Keystone 65 Basic Rx (HMO) offered by Keystone Health Plan East, Inc., a subsidiary of Independence Blue Cross, LLC ("IBX")

Annual Notice of Changes for 2025

You are currently enrolled as a member of Keystone 65 Basic Rx. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

OMB Approval 0938-1051 (Expires: August 31, 2026)

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Keystone 65 Basic 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, 2025.** This will end your enrollment with Keystone 65 Basic Rx.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Help Team number at 1-800-645-3965 for additional information. (TTY/TDD 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. This call is free.
- 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 Basic Rx

- Independence Blue Cross offers HMO and HMO-POS Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross HMO and HMO-POS 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 Basic Rx.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Keystone 65 Basic Rx in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
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.)	$7,550	$7,250
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $35 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $30 copayment per visit
Inpatient hospital stays	$250 copayment per day for days 1-7 per admission $1,750 maximum copayment per admission	$250 copayment per day for days 1-7 per admission $1,750 maximum copayment per admission
Part D prescription drug coverage (See Section 1.5 for details.)	Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $20 • Drug Tier 3: $47 You pay $35 per month supply of each covered	Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy: • Drug Tier 1: $9 • Drug Tier 2: $20 • Drug Tier 3: 25% You pay $35 per month supply of each covered

Cost	2024 (this year)	2025 (next year)
	insulin product on this tier. • Drug Tier 4: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% You pay $35 per month supply of each covered insulin product on this tier. Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $8 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	insulin product on this tier. • Drug Tier 4: 50% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% You pay $35 per month supply of each covered insulin product on this tier. Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: 25% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 50% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Part B Premium Reduction	$0	$6.10

- 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.

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	2024 (this year)	2025 (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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550	$7,250 Once you have paid $7,250 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

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred

cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at www.ibxmedicare.com/directory. You may also call our Member Help Team for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider/Pharmacy Directory*** www.ibxmedicare.com/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 2025 *Provider/Pharmacy Directory*** www.ibxmedicare.com/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	2024 (this year)	2025 (next year)
Additional Telehealth	You pay a $35 copay per Specialist visit. You pay a $35 copay per Other Healthcare Professional visit. Prior authorization is required for select services.	You pay a $30 copay per Specialist visit. You pay a $30 copay per Other Healthcare Professional visit. Prior authorization is not required.
Ambulatory Surgical Services (ASC)	You pay a $200 copay for this benefit.	You pay a $150 copay for this benefit.
Caregiver Support Services	Caregiver Support Services are not covered.	You pay a $0 copay for training, education, and resources for caregivers. A member's caregiver or a member who is a caregiver can enroll in the support

Cost	2024 (this year)	2025 (next year)
		services from the plan-specified vendor. For more information, contact our Member Help Team.
Dementia Support Program	You pay a $35 copay per Specialist visit.	You pay a $0 copay for neurology visits, including telehealth neurology visits for members with a diagnosis of dementia. Members must be enrolled in the dementia support program provided from the plan-specified vendor. To find out if you're eligible, contact our Member Help Team.
Dental Services – Medicare-Covered	You pay a $35 copay for Medicare-covered dental services.	You pay a $30 copay for Medicare-covered dental services.
Dental Services – Non-Medicare-Covered	You must use a participating United Concordia - Concordia Choice Plus Medicare Advantage dental network provider for in-network routine and comprehensive dental coverage not covered by Original Medicare. The following are non-Medicare-covered routine dental services: You pay a $0 copay for non-Medicare-covered routine dental services. • Two limited problem focused exams every 12 months are not covered.	You must use a participating IBX Medicare Dental Network provider for in-network preventive, diagnostic, and comprehensive dental coverage not covered by Original Medicare. The following are non-Medicare-covered preventive and diagnostic dental services: You pay a $0 copay for non-Medicare-covered preventive and diagnostic dental services. • Two limited problem focused exams every 12 months are covered.

Cost	2024 (this year)	2025 (next year)
	• One detailed and extensive problem focused exam every 12 months is not covered. • One comprehensive oral evaluation every 36 months is not covered. • One comprehensive periodontal evaluation every 36 months is not covered. • Two dental consultations every 12 months are not covered. • One fluoride treatment every 12 months is not covered. The following non-Medicare covered comprehensive dental services: You receive a $2,500 annual plan maximum allowance every year for the following comprehensive dental services: restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services. You pay 20% of the total cost for the following comprehensive dental services: restorative services, endodontics, periodontics, and extractions.	• One detailed and extensive problem focused exam every 12 months is covered. • One comprehensive oral evaluation every 36 months is covered. • One comprehensive periodontal evaluation every 36 months is covered. • Two dental consultations every 12 months are covered. • One fluoride treatment every 12 months is covered. The following non-Medicare covered comprehensive dental services: You receive a $2,500 allowance every year for the following comprehensive dental services: restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. You pay 10% of the total cost for the following comprehensive dental services: restorative services, endodontics, periodontics, and extractions.

<table>
<tr><th>Cost</th><th>2024 (this year)</th><th>2025 (next year)</th></tr>
<tr><td></td><td>You pay 40% of the total cost for the following comprehensive dental services: prosthodontics, other oral/maxillofacial surgery, and other services.

Your plan coverage of these services includes:

Endodontics:
• One root canal retreatment per tooth per lifetime, is <u>not</u> covered
• One root canal repair per tooth per lifetime, is <u>not</u> covered

Periodontics:
• Three periodontal maintenance procedures per year are covered
• One scaling and root planing procedure every 36 months per mouth quadrant is covered
• One full mouth debridement per lifetime is <u>not</u> covered

Prosthodontics:
• One implant per tooth every five years is <u>not</u> covered
• One set bridges every five years is <u>not</u> covered</td><td>You pay 10% of the total cost for the following comprehensive dental services: prosthodontics, implants, and other oral/maxillofacial surgery.

Your plan coverage of these services includes:

Endodontics:
• One root canal retreatment per tooth per lifetime, is covered
• One root canal repair per tooth per lifetime, is covered

Periodontics:
• Four periodontal maintenance procedures every 12 months are covered
• One scaling and root planing procedure every 24 months per mouth quadrant is covered
• One full mouth debridement per lifetime is covered

Prosthodontics:
• One implant per tooth every five years is covered
• One set bridges every five years is covered</td></tr>
</table>

Cost	2024 (this year)	2025 (next year)
	• One set dentures every four years is covered • One set partial dentures every five years is not covered • One denture rebase every two years is not covered • One denture repair every two years is not covered • One bridge/partial per mouth quadrant every four years is covered • One tissue conditioning per tooth per denture per life is not covered Oral/Maxillofacial Surgery: • One oral surgery procedure per year is covered	• One complete set of dentures every five years is covered • One set partial dentures every five years is covered • One denture rebase every 24 months is covered • One denture repair every 24 months is covered • One tissue conditioning per tooth per denture per life is covered Oral/Maxillofacial Surgery: • Unlimited oral surgery is covered
Emergency Care	You pay a $100 copay for this benefit.	You pay a $110 copay for this benefit.
Emergency Care – Worldwide	You pay a $100 copay for this benefit.	You pay a $110 copay for this benefit.
Hearing Services	You pay a $35 copay for Medicare-covered hearing exams.	You pay a $30 copay for Medicare-covered hearing exams.
Inpatient Hospital Stay-Acute due to COVID-19 Diagnosis	You pay a $0 copay for this benefit.	You pay a $250 copay per day for days 1-7 per admission. You pay a $1,750 maximum copay per admission.
Medical, Dental, Vision, and Hearing	A $300 annual allowance will be preloaded on the IBX Care Card.	A $300 annual allowance will be preloaded on the IBX Care Card.

<table>
<tr><th>Cost</th><th>2024 (this year)</th><th>2025 (next year)</th></tr>
<tr><td></td><td>This allowance can be used to:

Pay the out-of-pocket expenses (copayment or coinsurance) for covered dental, vision, and hearing benefits.

Pay for dental, vision, or hearing services or supplies provided by a licensed dental, vision, or hearing professional that accepts the IBX Care Card.

Any unused balance will not roll over to the next calendar year.</td><td>This allowance can be used to:

Pay the out-of-pocket expenses (copayment or coinsurance) for covered dental, vision, and hearing benefits.

Pay for dental, vision, or hearing services or supplies provided by a licensed dental, vision, or hearing professional that accepts the IBX Care Card.

Pay the out-of-pocket expenses (copayment or coinsurance) for select medical services from any licensed medical provider who accepts the IBX Care Card for the following covered services:
• Ambulance services
• Ambulatory surgical center
• Cardiac rehabilitation services (including intensive cardiac rehabilitation), pulmonary rehabilitation services, and supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD)
• Dialysis
• Emergency care</td></tr>
</table>

Cost	2024 (this year)	2025 (next year)
		• Inpatient hospital care - acute services • Inpatient services in a psychiatric hospital • Medicare Part B prescription drugs • Other healthcare professional visits • Outpatient hospital observation • Outpatient hospital services • Outpatient mental health care • Outpatient substance use disorder services • Physician/Practitioner services -physical, speech, and occupational therapy • Podiatry services • Radiation therapy • Routine and complex radiology • Select telehealth • Skilled nursing facility (SNF) care • Specialist visits • Urgently needed services Any unused balance will not roll over to the next calendar year. The Medical, Dental, Vision, and Hearing Flex benefit annual allowance is a separate allowance amount

Cost	2024 (this year)	2025 (next year)
		from the quarterly over-the-counter (OTC) benefit allowance that is also preloaded on the IBX Care Card. Members should use their current IBX Care Card through the expiration date.
Other Healthcare Professional	You pay a $35 copay per Other Healthcare Professional visit.	You pay a $30 copay per Other Healthcare Professional visit.
Outpatient Hospital Services	You pay a $350 copay for outpatient hospital services.	You pay a $300 copay for outpatient hospital services.
Outpatient Observation Stays	You pay a $350 copay for outpatient observation stays.	You pay a $300 copay for outpatient observation stays.
Outpatient Rehabilitation Services	Prior authorization is required.	Prior authorization is not required.
Skilled Nursing Facility (SNF) Care	You pay a $0 copay per day for days 1-20. You pay a $203 copay per day for days 21-100.	You pay a $0 copay per day for days 1-20. You pay a $214 copay per day for days 21-100.
Specialist Visits	You pay a $35 copay per Specialist visit.	You pay a $30 copay per Specialist visit.
Urgently Needed Services	You pay a $55 copay per urgent care center visit.	You pay a $45 copay per urgent care center visit.
Urgently Needed Services – Worldwide	You pay a $100 copay for this benefit.	You pay a $110 copay for this benefit.
Vision Services	You pay a $35 copay for Medicare-covered vision exams.	You pay a $30 copay for Medicare-covered vision exams.

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," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact our Member Help Team or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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, 2024, please call our Member Help Team and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

For drugs on Preferred Brand Tier (Tier 3) and Non-Preferred Drug Tier (Tier 4), your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (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**. For 2024 you paid a $47 for drugs on Preferred Brand Tier (Tier 3). For 2025 you will pay 25% for drugs on this tier. For 2024 you paid a $100 for drugs on Non-Preferred Drug Tier (Tier 4). For 2025	Your cost for a one-month supply is: **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 $8 per prescription.	Your cost for a one-month supply is: **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 $0 per prescription.

Stage	2024 (this year)	2025 (next year)
you will pay 50% for drugs on this tier. 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." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month mail-order prescription is $8. **Preferred Brand Tier (Tier 3):** *Standard cost sharing*: You pay $47 per prescription. *Preferred cost sharing*: You pay $47 per prescription. Your cost for a one-month mail-order prescription is $47. **Non-Preferred Drug Tier (Tier 4):** *Standard cost sharing*: You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. Your cost for a one-month mail-order prescription is $100. **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 you have paid $8,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month mail-order prescription is $0. **Preferred Brand Tier (Tier 3):** *Standard cost sharing*: You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost. **Non-Preferred Drug Tier (Tier 4):** *Standard cost sharing*: You pay 50% of the total cost. *Preferred cost sharing:* You pay 50% of the total cost. Your cost for a one-month mail-order prescription is 50% of the total cost. **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 you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Dental Claims Mailing Address Change	Dental claims are mailed to: P.O. Box 69422 Harrisburg, PA 17106	Dental claims will be mailed to: P.O. Box 211424 Eagan, MN 55121
Dental Network Change	You must use a participating **United Concordia – Concordia Choice Plus Medicare Advantage** network provider for in-network routine, and comprehensive dental coverage not covered by Original Medicare.	You must use a participating **IBX Medicare Dental** Network provider for in-network preventive, diagnostic, and comprehensive dental coverage not covered by Original Medicare. Visit our *Find a Dentist* tool, ibxmedicare.com/findadentist to check if your dentist is in-network.
Exceptions – Prescription Drug Coverage	If we approve your request for an exception, our approval usually is valid until the end of the plan year.	If we approve your request for an exception, our approval usually is valid until the end of the following plan year.
Explanation of Benefit (EOB) Change	You are mailed quarterly EOBs.	Your EOB will mail monthly.
Mail Order – Auto refills	Your prescription drug benefit does not offer automatic refills for mail-order prescriptions.	Your prescription drug benefit does offer automatic refills for mail-order prescriptions. You have the option to sign up for an automatic refill program. Under this program we will start to process your next refill

Description	2024 (this year)	2025 (next year)
		automatically when our records show you should be close to running out of your drug. If you choose not to use our auto-refill program, but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy seven to ten days before your current prescription will run out. This will ensure your order is shipped to you in time. To sign up for our auto refill program or request a refill, log in at ibx.com/login or call 1-888-678-7015 (TTY/TDD: 711) seven days a week, 24 hours a day.
Medicare Prescription Payment Plan	Not Applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January - December). To learn more about this payment option, please contact us at 1-800-645-3965 or visit Medicare.gov.
Member Identification (ID) Number Change	The member ID number has 15 characters. Your member ID number can be located on	The member ID number will have 13 characters. Your member ID number can be

Description	2024 (this year)	2025 (next year)
	the front of your member ID card.	located on the front of your member ID card. You will receive a new member ID card before January 1, 2025. Make sure to present this new member ID card and number when visiting your doctor, pharmacy, or receiving health care services.
Monthly Plan Premium and/or Part D Late Enrollment Penalty Billing Change for Electronic Funds Transfer (EFT)	If you use this payment option, your payment is withdrawn directly from your checking or savings account on the 15th of each month.	If you use this payment option, your payment will be withdrawn directly from your checking or savings account between the 5th and 15th of each month. The withdrawal will not occur on a weekend or bank holiday. At that time, the withdrawal occurs on the next business day.
Temporary Supply Coverage of your Drug	Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change. To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way.**	Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change. To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way.**

Description	2024 (this year)	2025 (next year)
	If you are a new member, we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan. **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **90 days** of the calendar year. This temporary supply will be for a maximum of a 30-day supply.	**If you are a new member,** we will cover a temporary supply of your drug during the first **120 days** of your membership in the plan. **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **120 days** of the calendar year. This temporary supply will be for a maximum of a 30-day supply.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Keystone 65 Basic Rx

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Keystone 65 Basic Rx.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Keystone Health Plan East, Inc. offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Keystone 65 Basic Rx.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Keystone 65 Basic Rx.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact our Member Help Team if you need more information on how to do 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 4 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 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 6 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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 am and 7 pm, 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.
- **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. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. 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, how to

enroll in the program or if you are currently enrolled how to continue receiving assistance, call the Pennsylvania Office of Medical Assistance Programs (OMAP) at 1-800-922-9384. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-800-645-3965 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Keystone 65 Basic Rx

Questions? We're here to help. Please call our Member Help Team at 1-800-645-3965. (TTY/TDD only, call 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 *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Keystone 65 Basic Rx. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at 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 7.2 – 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 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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.

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

IBX Medicare Dental Network administered by Dominion Dental Services, Inc., an independent company.

United Concordia Companies, Inc., an independent company.