Independence

Personal Choice 65℠ PPO

2023

Summary of Benefits

Effective January 1, 2023 through December 31, 2023

[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 **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 **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 **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections of this booklet

- Monthly Premium and Plan Costs
- 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
- Other Medical Benefits

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 **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: **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	$49
Bucks or Philadelphia County	$49

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	$163

Personal Choice 65 Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Rx PPO
	You pay...
Chester, Delaware, or Montgomery County	$163
Bucks or Philadelphia County	$277

Plan Costs

	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
Deductible	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	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.
Part B Premium Giveback*	This plan does not include a Part B Premium Giveback.	This plan does not include a Part B Premium Giveback.	This plan will reduce your monthly Part B premium by $51.	This plan does not include a Part B Premium Giveback.
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 the annual MOOP 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	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: $8,950 each year

*The Part B Premium Giveback is set up by Medicare and administered through the Social Security Administration (SSA). Members who pay their own Part B premium are eligible for the Giveback. The monthly credit is applied on either the member's Social Security check or Medicare Part B statement, depending on how they pay their Part B premium. It can take a few months for this Giveback to be processed, so the member may receive it as a lump sum.

Covered Medical and Hospital Benefits

	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
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	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 $1,750 maximum copayment per admission 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
Inpatient Hospital Stay — Acute Due to COVID-19 Diagnosis (1)	In-Network: $0 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
Outpatient Hospital Services (1)	In-Network: $250 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
Outpatient Observation Services	In-Network: $250 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
Ambulatory Surgical Services (1)	In-Network: $150 copayment 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
Doctor's Office Visits				
• **Primary Care Physician**	In-Network: $0 copayment 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
• **Specialist**	In-Network: $35 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

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

Covered Medical and Hospital Benefits (continued)

	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
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.	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.
Emergency Care — Covered Worldwide Worldwide copayment outside the U.S. does not count toward the annual MOOP amount	In-Network and Out-of-Network: $95 copayment Not waived if admitted	In-Network and Out-of-Network: $95 copayment Not waived if admitted	In-Network and Out-of-Network: $95 copayment Not waived if admitted	In-Network and Out-of-Network: $95 copayment Not waived if admitted
Urgently Needed Services — Covered Worldwide Worldwide copayment outside the U.S. does not count toward the annual MOOP amount	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: $95 copayment per visit outside of U.S. 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: $95 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: $95 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: $95 copayment per visit outside of U.S. Not waived if admitted

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

Covered Medical and Hospital Benefits (continued)

	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
Diagnostic Services, Lab and Radiology Services, and X-rays				
• **Diagnostic Radiology Services (1)**	In-Network: $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	In-Network: $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 $200 copayment depending on service Out-of-Network: 40% coinsurance	In-Network: $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 $285 copayment depending on service Out-of-Network: 40% coinsurance	In-Network: $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
• **Diagnostic Procedures, Tests, and Lab Services (1)**	In-Network: $0 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
• **Outpatient X-rays**	In-Network: $35 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services	In-Network: $40 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: 40% coinsurance for routine radiology services	In-Network: $40 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services
• **Therapeutic Radiology (1)** (Radiation Therapy)	In-Network: $60 copayment Out-of-Network: 30% coinsurance	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
• **Therapeutic Radiology for Breast Cancer**	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 30% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 40% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 40% coinsurance	In-Network: $0 copayment for members with a diagnosis of breast cancer Out-of-Network: 30% coinsurance

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

Covered Medical and Hospital Benefits (continued)

	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
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	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
• **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. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; up to two 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 toward the annual MOOP amount.	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. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; up to two 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 toward the annual MOOP amount.	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. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; up to two 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 toward the annual MOOP amount.	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. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations per year; up to two 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 toward the annual MOOP amount.

Covered Medical and Hospital Benefits (continued)

	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
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 non-Medicare-covered exam and cleaning every six months $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 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 amount.	In-Network: $35 copayment for Medicare-covered dental services Out-of-Network: 40% coinsurance for Medicare-covered dental services In-Network: $0 copayment for routine non-Medicare-covered exam and cleaning every six months $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 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 amount.	In-Network: $50 copayment for Medicare-covered dental services Out-of-Network: 40% coinsurance for Medicare-covered dental services In-Network: $0 copayment for routine non-Medicare-covered exam and cleaning every six months $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 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: $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 amount.	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 non-Medicare-covered exam and cleaning every six months $0 copayment for 1 set of dental bitewing X-rays every year, 1 periapical X-ray every 3 years, and 1 full-mouth X-ray (panoramic) every 3 years 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: $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 amount.

Covered Medical and Hospital Benefits (continued)

	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
Vision Services	In-Network: $0–$35 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 30% coinsurance for Medicare-covered eye exams, for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard 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. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. 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.	In-Network: $0–$35 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 40% coinsurance for Medicare-covered eye exams, for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard 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. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. 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.	In-Network: $0–$50 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 40% coinsurance for Medicare-covered eye exams, for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard 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. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. 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.	In-Network: $0–$35 copayment for Medicare-covered eye exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out-of-Network: 30% coinsurance for Medicare-covered eye exams, for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, and for one pair of Medicare-covered standard 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. Out-of-Network: 80% coinsurance Routine vision services do not count toward the annual MOOP amount. 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.

Covered Medical and Hospital Benefits (continued)

	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
Mental Health Services				
• **Inpatient Mental Health Care (1)**	In-Network: $525 copayment per stay $0 copayment per day for additional days per admission $0 copayment on day of discharge 190-day lifetime maximum Out-of-Network: 30% coinsurance	In-Network: $250 copayment per day for days 1–7 per admission $0 copayment per day for days 8 and beyond $0 copayment on day of discharge $1,750 maximum copayment per admission 190-day lifetime maximum 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 $0 copayment on day of discharge $1,750 maximum copayment per admission 190-day lifetime maximum 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 $0 copayment on day of discharge $1,440 maximum copayment per admission 190-day lifetime maximum Out-of-Network: 30% coinsurance
• **Outpatient Mental Health Care (1)** (Group and Individual)	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 30% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 40% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 40% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 30% coinsurance
• **Outpatient Substance Abuse Services** (Group and Individual)	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 30% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 40% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 40% coinsurance	In-Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out-of-Network: 30% coinsurance
• **Partial Hospitalization (1)**	In-Network: $30 copayment per day Out-of-Network: 30% coinsurance	In-Network: $30 copayment per day Out-of-Network: 40% coinsurance	In-Network: $30 copayment per day Out-of-Network: 40% coinsurance	In-Network: $30 copayment per day Out-of-Network: 30% coinsurance
Skilled Nursing Facility (1)	In-Network: $0 copayment per day for days 1–20 $196 copayment per day for days 21–100 per admission Out-of-Network: 30% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $196 copayment per day for days 21–100 per admission Out-of-Network: 40% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $196 copayment per day for days 21–100 per admission Out-of-Network: 40% coinsurance per day for days 1–100 100 days per benefit period	In-Network: $0 copayment per day for days 1–20 $196 copayment per day for days 21–100 per admission Out-of-Network: 30% coinsurance per day for days 1–100 100 days per benefit period
Physical Therapy (1)	In-Network: $30 copayment per visit Out-of-Network: 30% coinsurance per visit	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

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

Covered Medical and Hospital Benefits (continued)

	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
Ambulance (1) (Ground and air transportation)	In-Network and Out-of-Network: $225 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $250 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $260 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	In-Network and Out-of-Network: $175 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Transportation	Not covered (offered under uniform flexibility, see page 34)	Not covered (offered under uniform flexibility, see page 34)	Not covered	Not covered (offered under uniform flexibility, see page 34)
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	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

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

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.

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

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 Rx PPO
Prescription Drug Benefits	You pay the following until your total yearly drug costs reach $4,660. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the Personal Choice 65 Rx PPO *Evidence of Coverage*.	You pay the following until your total yearly drug costs reach $4,660. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the Personal Choice 65 Rx PPO *Evidence of Coverage*.	You pay the following until your total yearly drug costs reach $4,660. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the Personal Choice 65 Rx PPO *Evidence of Coverage*.	You pay the following until your total yearly drug costs reach $4,660. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies or through mail order. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. For information, please review the Personal Choice 65 Rx PPO *Evidence of Coverage*.

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

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

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.

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

	Personal Choice 65 Elite Rx PPO			Personal Choice 65 Prime Rx PPO			Personal Choice 65 Saver Rx PPO			Personal Choice 65 Rx PPO		
Retail Cost-sharing (what you pay at a pharmacy location)	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	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)												
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$9 copayment	$18 copayment	$27 copayment	$9 copayment	$18 copayment	$27 copayment	$9 copayment	$18 copayment	$27 copayment	$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)												
• **Preferred Pharmacy**	$8 copayment	$16 copayment	$16 copayment	$8 copayment	$16 copayment	$16 copayment	$8 copayment	$16 copayment	$16 copayment	$7 copayment	$14 copayment	$14 copayment
• **Standard Pharmacy**	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$40 copayment	$60 copayment
Tier 3 (Preferred Brand Drugs)												
• **Preferred Pharmacy**	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment
• **Standard Pharmacy**	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment	$47 copayment	$94 copayment	$141 copayment
Tier 4 (Non-Preferred Drugs)												
• **Preferred Pharmacy**	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment
• **Standard Pharmacy**	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment	$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty Drugs)												
• **Preferred Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
• **Standard Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Covered Insulin*												
• **Preferred Pharmacy**	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment
• **Standard Pharmacy**	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment	$35 copayment	$70 copayment	$105 copayment

*$35 copayment for each one-month supply of covered insulins during all coverage stages.

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.

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

	Personal Choice 65 Elite Rx PPO			Personal Choice 65 Prime Rx PPO			Personal Choice 65 Saver Rx PPO			Personal Choice 65 Rx PPO		
Mail-order Cost-sharing (what you pay when you order a prescription by mail)	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	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic Drugs)	$8 copayment	$16 copayment	$16 copayment	$8 copayment	$16 copayment	$16 copayment	$8 copayment	$16 copayment	$16 copayment	$7 copayment	$14 copayment	$14 copayment
Tier 3 (Preferred Brand Drugs)	$47 copayment	$94 copayment	$94 copayment	$47 copayment	$94 copayment	$94 copayment	$47 copayment	$94 copayment	$94 copayment	$47 copayment	$94 copayment	$94 copayment
Tier 4 (Non-Preferred Drugs)	$100 copayment	$200 copayment	$200 copayment	$100 copayment	$200 copayment	$200 copayment	$100 copayment	$200 copayment	$200 copayment	$100 copayment	$200 copayment	$200 copayment
Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Covered Insulin*	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment

*$35 copayment for each one-month supply of covered insulins during all coverage stages.

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.

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

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 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 $4,660. If you reside in a long-term care facility, you pay the same as at a standard retail 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 $4,660. If you reside in a long-term care facility, you pay the same as at a standard retail 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 $4,660. If you reside in a long-term care facility, you pay the same as at a standard retail 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 $4,660. If you reside in a long-term care facility, you pay the same as at a standard retail 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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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.

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

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 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 $7,400, you pay the greater of: • 5% of the costs, or; • $4.15 copayment for generic (including brand drugs tested as generic) and a $10.35 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 $7,400, you pay the greater of: • 5% of the costs, or; • $4.15 copayment for generic (including brand drugs tested as generic) and a $10.35 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 $7,400, you pay the greater of: • 5% of the costs, or; • $4.15 copayment for generic (including brand drugs tested as generic) and a $10.35 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 $7,400, you pay the greater of: • 5% of the costs, or; • $4.15 copayment for generic (including brand drugs tested as generic) and a $10.35 copayment for all other drugs

Other Medical Benefits

	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
Over-the-Counter (OTC) Items	In-Network and Out-of-Network: $125 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the 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 $125 quarterly allowance. OTC costs do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $70 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the 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 $70 quarterly allowance. OTC costs do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $30 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the 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. OTC costs do not count toward the annual MOOP amount.	In-Network and Out-of-Network: $30 allowance per quarter for OTC items. Allowance does not carry forward to the next quarter if not used. You must use the 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. OTC costs do not count toward the annual MOOP amount.

Other Medical Benefits

	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
Telemedicine • Telemedicine Visits	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; $0 copayment for dermatology visits focused on treating and diagnosing skin, hair, and nail conditions. Telemedicine physicians are available 24/7 365 days per year. MDLIVE® must be used for telemedicine visits. MDLIVE® doctors are state-licensed physicians.	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; $0 copayment for dermatology visits focused on treating and diagnosing skin, hair, and nail conditions. Telemedicine physicians are available 24/7 365 days per year. MDLIVE® must be used for telemedicine visits. MDLIVE® doctors are state-licensed physicians.	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; $0 copayment for dermatology visits focused on treating and diagnosing skin, hair, and nail conditions. Telemedicine physicians are available 24/7 365 days per year. MDLIVE® must be used for telemedicine visits. MDLIVE® doctors are state-licensed physicians.	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; $0 copayment for dermatology visits focused on treating and diagnosing skin, hair, and nail conditions. Telemedicine physicians are available 24/7 365 days per year. MDLIVE® must be used for telemedicine visits. MDLIVE® doctors are state-licensed physicians.
• **Additional Telehealth (1)** (Primary care physician (PCP), specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	In-Network: $0 copayment per PCP visit; $35 copayment per specialist visit; $30 copayment per physical therapy, occupational therapy, and speech therapy visit; $35 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $0 copayment per PCP visit; $35 copayment per specialist visit; $30 copayment per physical therapy, occupational therapy, and speech therapy visit; $35 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $10 copayment per PCP visit; $50 copayment per specialist visit; $40 copayment per physical therapy, occupational therapy, and speech therapy visit; $50 copayment per other health care professional visit Out-of-Network: Not covered	In-Network: $0 copayment per PCP visit; $35 copayment per specialist visit; $20 copayment per physical therapy, occupational therapy, and speech therapy visit; $35 copayment per other health care professional visit Out-of-Network: Not 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	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
• **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 the annual MOOP amount	In-Network: $20 copayment per visit (up to 6 visits combined in- and out-of-network each year) 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

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

Other Medical Benefits (continued)

	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
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	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
• **Routine Care** (non-Medicare-covered) (Routine visits do NOT count toward the annual MOOP amount)	$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.	$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.
Podiatry Services				
• **Medical Condition** (Medicare-covered)	In-Network: $25 copayment per visit for condition treatment Out-of-Network: 30% coinsurance	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
• **Routine Foot Care** (non-Medicare-covered) (Routine visits do NOT count toward the annual MOOP amount)	In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance	In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 40% coinsurance	In-Network: $25 copayment per visit (up to 6 visits each year) Out-of-Network: 40% coinsurance	In-Network: $20 copayment per visit (up to 6 visits each year) Out-of-Network: 30% coinsurance

Other Medical Benefits (continued)

	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
Grocery Benefit*	In-Network and Out-of-Network: $0 copayment Members must be diagnosed with both diabetes and depression or diabetes and depressive disorders to be eligible. Grocery boxes containing food and produce will be provided for a maximum of 4 weeks per year, per member.	In-Network and Out-of-Network: $0 copayment Members must be diagnosed with both diabetes and depression or diabetes and depressive disorders to be eligible. Grocery boxes containing food and produce will be provided 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 be diagnosed with both diabetes and depression or diabetes and depressive disorders to be eligible. Grocery boxes containing food and produce will be provided for a maximum of 4 weeks per year, per member.
Transportation Services	In-Network and Out-of-Network: $0 copayment 24 one-way trips per year through Roundtrip to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Members must be diagnosed with both diabetes and congestive heart failure to be eligible. Maximum 80 miles per trip.	In-Network and Out-of-Network: $0 copayment 24 one-way trips per year through Roundtrip to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Members must be diagnosed with both diabetes and congestive heart failure to be eligible. Maximum 80 miles per trip.	This plan does not offer transportation services.	In-Network and Out-of-Network: $0 copayment 24 one-way trips per year through Roundtrip to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Members must be diagnosed with both diabetes and congestive heart failure to be eligible. Maximum 80 miles per trip.
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	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

*This benefit is a part of a special supplemental program for the chronically ill. Not all members qualify.
Services with a (1) may require prior authorization (in-network only).

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

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **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.
- ☐ Review the formulary to make sure your drugs are covered.

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, 2024.
- ☐ 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 **ibxmedicare.com**, or call our Member Help Team at **1-888-718-3333 (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 (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.

Personal Choice 65 offers PPO plans with a Medicare contract. Enrollment in Personal Choice 65 Medicare Advantage plans depends on contract renewal.

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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

Vision benefits are underwritten by QCC Insurance Company 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 QCC Insurance Company and administered by United Concordia Companies, Inc., an independent company.

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

Telemedicine is provided through MDLIVE, by Evernorth, an independent company.

Roundtrip is an independent company that administers our transportation benefit.

To receive this document in an alternate format such as Braille, large print, or audio, please call **1-877-393-6733 (TTY/TDD: 711)** (non-members) (by calling this number you will be directed to a licensed sales agent) or **1-888-718-3333 (TTY/TDD: 711)** (members).

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

Notes

Notes

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-275-2583 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-275-2583 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 们 费 译 务 帮 您 关 药 险 问 您 译 务 请 电 1-800-275-2583 (TTY: 711) 们 员 乐 帮 您 这 项 费 务

Chinese Cantonese: 您 為 1-800-275-2583 (TTY: 711) 為您

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-275-2583 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-275-2583 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-275-2583 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-275-2583 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-275-2583 (TTY: 711) سيقوم . بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

Korean: 1-800-275-2583 (TTY: 711)

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-275-2583 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-275-2583 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-275-2583 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-275-2583 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-275-2583 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-275-2583 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当 険 薬 処 薬 関 訳 一 訳 1-800-275-2583 (TTY: 711) 一

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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*.

Independence

Personal Choice 65℠ PPO

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Philadelphia, PA 19101-3713
ibxmedicare.com

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