji' 1-800-275-2583.

### Urdu:

توجہ 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: [civilrightscoordinator@1901market.com](mailto:civilrightscoordinator@1901market.com). If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# Independence

## Keystone 65 HMO

PO Box 13713  
Philadelphia, PA 19101-3713

### For more information

For updated information regarding plan providers, visit our website at [www.ibxmedicare.com](http://www.ibxmedicare.com), or call the Member Help Team at 1-800-645-3965 (TTY/TDD: 711), seven days a week, 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.

If you are not yet a member and have questions, please call 1-877-393-6733 or TTY/TDD: 711, seven days a week, 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. By calling this number you will be directed to a licensed sales agent.

Keystone 65 offers HMO plans with a Medicare contract. Enrollment in Keystone 65 Medicare Advantage plans depends on contract renewal.

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

To receive this document in an alternate format such as Braille, large print, or audio, please call 1-877-393-6733 (non-members) (by calling this number you will be directed to a licensed sales agent) or 1-800-645-3965 (members) (TTY/TDD: 711).

This information is not a complete description of benefits. Contact 1-877-393-6733 (TTY/TDD: 711), for more information.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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.

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

Telemedicine is provided by MDLive, an independent company.

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

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PO Box 190  
Dunmore, PA 18512

Important Keystone 65 Preferred HMO information