Independence
Keystone 65 HMO

2022
Summary of Benefits

Effective January 1, 2022 through December 31, 2022

[redacted]

- Keystone 65 Basic Rx HMO
- Keystone 65 Focus Rx HMO-POS
- Keystone 65 Select Medical-Only HMO
- Keystone 65 Select Rx HMO

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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**.

This *Summary of Benefits* booklet gives you a summary of what Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select Rx HMO cover and what you pay.

Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select 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. Keystone 65 Focus Rx HMO-POS has a Point-of-Service (POS) option. "Point-of-service" means you can use providers outside the plan's network for an additional cost. Members pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. If you choose to see a doctor or specialist out of network, you may pay a higher cost-share except in the case of an emergency.

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. 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 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 and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Keystone 65 Basic Rx, Keystone 65 Focus Rx, and Keystone 65 Select Rx

Who can join?

To join Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, Keystone 65 Select Medical-Only HMO, or Keystone 65 Select 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 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select Rx HMO have networks of doctors, hospitals, pharmacies, and other providers. Keystone 65 Basic Rx HMO, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select Rx HMO: If you use providers that are not in our networks, the plans may not pay for the services. With Keystone 65 Focus Rx HMO-POS, if you choose to see a doctor or specialist out of network, you may pay a higher cost-share except in the case of an emergency.

Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO cover Part D drugs. In addition, the plans cover 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: **www.ibxmedicare.com.**

Keystone 65 Select 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.

Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO have a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our lists of network providers and pharmacies (Provider/Pharmacy Directory), please visit **www.ibxmedicare.com.**

Monthly Plan Premium

Keystone 65 Basic Rx HMO	
	And You Have...
	Keystone 65 Basic Rx HMO
If You Live In...	You Pay...
Chester, Delaware, or Montgomery County	$0
Bucks or Philadelphia County	$0

Keystone 65 Focus Rx HMO-POS	
	And You Have...
	Keystone 65 Focus Rx HMO-POS
If You Live In...	You Pay...
Chester, Delaware, or Montgomery County	$15
Bucks or Philadelphia County	$0

Keystone 65 Select Rx HMO	
	And You Have...
	Keystone 65 Select Rx HMO
If You Live In...	You Pay...
Chester, Delaware, or Montgomery County	$83.50
Bucks or Philadelphia County	$57.50

Keystone 65 Select Medical-Only HMO	
	And You Have...
	Keystone 65 Select Medical-Only HMO
If You Live In...	You Pay...
Chester, Delaware, or Montgomery County	$49.50
Bucks or Philadelphia County	$34.50

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Deductible	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.
Maximum Out-of-Pocket (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)	$7,550 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	$6,500 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. The Point-of-Service annual maximum is $1,000. Out-of-network cost-sharing does NOT apply to the MOOP.

Covered Medical and Hospital Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Inpatient Hospital Coverage (1)	$250 copayment per day for days 1 through 7 per admission. You pay nothing per day for days 8 and beyond per admission; $1,750 maximum copayment per admission. No copayment on day of discharge. Unlimited days per benefit period.	$210 copayment per day for days 1 through 6 per admission. You pay nothing per day for days 7 and beyond per admission; $1,260 maximum copayment per admission. No copayment on day of discharge. Unlimited days per benefit period.
Inpatient Hospital Stay - Acute due to COVID-19 diagnosis (1)	$0 copayment	In-Network: $0 copayment Out-of-Network: 20% coinsurance
Outpatient Hospital Coverage		
• **Outpatient Hospital Facility (1)**	$350 copayment	In-Network: $325 copayment Out-of-Network: 20% coinsurance
• **Observation Services**	$350 copayment per stay	$325 copayment per stay Out-of-Network: 20% coinsurance

Services with a (1) may require prior authorization.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
This plan does not have a deductible for covered medical services.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.
$4,900 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	$4,900 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$250 copayment per day for days 1 through 6 per admission. You pay nothing per day for days 7 and beyond per admission; $1,500 maximum copayment per admission. No copayment on day of discharge. Unlimited days per benefit period.	$250 copayment per day for days 1 through 6 per admission. You pay nothing per day for days 7 and beyond per admission; $1,500 maximum copayment per admission. No copayment on day of discharge. Unlimited days per benefit period.
$0 copayment	$0 copayment
$350 copayment	$350 copayment
$350 copayment per stay	$350 copayment per stay

Services with a (1) may require prior authorization.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Doctor's Office Visits		
• **Primary Care Physician**	$0 copayment	In-Network: $0 copayment Out-of-Network: 20% coinsurance
• **Specialist**	$35 copayment	In-Network: $40 copayment Out-of-Network: 20% coinsurance
Preventive Care (1) (e.g., flu vaccine, diabetic screenings)	You pay nothing. 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.	You pay nothing. 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. Out-of-Network: 20% coinsurance
Emergency Care - covered worldwide	$90 copayment Not waived if admitted	$90 copayment Not waived if admitted
Urgently Needed Services - covered worldwide	$15 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $90 copayment per visit for Worldwide Urgent Coverage Not waived if admitted Emergency and urgently needed care services received outside the U.S. do not count toward the MOOP.	$10 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted In-Network: $90 copayment per visit for Worldwide Urgent Coverage Not waived if admitted. Out-ot-Network: Not covered Emergency and urgently needed care services received outside the U.S. do not count toward the MOOP.
Diagnostic Services, Lab and Radiology Services, and X-rays	$0 copayment applies to certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopies that result from a preventive colonoscopy).	In-Network: $0 copayment applies to certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopies that result from a preventive colonoscopy).
• **Diagnostic Radiology Services (1)**	$45 or $250 copayment depending on service	$40 or $250 copayment depending on service
• **Diagnostic procedures, tests, and lab services (1)**	$0 copayment	$0 copayment
• **Outpatient X-rays**	$45 copayment for routine radiology services	$40 copayment for routine radiology services
• **Therapeutic Radiology (1)**	$60 copayment	$60 copayment Out-of-network: 20% coinsurance
• **Therapeutic Radiology for Breast Cancer**	$0 copayment with a diagnosis of breast cancer	$0 copayment with a diagnosis of breast cancer

Services with a (1) may require prior authorization.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$0 copayment	$0 copayment
$40 copayment	$40 copayment
You pay nothing. 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.	You pay nothing. 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.
$90 copayment Not waived if admitted	$90 copayment Not waived if admitted
$15 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $90 copayment per visit for Worldwide Urgent Coverage Not waived if admitted Emergency and urgently needed care services received outside the U.S. do not count toward MOOP.	$15 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $90 copayment per visit for Worldwide Urgent Coverage Not waived if admitted Emergency and urgently needed care services received outside the U.S. do not count toward MOOP.
$0 copayment applies to certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopies that result from a preventive colonoscopy). $40 or $200 copayment depending on service $0 copayment $40 copayment for routine radiology services $60 copayment $0 copayment with a diagnosis of breast cancer	$0 copayment applies to certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopies that result from a preventive colonoscopy). $40 or $200 copayment depending on service $0 copayment $40 copayment for routine radiology services $60 copayment $0 copayment with a diagnosis of breast cancer

Services with a (1) may require prior authorization.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Hearing Services		
• **Hearing Exam**	$35 copayment for Medicare-covered hearing exams $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $40 copayment for Medicare-covered hearing exams Out-of-Network: 20% coinsurance $0 copayment for routine non-Medicare-covered hearing exams once every year
• **Hearing Aid**	$699 copayment for an advanced digital hearing aid or $999 copayment for a premium digital hearing aid per year, per ear; premium includes a rechargeable hearing aid option; unlimited hearing aid fittings per year; and up to 2 hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing provider. Routine hearing services do not count towards annual MOOP.	$699 copayment for an advanced digital hearing aid or $999 copayment for a premium digital hearing aid per year, per ear; premium includes a rechargeable hearing aid option; unlimited hearing aid fittings per year; and up to 2 hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing provider. Routine hearing services do not count towards annual MOOP.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$40 copayment for Medicare-covered hearing exams	$40 copayment for Medicare-covered hearing exams
$0 copayment for routine non-Medicare-covered hearing exams once every year	$0 copayment for routine non-Medicare-covered hearing exams once every year
$499 copayment for an advanced digital hearing aid or $799 copayment for a premium digital hearing aid per year, per ear; premium includes a rechargeable hearing aid option; unlimited hearing aid fittings per year; and up to 2 hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing provider. Routine hearing services do not count towards annual MOOP.	$499 copayment for an advanced digital hearing aid or $799 copayment for a premium digital hearing aid per year, per ear; premium includes a rechargeable hearing aid option; unlimited hearing aid fittings per year; and up to 2 hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing provider. Routine hearing services do not count towards annual MOOP.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Dental Services	$35 copayment for non-routine Medicare-covered dental services in a specialist office	In-Network: $40 copayment for non-routine Medicare-covered dental services in a specialist office Out-of-Network: 20% coinsurance
	$0 copayment for routine non-Medicare-covered exam and cleaning every six months; $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 3 years.	$0 copayment for routine non-Medicare-covered exam and cleaning every six months; $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 3 years.
	$2,500 in-network allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services.	$2,000 in-network allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services.
	20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, other oral/maxillofacial surgery, and other services.	20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, other oral/maxillofacial surgery, and other services.
	Member must use in-network United Concordia dental providers.	Member must use in-network United Concordia dental providers.
	Routine dental services do NOT count toward the annual MOOP.	Routine dental services do NOT count toward the annual MOOP.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$40 copayment for non-routine Medicare-covered dental services in a specialist office	$40 copayment for non-routine Medicare-covered dental services in a specialist office
$0 copayment for routine non-Medicare-covered exam and cleaning every six months; $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 3 years.	$0 copayment for routine non-Medicare-covered exam and cleaning every six months; $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 3 years.
$2,000 in-network allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services.	$2,000 in-network allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services.
20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services.	20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services.
Member must use in-network United Concordia dental providers.	Member must use in-network United Concordia dental providers.
Routine dental services do NOT count toward the annual MOOP.	Routine dental services do NOT count toward the annual MOOP.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Vision Services	$35 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; and $0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 plan allowance every year on eyewear (glasses and lenses) purchased through Visionworks; $150 plan allowance every year for all other eyewear (glasses and lenses) purchased through Davis Vision; $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear does not include lens options, such as tints, progressives, Transitions lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.	In-Network: $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; and $0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: 20% coinsurance $0 copay for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 plan allowance every year on eyewear (glasses and lenses) purchased through Visionworks; $150 plan allowance every year for all other eyewear (glasses and lenses) purchased through Davis Vision; $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear does not include lens options, such as tints, progressives, Transitions lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$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; and $0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery.	$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; and $0 copayment for Medicare-covered eyeglasses or contact lenses after cataract surgery.
$0 copay for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 plan allowance every year on eyewear (glasses and lenses) purchased through Visionworks; $150 plan allowance every year for all other eyewear (glasses and lenses) purchased through Davis Vision; $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear does not include lens options, such as tints, progressives, Transitions lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.	$0 copay for one routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 plan allowance every year on eyewear (glasses and lenses) purchased through Visionworks; $150 plan allowance every year for all other eyewear (glasses and lenses) purchased through Davis Vision; $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear does not include lens options, such as tints, progressives, Transitions lenses, polish, and insurance. Routine vision services (exam and eyewear) do not count towards the annual MOOP.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Mental Health Services		
• Inpatient Mental Health Care (2)	$250 copayment per day for days 1 through 7 per admission You pay nothing for day 8 and beyond per admission $1,750 maximum copayment per admission 190-day lifetime maximum in a mental health facility	$210 copayment per day for days 1 through 6 per admission You pay nothing for day 7 and beyond per admission $1,260 maximum copayment per admission 190-day lifetime maximum in a mental health facility Out-of-Network: 20% coinsurance
• Outpatient Therapy (Group and Individual) (2)	$40 copayment	In-Network: $40 copayment Out-of-Network: 20% coinsurance
• Outpatient Substance Abuse Services (Group and Individual)	$40 copayment	In-Network: $40 copayment Out-of-Network: 20% coinsurance
• Partial Hospitalization (2)	$40 copayment	In-Network: $40 copayment Out-of-Network: 20% coinsurance
Skilled Nursing Facility (1)	$0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 100 days per benefit period	$0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 100 days per benefit period Out-of-Network: 20% coinsurance
Physical Therapy (1)	$25 copayment	$20 copayment Out-of-Network: 20% coinsurance
Ambulance (1)	$300 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	$275 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization Out-of-Network: 20% coinsurance
Transportation	Not covered (offered under uniform flexibility, see page 26)	Not covered
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	20% coinsurance for Part B drugs, such as chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.	20% coinsurance for Part B drugs, such as chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 20% coinsurance
Ambulatory Surgical Services (1)	$200 copayment	In-Network: $200 copayment Out-of-Network: 20% coinsurance

Services with a (1) may require prior authorization.
(2) Prior authorization is required by Magellan Behavioral Health.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$250 copayment per day for days 1 through 6 per admission You pay nothing for day 7 and beyond per admission $1,500 maximum copayment per admission 190-day lifetime maximum in a mental health facility	$250 copayment per day for days 1 through 6 per admission You pay nothing for day 7 and beyond per admission $1,500 maximum copayment per admission 190-day lifetime maximum in a mental health facility
$40 copayment	$40 copayment
$40 copayment	$40 copayment
$40 copayment	$40 copayment
$0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 100 days per benefit period	$0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 100 days per benefit period
$20 copayment	$20 copayment
$250 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	$250 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Not covered (offered under uniform flexibility, see page 26)	Not covered (offered under uniform flexibility, see page 26)
20% coinsurance for Part B drugs, such as chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.	20% coinsurance for Part B drugs, such as chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.
$200 copayment	$200 copayment

Services with a (1) may require prior authorization.

Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Keystone 65 Basic Rx HMO, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO. This benefit is not available for members of Keystone 65 Select Medical-Only HMO.

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Initial Coverage Stage	You pay the following until your total yearly drug costs reach $4,430. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. 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. For information, please review the Keystone 65 HMO *Evidence of Coverage*.	You pay the following until your total yearly drug costs reach $4,430. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. 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. For information, please review the Keystone 65 HMO *Evidence of Coverage*.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
Part D prescription drugs are not available with this plan.	You pay the following until your total yearly drug costs reach $4,430. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. 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. For information, please review the Keystone 65 HMO *Evidence of Coverage*.

Prescription Drug Benefits (Part D) (cont.)	Keystone 65 Basic Rx HMO		
Retail Cost-Sharing (what you pay at a pharmacy location)	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)			
Preferred Pharmacy	$0 copayment	$0 copayment	$0 copayment
Standard Pharmacy	$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)			
Preferred Pharmacy	$10 copayment	$20 copayment	$20 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 3 (Insulin Savings Program)			
Preferred Pharmacy	Not covered	Not covered	Not covered
Standard Pharmacy			

Keystone 65 Focus Rx HMO-POS			Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO		
One-Month Supply	Two-Month Supply	Three-Month Supply	Part D prescription drugs are not available with this plan.	One-Month Supply	Two-Month Supply	Three-Month Supply
$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment		$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment
$10 copayment $20 copayment	$20 copayment $40 copayment	$20 copayment $60 copayment		$9 copayment $20 copayment	$18 copayment $40 copayment	$18 copayment $60 copayment
$47 copayment $47 copayment	$94 copayment $94 copayment	$141 copayment $141 copayment		$47 copayment $47 copayment	$94 copayment $94 copayment	$141 copayment $141 copayment
Insulin: $35 copayment* Insulin: $35 copayment*	Insulin: $70 copayment* Insulin: $70 copayment*	Insulin: $105 copayment* Insulin: $105 copayment*		Insulin: $35 copayment* Insulin: $35 copayment*	Insulin: $70 copayment* Insulin: $70 copayment*	Insulin: $105 copayment* Insulin: $105 copayment*

*Insulin copayment through the coverage gap for covered select insulins offered under the Insulin Savings Program.

Prescription Drug Benefits (Part D) (cont.)	Keystone 65 Basic Rx HMO		
Retail Cost-Sharing (what you pay at a pharmacy location) continued	One-Month Supply	Two-Month Supply	Three-Month Supply
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
Mail-Order Cost-Sharing (what you pay when you order a prescription by mail)			
Tier 1 (Preferred Generic Drugs)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic Drugs)	$10 copayment	$20 copayment	$20 copayment
Tier 3 (Preferred Brand Drugs)	$47 copayment	$94 copayment	$94 copayment
Tier 4 (Non-Preferred Drugs)	$100 copayment	$200 copayment	$200 copayment
Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	33% coinsurance

Keystone 65 Focus Rx HMO-POS			Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO		
One-Month Supply	Two-Month Supply	Three-Month Supply	Part D prescription drugs are not available with this plan.	One-Month Supply	Two-Month Supply	Three-Month Supply
$100 copayment $100 copayment	$200 copayment $200 copayment	$300 copayment $300 copayment		$100 copayment $100 copayment	$200 copayment $200 copayment	$300 copayment $300 copayment
33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance		33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance
$0 copayment	$0 copayment	$0 copayment		$0 copayment	$0 copayment	$0 copayment
$10 copayment	$20 copayment	$20 copayment		$9 copayment	$18 copayment	$18 copayment
$47 copayment Insulin* $35 copayment	$94 copayment Insulin* $70 copayment	$94 copayment Insulin* $70 copayment		$47 copayment Insulin* $35 copayment	$94 copayment Insulin* $70 copayment	$94 copayment Insulin* $70 copayment
$100 copayment	$200 copayment	$200 copayment		$100 copayment	$200 copayment	$200 copayment
33% coinsurance	33% coinsurance	33% coinsurance		33% coinsurance	33% coinsurance	33% coinsurance

*Insulin copayment through the coverage gap for covered select insulins offered under the Insulin Savings Program.

Prescription Drug Benefits (Part D) (cont.)	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
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. 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 $4,430. 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. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.	During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. 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 $4,430. 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. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
Coverage Gap Stage	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 $4,430. 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 $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.	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 $4,430. 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 $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the costs; or • $3.95 copayment for generic (including brand drugs tested as generic) and a $9.85 copayment for all other drugs	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the cost; or • $3.95 copayment for generic (including brand drugs tested as generic) and a $9.85 copayment for all other drugs

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
Part D prescription drugs are not available with this plan.	During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. 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 $4,430. 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. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
	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 $4,430. 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 $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the cost; or • $3.95 copayment for generic (including brand drugs tested as generic) and a $9.85 copayment for all other drugs

Other Medical Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS
Podiatry Services		
• Medical Condition (Medicare-covered podiatry care)	$25 copayment per visit for condition treatment	In-Network: $25 copayment per visit for condition treatment Out-of-Network: 20% coinsurance per visit
• Routine Foot Care (non-Medicare-covered)	$25 copayment per visit (up to 6 visits each year)*	In-Network: $25 copayment per visit (up to 6 visits each year)* Out-ot-Network: Not covered
Over-the-Counter (OTC) Items	$60 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 card to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via catalog by phone or through the specified online retailer(s).	$60 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 card to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via catalog by phone or through the specified online retailer(s).
Telemedicine Visits	$0 copayment for medical doctor visits focused on non-urgent medical conditions; $0 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 visits from another provider will not be covered.	$0 copayment for medical doctor visits focused on non-urgent medical conditions; $0 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 visits from another provider will not be covered.
Chiropractic Services		
• Medical Condition (Medicare-covered)	$20 copayment per visit for spinal manipulations	In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 20% coinsurance
• Routine Care* (non-Medicare-covered)	$20 copayment per visit (up to 6 visits each year)	$20 copayment per visit (up to 6 visits each year)
Acupuncture		
• Medical Condition (Medicare-covered)	$20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made	In-Network: $20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made Out-of-Network: 20% coinsurance
• Routine Care† (non-Medicare-covered)	$20 copayment per visit (up to 6 visits each year)	In-Network: $20 copayment per visit (up to 6 visits each year) Out-of-Network: Not covered

 *Routine visits does not count toward MOOP.

Keystone 65 Select Medical-Only HMO	Keystone 65 Select Rx HMO
$20 copayment per visit for condition treatment	$20 copayment per visit for condition treatment
$20 copayment per visit (up to 6 visits each year)*	$20 copayment per visit (up to 6 visits each year)*
$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 card to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via catalog by phone or through the specified online retailer(s).	$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 card to purchase OTC items at participating retailers. Over-the-counter items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via catalog by phone or through the specified online retailer(s).
$0 copayment for medical doctor visits focused on non-urgent medical conditions; $0 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 visits from another provider will not be covered.	$0 copayment for medical doctor visits focused on non-urgent medical conditions; $0 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. MDLIVEdoctors are state-licensed physicians. Telemedicine visits from another provider will not be covered.
$20 copayment per visit for spinal manipulations $20 copayment per visit (up to 6 visits each year)	$20 copayment per visit for spinal manipulations $20 copayment per visit (up to 6 visits each year)
$20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made $20 copayment per visit (up to 6 visits each year)	$20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made $20 copayment per visit (up to 6 visits each year)

† Routine services **must** have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, chemotherapy-induced nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.

Uniform Flexibility Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS	Keystone 65 Select Rx HMO and Keystone 65 Select Medical-Only HMO
Vital Care Program*	$10 copayment for cardiology specialist visits $10 copayment for endocrinology specialist visits $5 copayment for Medicare-covered podiatry visits $5 copayment for routine podiatry visits, up to 6 visits per year. Routine podiatry visits do NOT apply to MOOP. Members must have both diabetes and congestive heart failure to participate.	Not covered	$10 copayment for cardiology specialist visits $10 copayment for endocrinology specialist visits $5 copayment for Medicare-covered podiatry visits $5 copayment for routine podiatry visits, up to 6 visits per year. Routine podiatry visits do NOT apply to MOOP. Members must have both diabetes and congestive heart failure to participate.
Vital Care Plus Program*	Not covered	$10 copayment for cardiology specialist visits $10 copayment for endocrinology specialist visits $10 copayment for pulmonary specialist visits $5 copayment for Medicare-covered podiatry visits $5 copayment for routine podiatry visits, up to six visits per year $80 quarterly allowance for over-the-counter (OTC) items Members must have diabetes to participate.	Not covered
Transportation Services	$0 copayment 12 one-way trips per year by Roundtrip to plan-approved medical facilities. Members must have both diabetes and congestive heart failure to participate.	Not covered	$0 copayment 12 one-way trips per year by Roundtrip to plan-approved medical facilities. Members must have both diabetes and congestive heart failure to participate.

Insulin Savings Program Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Focus Rx HMO-POS	Keystone 65 Select Rx HMO and Keystone 65 Select Medical-Only HMO
Grocery Benefits	$0 copayment Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member. Members must have both diabetes and depression to be eligible for the grocery benefit.	$0 copayment Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member. Members must have both diabetes and depression to be eligible for the grocery benefit.	$0 copayment Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member. Members must have both diabetes and depression to be eligible for the grocery benefit.
Meals Program	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups. Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer. Group 2: Must have both diabetes and congestive heart failure.†	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups. Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer. Group 2: Must have both diabetes and congestive heart failure.†	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups. Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer. Group 2: Must have both diabetes and congestive heart failure.†

* Cardiology, endocrinology, and podiatry visits apply toward your maximum out-of-pocket amount. Routine podiatry visits do not apply toward your maximum out-of-pocket amount.

† Group 2 member 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.

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** 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, 2023.

- ☐ 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).

- ☐ Our Keystone 65 Focus Rx HMO-POS plan allows you to see providers outside of our network (non-contracted providers). However, while we pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

For more information

For updated information regarding plan providers, visit our website at **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 January 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.

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

Magellan Behavioral Health, Inc., an independent company, manages mental health and substance abuse benefits for most Independence Blue Cross members.

Quartet is a separate and independent company that provides mental health services for Independence Blue Cross members.

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

Vision benefits are underwritten by Keystone Health Plan East and administered by Davis Vision, an independent company. An affiliate of Independence Blue Cross has a financial interest in Visionworks, an independent company.

Dental benefits are underwritten by Keystone Health Plan East and administered by United Concordia Companies, Inc., an independent company.

FutureScripts® Secure is an independent company that provides pharmacy benefit management services.

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

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

Telemedicine is provided by MDLIVE, an independent company.

Strive Health, LLC is an independent company that administers kidney care management to select members of Independence Blue Cross Medicare Advantage plans.

Roundtrip is an independent company that administers our transportation benefit.

United by Blue is an independent company that administers our grocery delivery benefit.

MANNA is an independent company and administers our meals program benefit.

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** or **TTY/TDD: 711** for more information.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

1-800-275-2583 કોલ કરો.

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

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

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

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

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

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

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

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

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, 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'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: 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 នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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. 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*.

Notes

Independence

Keystone 65 HMO

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www.ibxmedicare.com

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