Independence

Personal Choice 65℠ PPO

2022

Summary of Benefits

Effective January 1, 2022 through December 31, 2022

[redacted]

- Personal Choice 65℠ Elite Rx PPO
- Personal Choice 65℠ Prime Rx PPO
- Personal Choice 65℠ Saver Rx PPO
- Personal Choice 65℠ Medical-Only PPO
- Personal Choice 65℠ Rx PPO

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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 Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, Personal Choice 65 Medical-Only PPO, and Personal Choice 65 Rx PPO cover and what you pay.

Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, Personal Choice 65 Medical-Only PPO, and Personal Choice 65 Rx PPO are Medicare Advantage PPO (Preferred Provider Organization) plans. With a PPO plan, members don't have to choose a primary care physician (PCP) and can go to doctors in or out of the plan's network. If members use out-of-network doctors, hospitals, or other health care providers, they will pay more for their services.

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, Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO

Who can join?

To join a Personal Choice 65 PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

The service area for Personal Choice 65 Medical-Only PPO is Bucks and Philadelphia counties in Pennsylvania.

The service area for Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO is Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania.

Which doctors, hospitals, and pharmacies can I use?

The Personal Choice 65 PPO plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, a higher cost-sharing may apply. Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO have a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our list of network providers and pharmacies *(Provider/Pharmacy Directory)*, please visit www.ibxmedicare.com.

Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO 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.

Personal Choice 65 Medical-Only PPO covers Part B drugs, including chemotherapy and some other drugs administered by your provider. However, the plan does not cover Part D prescription drugs.

Monthly Plan Premium

Personal Choice 65 Elite Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Elite Rx PPO
	You pay...
Chester, Delaware, or Montgomery County	$51
Bucks or Philadelphia County	$51

Personal Choice 65 Prime Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Prime Rx PPO
	You pay...
Chester, Delaware, or Montgomery County	$0
Bucks or Philadelphia County	$0

Personal Choice 65 Saver Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Saver Rx PPO
	You pay...
Chester, Delaware, or Montgomery County	$0
Bucks or Philadelphia County	$0

Personal Choice 65 Medical-Only PPO	
If you live in...	And you have...
	Personal Choice 65 Medical-Only PPO
	You pay...
Chester, Delaware, or Montgomery County	n/a
Bucks or Philadelphia County	$179

Personal Choice 65 Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Rx PPO
	You pay...
Chester, Delaware, or Montgomery County	$165
Bucks or Philadelphia County	$294

Plan Costs

	Personal Choice 65 Elite Rx PPO
Deductible	This plan does not have a deductible for covered medical services or for Part D prescription drugs.
Part B Premium Reduction	This plan does not include a Part B premium reduction.
Maximum Out-of-Pocket (MOOP) Amount (the amounts you pay for your premium, Part D prescription drugs, and some medical services do not count toward your maximum out-of-pocket amount)	In-Network: $6,500 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In-Network and Out-of-Network: $10,000 each year

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
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.	Personal Choice 65 Medical-Only PPO does not have a deductible for covered medical services. Personal Choice 65 Rx PPO does not have a deductible for covered medical services or for Part D prescription drugs.
This plan does not include a Part B premium reduction.	This plan will reduce your monthly Part B premium by $50.	This plan does not include a Part B premium reduction.
In-Network: $7,550 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In-Network and Out-of-Network: $11,300 each year	In-Network: $7,550 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In-Network and Out-of-Network: $11,300 each year	In-Network: $5,000 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In-Network and Out-of-Network: $10,000 each year

Covered Medical and Hospital Benefits

	Personal Choice 65 Elite Rx PPO
Inpatient Hospital Coverage (1)	In-Network: $525 copayment per stay $0 copayment per day for additional days per admission $0 copayment on day of discharge Out-of-Network: 30% coinsurance
Inpatient Hospital Stay — Acute due to COVID-19 diagnosis (1)	In-Network: $0 copayment Out-of-Network: 30% coinsurance
Outpatient Hospital Services (1)	In-Network: $250 copayment per visit Out-of-Network: 30% coinsurance
• **Observation Services**	In-Network: $250 copayment per visit Out-of-Network: 30% coinsurance
Doctor's Office Visits	
• **Primary Care Physician**	In-Network: $0 copayment Out-of-Network: 30% coinsurance
• **Specialist**	In-Network: $35 copayment Out-of-Network: 30% coinsurance

Services with a (1) may require prior authorization (in-network only).

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $250 copayment per day for days 1-7 per admission $0 copayment per day for days 8 and beyond per admission $0 copayment on day of discharge Out-of-Network: 40% coinsurance	In-Network: $350 copayment per day for days 1-5 per admission $0 copayment per day for days 6 and beyond per admission $0 copayment on day of discharge $1,750 maximum copayment per admission Out-of-Network: 40% coinsurance	In-Network: $240 copayment per day for days 1-6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,440 maximum copayment per admission Out-of-Network: 30% coinsurance
In-Network: $0 copayment for In-Network Inpatient Hospital Stay — Acute Out-of-Network: 40% coinsurance	In-Network: $0 copayment for In-Network Inpatient Hospital Stay — Acute Out-of-Network: 40% coinsurance	In-Network: $0 copayment for In-Network Inpatient Hospital Stay — Acute Out-of-Network: 30% coinsurance
In-Network: $375 copayment per visit Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance per visit Out-of-Network: 40% coinsurance	In-Network: $300 copayment per visit Out-of-Network: 30% coinsurance
In-Network: $375 copayment per visit Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance per visit Out-of-Network: 40% coinsurance	In-Network: $300 copayment per visit Out-of-Network: 30% coinsurance
In-Network: $0 copayment Out-of-Network: 40% coinsurance	In-Network: $10 copayment Out-of-Network: 40% coinsurance	In-Network: $0 copayment Out-of-Network: 30% coinsurance
In-Network: $35 copayment Out-of-Network: 40% coinsurance	In-Network: $50 copayment Out-of-Network: 40% coinsurance	In-Network: $35 copayment Out-of-Network: 30% coinsurance

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Preventive Care (1) (e.g., flu vaccine, diabetic screenings)	In-Network: $0 copayment Out-of-Network: 30% coinsurance 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.
Emergency Care — covered worldwide Worldwide copayment outside the U.S. does not count towards the annual (MOOP)	In-Network and Out-of-Network: $90 copayment Not waived if admitted
Urgently Needed Services — covered worldwide Worldwide copayment outside the U.S. does not count towards the annual (MOOP)	In-Network and Out-of-Network: $5 copayment in a retail clinic Not waived if admitted In-Network and Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network and Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted

Services with a (1) may require prior authorization.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $0 copayment Out-of-Network: 40% coinsurance 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.	In-Network: $0 copayment Out-of-Network: 40% coinsurance 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.	In-Network: $0 copayment Out-of-Network: 30% coinsurance 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.
In-Network and Out-of-Network: $90 copayment Not waived if admitted	In-Network and Out-of-Network: $90 copayment Not waived if admitted	In-Network and Out-of-Network: $90 copayment Not waived if admitted.
In-Network and Out-of-Network: $10 copayment in a retail clinic Not waived if admitted In-Network and Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network and Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted	In-Network and Out-of-Network: $15 copayment in a retail clinic Not waived if admitted In-Network and Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network and Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted	In-Network and Out-of-Network: $5 copayment in a retail clinic Not waived if admitted In-Network and Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network and Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Diagnostic Services (1), Lab and Radiology Services (1), and X-rays	
• Diagnostic Radiology Services	$0 copayment for certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopy that results from a preventive colonoscopy) In-Network: $35 or $275 copayment, depending on service Out-of-Network: 30% coinsurance
• Diagnostic procedures, tests, and lab services	In-Network: $0 copayment Out-of-Network: 30% coinsurance
• Outpatient X-rays	In-Network: $35 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services
• Therapeutic Radiology (1)	In-Network: $60 copayment Out-of-Network: 30% coinsurance
• Therapeutic Radiology for Breast Cancer	In-Network: $0 copayment Out-of-Network: 30% coinsurance

Services with a (1) may require prior authorization (in-network only)

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
$0 copayment for certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopy that results from a preventive colonoscopy) In-Network: $50 or $300 copayment, depending on service Out-of-Network: 40% coinsurance	$0 copayment for certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopy that results from a preventive colonoscopy) In-Network: $55 or $350 copayment, depending on service Out-of-Network: 40% coinsurance	$0 copayment for certain diagnostic tests (e.g. home-based sleep studies provided by a home health agency; diagnostic colonoscopy that results from a preventive colonoscopy) In-Network: $40 or $175 copayment, depending on service Out-of-Network: 30% coinsurance
In-Network: $0 copayment Out-of-Network: 40% coinsurance	In-Network: $0 copayment Out-of-Network: 40% coinsurance	In-Network: $0 copayment Out-of-Network: 30% coinsurance
In-Network: $50 copayment for routine radiology services Out-of-Network: 40% coinsurance for routine radiology services	In-Network: $55 copayment for routine radiology services Out-of-Network: 40% coinsurance for routine radiology services	In-Network: $40 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services
In-Network: $60 copayment Out-of-Network: 40% coinsurance	In-Network: $60 copayment Out-of-Network: 40% coinsurance	In-Network: $60 copayment Out-of-Network: 30% coinsurance
In-Network: $0 copayment Out-of-Network: 40% coinsurance	In-Network: $0 copayment Out-of-Network: 40% coinsurance	In-Network: $0 copayment Out-of-Network: 30% coinsurance

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Hearing Services	
• **Hearing Exam**	In-Network: $35 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year
• **Hearing Aid**	In-Network and Out-of-Network: $399 copayment for an advanced digital hearing aid, per aid; or $699 copayment for a premium digital hearing aid, per aid. Premium includes rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; 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 maximum out-of-pocket (MOOP) cost.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $35 copayment for Medicare-covered hearing exams Out-of-Network: 40% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $50 copayment for Medicare-covered hearing exams Out-of-Network: 40% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In-Network: $35 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance In-Network and Out-of-Network: $0 copayment for routine non-Medicare-covered hearing exams once every year
In-Network and Out-of-Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Premium includes rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; 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 maximum out-of-pocket (MOOP) cost.	In-Network and Out-of-Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Premium includes rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; 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 maximum out-of-pocket (MOOP) cost.	In-Network and Out-of-Network: $499 copayment for an advanced digital hearing aid, per aid; or $799 copayment for a premium digital hearing aid, per aid. Premium includes rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; 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 maximum out-of-pocket (MOOP) cost.

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Dental Services	In-Network: $35 copayment for Medicare-covered dental services Out-of-Network: 30% coinsurance for Medicare-covered dental services In-Network: $0 copayment for routine 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 20% coinsurance for restorative services, endodontics, periodontics, and extractions 40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services Out-of-Network: 80% coinsurance for routine dental services 80% coinsurance for dental X-ray 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services In-Network and Out-of-Network: $2,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP cost.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $35 copayment for Medicare-covered dental services	In-Network: $50 copayment for Medicare-covered dental services	In-Network: $35 copayment for Medicare-covered dental services
Out-of-Network: 40% coinsurance for Medicare-covered dental services	Out-of-Network: 40% coinsurance for Medicare-covered dental services	Out-of-Network: 30% coinsurance for Medicare-covered dental services
In-Network: $0 copayment for routine exam and cleaning every six months	In-Network: $0 copayment for routine exam and cleaning every six months	In-Network: $0 copayment for routine 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 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 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
20% coinsurance for restorative services, endodontics, periodontics, and extractions	20% coinsurance for restorative services, endodontics, periodontics, and extractions	20% coinsurance for restorative services, endodontics, periodontics, and extractions
40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services	40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services	40% coinsurance for prosthodontics, other oral/ maxillofacial surgery, and other services
Out-of-Network: 80% coinsurance for routine dental services	Out-of-Network: 80% coinsurance for routine dental services	Out-of-Network: 80% coinsurance for routine dental services
80% coinsurance for dental X-ray	80% coinsurance for dental X-ray	80% coinsurance for dental X-ray
80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services
In-Network and Out-of-Network: $2,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services	In-Network and Out-of-Network: $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services	In-Network and Out-of-Network: $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, other oral/ maxillofacial surgery, and other services
Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP cost.	Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP cost.	Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP cost.

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Vision Services	In-Network: $0-35 copayment for Medicare-covered eye exams; $0 copayment for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery Out-of-Network: 30% coinsurance for Medicare-covered eye exams, for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery In-Network: $0 copayment for routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks $150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses) Eyewear coverage does not include lens options, such as tints, progressives, transitions lenses, polish and insurance Routine vision services do not count towards the annual MOOP Out-of-Network: 80% coinsurance Eyewear (frames and lenses, or contact lenses) have a $150 combined in- and out-of-network plan maximum benefit payable per year Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $0-35 copayment for Medicare-covered eye exams; $0 copayment for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	In-Network: $0-50 copayment for Medicare-covered eye exams; $0 copayment for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	In-Network: $0-35 copayment for Medicare-covered eye exams; $0 copayment for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
Out-of-Network: 40% coinsurance for Medicare-covered eye exams, for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	Out-of-Network: 40% coinsurance for Medicare-covered eye exams, for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	Out-of-Network: 30% coinsurance for Medicare-covered eye exams, for diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
In-Network: $0 copayment for routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection	In-Network: $0 copayment for routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection	In-Network: $0 copayment for routine eye exam every year; contact lenses or 1 pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection
$250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks	$250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks	$250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks
$150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider	$150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider	$150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider
$150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses)	$150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses)	$150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses)
Eyewear coverage does not include lens options, such as tints, progressives, transitions lenses, polish and insurance	Eyewear coverage does not include lens options, such as tints, progressives, transitions lenses, polish and insurance	Eyewear coverage does not include lens options, such as tints, progressives, transitions lenses, polish and insurance
Routine vision services do not count towards the annual MOOP	Routine vision services do not count towards the annual MOOP	Routine vision services do not count towards the annual MOOP
Out-of-Network: 80% coinsurance	Out-of-Network: 80% coinsurance	Out-of-Network: 80% coinsurance
Eyewear (frames and lenses, or contact lenses) have a $150 combined in- and out-of-network plan maximum benefit payable per year	Eyewear (frames and lenses, or contact lenses) have a $150 combined in- and out-of-network plan maximum benefit payable per year	Eyewear (frames and lenses, or contact lenses) have a $150 combined in- and out-of-network plan maximum benefit payable per year
Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area	Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area	Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Mental Health Services	
• Inpatient Mental Health Care (2)	In-Network: $525 copayment per stay $0 copayment per day for additional days per admission $0 copayment on day of discharge Out-of-Network: 30% coinsurance
• Outpatient Therapy (1) (Group and Individual)	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
• Outpatient Substance Abuse Services (Group and Individual)	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
• Partial Hospitalization (1)	In-Network: $40 copayment per day Out-of-Network: 30% coinsurance
Skilled Nursing Facility (1)	In-Network: $0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 per admission Out-of-Network: 30% coinsurance 100 days per benefit period
Physical Therapy (1)	In-Network: $30 copayment per visit Out-of-Network: 30% coinsurance per visit

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

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $250 copayment per day for days 1 through 7 per admission $0 copayment per day for days 8 and beyond Out-of-Network: 40% coinsurance	In-Network: $350 copayment per day for days 1 through 5 per admission $0 copayment per day for days 6 and beyond $1,750 maximum copayment per admission Out-of-Network: 40% coinsurance	In-Network: $240 copayment per day for days 1 through 6 per admission $0 copayment per day for days 7 and beyond $1,440 maximum copayment per admission Out-of-Network: 30% coinsurance
In-Network: $40 copayment per therapy session Out-of-Network: 40% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 40% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
In-Network: $40 copayment per therapy session Out-of-Network: 40% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 40% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
In-Network: $40 copayment per visit Out-of-Network: 40% coinsurance	In-Network: $40 copayment per visit Out-of-Network: 40% coinsurance	In-Network: $40 copayment per visit Out-of-Network: 30% coinsurance
In-Network: $0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 per admission Out-of-Network: 40% coinsurance per day for days 1 through 100 100 days per benefit period	In-Network: $0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 per admission Out-of-Network: 40% coinsurance per day for days 1 through 100 100 days per benefit period	In-Network: $0 copayment per day for days 1 through 20 $188 copayment per day for days 21 through 100 per admission Out-of-Network: 30% coinsurance per day for days 1 through 100 100 days per benefit period
In-Network: $30 copayment per visit Out-of-Network: 40% coinsurance per visit	In-Network: $40 copayment per visit Out-of-Network: 40% coinsurance per visit	In-Network: $20 copayment per visit Out-of-Network: 30% coinsurance per visit

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Ambulance (1)	In-Network and Out-of-Network: $225 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Transportation	Not covered
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	In-Network: 20% coinsurance for Part B drugs, including chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 30% coinsurance
Ambulatory Surgical Services (1)	In-Network: $150 copayment Out-of-Network: 30% coinsurance

Services with a (1) may require prior authorization (in-network only).

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network and Out-of-Network: $300 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $325 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $175 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Not covered	Not covered	Not covered
In-Network: 20% coinsurance for Part B drugs, including chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance for Part B drugs, including chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance for Part B drugs, including chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*. Out-of-Network: 30% coinsurance
In-Network: $245 copayment Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance	In-Network: $150 copayment Out-of-Network: 30% coinsurance

Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO.

	Personal Choice 65 Elite Rx PPO		
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 Personal Choice 65 PPO *Evidence of Coverage*.		
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

This benefit is not available for members of Personal Choice 65 Medical-Only PPO.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Rx PPO
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 Personal Choice 65 PPO *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 Personal Choice 65 PPO *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 Personal Choice 65 PPO *Evidence of Coverage*.

One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	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	$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment
$10 copayment $20 copayment	$20 copayment $40 copayment	$20 copayment $60 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

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO.

	Personal Choice 65 Elite Rx PPO		
Retail Cost-sharing (what you pay at a pharmacy location)	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 3 (Preferred Brand Drugs)			
Preferred Pharmacy	$47 copayment	$94 copayment	$141 copayment
Standard Pharmacy	$47 copayment	$94 copayment	$141 copayment
Tier 4 (Non-Preferred Drugs)			
Preferred Pharmacy	$100 copayment	$200 copayment	$300 copayment
Standard Pharmacy	$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty Drugs)			
Preferred Pharmacy	33% coinsurance	33% coinsurance	33% coinsurance
Standard Pharmacy	33% coinsurance	33% coinsurance	33% coinsurance
Mail-Order Cost-sharing (what you pay when you order a prescription by mail)	One-Month Supply	Two-Month Supply	Three-Month Supply
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

This benefit is not available for members of Personal Choice 65 Medical-Only PPO.

Personal Choice 65 Prime Rx PPO			Personal Choice 65 Saver Rx PPO			Personal Choice 65 Rx PPO		
One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply
$47 copayment $47 copayment	$94 copayment $94 copayment	$141 copayment $141 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
$100 copayment $100 copayment	$200 copayment $200 copayment	$300 copayment $300 copayment	$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	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance
One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply
$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
$10 copayment	$20 copayment	$20 copayment	$10 copayment	$20 copayment	$20 copayment	$9 copayment	$18 copayment	$18 copayment
$47 copayment	$94 copayment	$94 copayment	$47 copayment	$94 copayment	$94 copayment	$47 copayment	$94 copayment	$94 copayment
$100 copayment	$200 copayment	$200 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	33% coinsurance	33% coinsurance	33% coinsurance

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO.

	Personal Choice 65 Elite Rx PPO
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's payments) total $4,430. If you reside in a long-term care facility, you pay the same as at a standard 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.

This benefit is not available for members of Personal Choice 65 Medical-Only PPO.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Rx PPO
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's payments) total $4,430. If you reside in a long-term care facility, you pay the same as at a standard 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's payments) total $4,430. If you reside in a long-term care facility, you pay the same as at a standard 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's payments) total $4,430. If you reside in a long-term care facility, you pay the same as at a standard 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.	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.

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of Personal Choice 65 Elite Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO.

	Personal Choice 65 Elite Rx PPO
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

Other Medical Benefits

	Personal Choice 65 Elite Rx PPO
Over-the-Counter (OTC) Items	In-Network and Out-of-Network: $100 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our IBX Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Each order cannot exceed the $100 quarterly allowance.

This benefit is not available for members of Personal Choice 65 Medical-Only PPO.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Rx PPO
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 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 costs, or; • $3.95 copayment for generic (including brand drugs tested as generic) and a $9.85 copayment for all other drugs

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network and Out-of-Network: $60 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our IBX Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Each order cannot exceed the $60 quarterly allowance.	In-Network and Out-of-Network: $30 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our IBX Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Each order cannot exceed the $30 quarterly allowance.	In-Network and Out-of-Network: $30 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our IBX Care Card to purchase OTC items at participating retailers. Items purchased from other pharmacies or retailers will not be covered. Each order cannot exceed the $30 quarterly allowance.

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Telemedicine	In-Network and Out-of-Network: $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 services received from other providers will not be covered.
Chiropractic Services	
• **Medical-covered (Medicare-covered)** Medicare-covered chiropractic care is ONLY for spinal manipulation to correct subluxation	In-Network: $20 copayment per visit for spinal manipulation Out-of-Network: 30% coinsurance
• **Routine Care (non-Medicare-covered)** Non-Medicare-covered routine visits are in addition to Medicare-covered spinal manipulation visits. Routine visits do NOT count toward MOOP	In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 30% coinsurance

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network and Out-of-Network: $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 services received from other providers will not be covered.	In-Network and Out-of-Network: $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 services received from other providers will not be covered.	In-Network and Out-of-Network: $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 services received from other providers will not be covered.
In-Network: $20 copayment per visit for spinal manipulation Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit for spinal manipulation Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit for spinal manipulation Out-of-Network: 30% coinsurance
In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 30% coinsurance

Other Medical Benefits

	Personal Choice 65 Elite Rx PPO
Acupuncture	
• Medical-covered (Medicare-covered)	In-Network: $20 copayment per visit, up to 12 visits per year; 8 additional if determined that progress is made
• Routine Care (non-Medicare-covered)	$20 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.
Podiatry Services	
• Medical Condition (Medicare-covered podiatry care)	In-Network: $25 copayment per visit for condition treatment Out-of-Network: 30% coinsurance
• Routine Foot Care (non-Medicare-covered) Routine visits do NOT count toward MOOP costs	In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance Routine visits do not count toward MOOP.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network: $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	In-Network: $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) Out-of-Network: 40% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.	$20 copayment per visit (up to 6 visits each year) Out-of-Network: 40% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.	$20 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance Members must have one of the following conditions: headache (migraine and tension), post-operative nausea and vomiting, low back pain, chronic neck pain, or pain from osteoarthritis of the knee and hip.
In-Network: $25 copayment per visit for condition treatment Out-of-Network: 40% coinsurance	In-Network: $25 copayment per visit for condition treatment Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit for condition treatment Out-of-Network: 30% coinsurance
In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 40% coinsurance Routine visits do not count toward MOOP.	In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 40% coinsurance Routine visits do not count toward MOOP.	In-Network: $20 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance Routine visits do not count toward MOOP.

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO
Grocery Benefit	In-Network and Out-of-Network: $0 copayment Members must have both diabetes and depression to be eligible. Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member.
Diabetic Supplies (1)	In-Network: 0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors from Accu-Chek and OneTouch; 20% coinsurance for plan-specified flash glucose monitors at a retail pharmacy. Test strips and monitors from other vendors will not be covered. $0 copayment for lancets and solutions, insulin pumps, and related supplies; $0 copayment for diabetic shoes and inserts. Any network vendor may be used to purchase these supplies. Out-of-Network: 30% coinsurance

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO
In-Network and Out-of-Network: $0 copayment Members must have both diabetes and depression to be eligible. Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member.	This plan does not offer the grocery benefit.	In-Network and Out-of-Network: $0 copayment Members must have both diabetes and depression to be eligible. Grocery boxes containing food and produce will be provided by United by Blue for a maximum of 4 weeks per year, per member.
In-Network: 0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors from Accu-Chek and OneTouch; 20% coinsurance for plan-specified flash glucose monitors at a retail pharmacy. Test strips and monitors from other vendors will not be covered. $0 copayment for lancets and solutions, insulin pumps, and related supplies; $0 copayment for diabetic shoes and inserts. Any network vendor may be used to purchase these supplies. Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors from Accu-Chek and OneTouch; 20% coinsurance for plan-specified flash glucose monitors at a retail pharmacy. Test strips and monitors from other vendors will not be covered. $0 copayment for lancets and solutions, insulin pumps, and related supplies; $0 copayment for diabetic shoes and inserts. Any network vendor may be used to purchase these supplies. Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors from Accu-Chek and OneTouch; 20% coinsurance for plan-specified flash glucose monitors at a retail pharmacy. Test strips and monitors from other vendors will not be covered. $0 copayment for lancets and solutions, insulin pumps, and related supplies; $0 copayment for diabetic shoes and inserts. Any network vendor may be used to purchase these supplies. Out-of-Network: 30% coinsurance

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 1-888-718-3333 (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 1-888-718-3333 (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.

- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, 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

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