2025

Summary of Benefits

Effective January 1, 2025 through December 31, 2025

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

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

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

Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, Keystone 65 Liberty Medical-Only HMO, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select Rx HMO are Medicare Advantage HMO (Health Maintenance Organization) plans. With an HMO plan, members choose a family doctor, called a primary care physician (PCP), who provides the services they need. When they need specialized care, PCPs coordinate care for members with other doctors or health care providers within the HMO provider network. Keystone 65 Essential Rx HMO-POS and Keystone 65 Focus Rx HMO-POS have a Point-of-Service (POS) option. POS means you can use providers outside the plan's network for an additional cost.

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 Plan Premium
- Plan Costs
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits (for Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO members)
- Other Medical Benefits

Who can join?

To join Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, Keystone 65 Liberty Medical-Only HMO, Keystone 65 Select Medical-Only HMO, or Keystone 65 Select Rx HMO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Which doctors, hospitals, and pharmacies can I use?

Doctors and hospitals:

Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, Keystone 65 Liberty Medical-Only HMO, Keystone 65 Select Medical-Only HMO, and Keystone 65 Select Rx HMO have networks of doctors, hospitals, pharmacies, and other providers.

You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan) will not be covered. If you use providers that are not in network, the plan may not pay for the services. The only exceptions are emergencies, urgently needed services (that is, in situations when it is unreasonable or not possible to obtain services in network), out-of-area dialysis services, and cases in which the plan authorizes use of out-of-network providers.

Keystone 65 Essential Rx HMO-POS: This plan has a POS option for non-Medicare-covered dental services. This means there are some dental services where you can use dental providers outside the plan's network for a higher cost-share.

Keystone 65 Focus Rx HMO-POS: The plan will cover services from either in-network or out-of-network providers if the services are covered benefits and are medically necessary. If you use an out-of- network provider, your share of the costs for your covered services may be higher.

Part D drugs and pharmacies:

Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO cover Part D drugs. In addition, the plans cover Part B drugs, such as chemotherapy and some other drugs administered by your provider. You can see our complete plan *Formulary (List of Covered Drugs)* and any restrictions on our website: **ibxmedicare.com**.

Keystone 65 Liberty Medical-Only HMO and Keystone 65 Select Medical-Only HMO cover Part B drugs, including chemotherapy and some other drugs administered by your provider. However, these plans do not cover Part D prescription drugs.

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

Monthly Plan Premium

Keystone 65 Basic Rx HMO	
	And You Have...
	Keystone 65 Basic Rx HMO
If You Live In...	You Pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$0.00

Keystone 65 Essential Rx HMO-POS	
	And You Have...
	Keystone 65 Essential Rx HMO-POS
If You Live In...	You Pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$2.10

Keystone 65 Focus Rx HMO-POS	
	And You Have...
	Keystone 65 Focus Rx HMO-POS
If You Live In...	You Pay...
Philadelphia or Bucks County	$0.00
Chester, Delaware, or Montgomery County	$10.00

Keystone 65 Liberty Medical-Only HMO	
	And You Have...
	Keystone 65 Liberty Medical-Only HMO
If You Live In...	You Pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$0.00

Keystone 65 Select Medical-Only HMO	
	And You Have...
	Keystone 65 Select Medical-Only HMO
If You Live In...	You Pay...
Philadelphia or Bucks County	$13.50
Chester, Delaware, or Montgomery County	$3.50

Keystone 65 Select Rx HMO	
	And You Have...
	Keystone 65 Select Rx HMO
If You Live In...	You Pay...
Philadelphia or Bucks County	$42.00
Chester, Delaware, or Montgomery County	$69.00

Plan Costs

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Deductible	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.
Part B Premium Giveback*	This plan will reduce your monthly Part B premium by $6.10.	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)	$7,250 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	$7,650 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. The Point-of-Service annual maximum for out-of-network non-Medicare-covered dental services is $3,000. Out-of-network cost-sharing does NOT apply toward the annual MOOP amount.

*The giveback is set up by Medicare and administered through the Social Security Administration (SSA). The giveback incentive only participates with Social Security and is credited monthly on your Social Security check or Medicare Part B premium statement. There are no direct payments made to beneficiaries by Independence Blue Cross. Beneficiaries who pay their own Part B premium are eligible for the Giveback. Meaning, beneficiaries cannot receive Medicaid or any other assistance from a health program that could potentially pay their Part B premium.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
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.	Keystone 65 Select Medical-Only HMO does not have a deductible for covered medical services. Keystone 65 Select Rx HMO does not have a deductible for covered medical services or for Part D prescription drugs.
If you live in Philadelphia or Bucks county, this plan will reduce your monthly Part B premium by $9.50. If you live in Chester, Delaware, or Montgomery county, this plan will reduce your monthly Part B premium by $9.30.	This plan will reduce your monthly Part B premium by $90.	This plan does not include a Part B Premium Giveback.
$6,750 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. The Point-of-Service annual maximum for out-of-network benefits is $1,000. Out-of-network cost-sharing does NOT apply toward the annual MOOP amount.	$9,350 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	$6,000 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Inpatient Hospital Coverage (1)	$250 copayment per day for days 1 through 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 Unlimited medically necessary days per admission	$525 copayment per stay $0 copayment per day for additional days per admission $0 copayment on day of discharge Unlimited medically necessary days per admission
Outpatient Hospital Services (1)	$300 copayment	$275 copayment
Outpatient Observation Services	$300 copayment per stay	$275 copayment per stay
Ambulatory Surgical Services (1)	$150 copayment	$225 copayment
Doctor's Office Visits		
• **Primary Care Physician**	$0 copayment per visit	$0 copayment per visit
• **Specialist**	$30 copayment per visit	$25 copayment per visit

Services with a (1) may require prior authorization.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $210 copayment per day for days 1 through 6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,260 maximum copayment per admission Unlimited medically necessary days per admission Out of Network: 20% coinsurance	$285 copayment per day for days 1 through 7 per admission $0 copayment per day for days 8 and beyond per admission $0 copayment on day of discharge $1,995 maximum copayment per admission Unlimited medically necessary days per admission	$275 copayment per day for days 1 through 6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,650 maximum copayment per admission Unlimited medically necessary days per admission
In Network: $325 copayment Out of Network: 20% coinsurance	20% coinsurance	$350 copayment
In Network: $325 copayment per stay Out of Network: 20% coinsurance	20% coinsurance per stay	$350 copayment per stay
In Network: $200 copayment Out of Network: 20% coinsurance	20% coinsurance	$200 copayment
In Network: $0 copayment per visit Out of Network: 20% coinsurance	$0 copayment per visit	$0 copayment per visit
In Network: $30 copayment per visit Out of Network: 20% coinsurance	$40 copayment per visit	$40 copayment per visit

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Preventive Care (1) (e.g., flu vaccine, diabetic screenings)	$0 copayment 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.	$0 copayment 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 of the U.S. does not count toward the annual MOOP amount	$110 copayment per visit Not waived if admitted	$110 copayment per visit Not waived if admitted
Urgently Needed Services — Covered Worldwide Worldwide copayment outside of the U.S. does not count toward the annual MOOP amount	$15 copayment in a retail clinic Not waived if admitted $45 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted	$5 copayment in a retail clinic Not waived if admitted $45 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted

Services with a (1) may require prior authorization.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $0 copayment Out of Network: 20% 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.	$0 copayment 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.	$0 copayment 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: $125 copayment per visit Not waived if admitted	$110 copayment per visit Not waived if admitted	$125 copayment per visit Not waived if admitted
In Network and Out of Network: $10 copayment in a retail clinic Not waived if admitted $40 copayment in an urgent care center Not waived if admitted $125 copayment per visit outside of U.S. Not waived if admitted	$15 copayment in a retail clinic Not waived if admitted $45 copayment in an urgent care center Not waived if admitted $110 copayment per visit outside of U.S. Not waived if admitted	$15 copayment in a retail clinic Not waived if admitted $55 copayment in an urgent care center Not waived if admitted $125 copayment per visit outside of U.S. Not waived if admitted

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Diagnostic Radiology Services (1)	$0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) $40 or $170 copayment depending on service	$0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) $30 or $260 copayment depending on service
Diagnostic Procedures, Tests, and Lab Services (1)	$0 copayment	$0 copayment
Outpatient X-rays	$40 copayment for routine radiology	$30 copayment for routine radiology
Therapeutic Radiology (1) (Radiation Therapy)	$60 copayment per visit	$80 copayment per visit
Radiation for Breast Cancer (Uniform Flexibility)	$0 copayment for members with a diagnosis of breast cancer	$0 copayment for members with a diagnosis of breast cancer

Services with a (1) may require prior authorization.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) $30 or $160 copayment depending on service Out of Network: 20% coinsurance	$0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) $45 or $275 copayment depending on service	$0 copayment for certain diagnostic tests (e.g., home-based sleep studies provided by a home health agency; diagnostic mammogram that results from a preventive mammogram) $40 or $200 copayment depending on service
In Network: $0 copayment Out of Network: 20% coinsurance	$0 copayment	$0 copayment
In Network: $30 copayment for routine radiology Out of Network: 20% coinsurance	$45 copayment for routine radiology	$40 copayment for routine radiology
In Network: $60 copayment per visit Out of Network: 20% coinsurance	$80 copayment per visit	$80 copayment per visit
In Network: $0 copayment for members with a diagnosis of breast cancer Out of Network: 20% coinsurance	$0 copayment for members with a diagnosis of breast cancer	$0 copayment for members with a diagnosis of breast cancer

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Hearing Services		
• Medicare-covered Hearing Exam	$30 copayment for Medicare-covered hearing exams	$25 copayment for Medicare-covered hearing exams
• Routine Hearing Exams	$0 copayment for routine non-Medicare-covered hearing exams once every year	$0 copayment for routine non-Medicare-covered hearing exams once every year
• Routine Hearing Aids	$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. No copayment for hearing aid fittings and evaluations; unlimited hearing aid fittings and evaluations for the first 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.	$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. No copayment for hearing aid fittings and evaluations; unlimited hearing aid fittings and evaluations for the first 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.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $30 copayment for Medicare-covered hearing exams Out of Network: 20% coinsurance	$40 copayment for Medicare-covered hearing exams	$40 copayment for Medicare-covered hearing exams
In Network: $0 copayment for routine non-Medicare-covered hearing exams once every year Out of Network: Not covered	$0 copayment for routine non-Medicare-covered hearing exams once every year	$0 copayment for routine non-Medicare-covered hearing exams once every year
In 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.	$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.	$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.
No copayment for hearing aid fittings and evaluations; unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear Out of Network: Not covered	No copayment for hearing aid fittings and evaluations; unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear	No copayment for hearing aid fittings and evaluations; unlimited hearing aid fittings and evaluations for the first 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.	Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	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)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Dental Services		
• **Medicare-covered Dental Services**	$30 copayment for Medicare-covered dental services	In Network: $25 copayment for Medicare-covered dental services Out of Network: 50% coinsurance
• **Routine Dental Care** (includes preventive and comprehensive dental)	$0 copayment for one routine non-Medicare-covered exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months; $0 copayment for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months 10% coinsurance for restorative services, endodontics, periodontics, and extractions; 10% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery $2,500 in-network allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery Member must use a participating IBX Medicare Dental Network provider for in-network coverage. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	In Network: $0 copayment for one routine non-Medicare-covered exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months; $0 copayment for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months 0% coinsurance for restorative services, endodontics, periodontics, and extractions; 0% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery In Network and Out of Network: $3,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery Out of Network: 50% coinsurance for routine dental exam, cleaning, and fluoride services; 50% coinsurance for dental X-ray; 50% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery Member must use a participating IBX Medicare Dental Network provider for in-network coverage. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $30 copayment for Medicare-covered dental services Out of Network: 20% coinsurance	$40 copayment for Medicare-covered dental services	$40 copayment for Medicare-covered dental services
In Network: $0 copayment for one routine non-Medicare-covered exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months; $0 copayment for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months 20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery $2,000 in-network allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery Out of Network: Not covered	$0 copayment for one routine non-Medicare-covered exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months; $0 copayment for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months 20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery $2,000 in-network allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery	$0 copayment for one routine non-Medicare-covered exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months; $0 copayment for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months 20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery $2,000 in-network allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery
Member must use a participating IBX Medicare Dental Network provider for in-network coverage. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	Member must use a participating IBX Medicare Dental Network provider for in-network coverage. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	Member must use a participating IBX Medicare Dental Network provider for in-network coverage. Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Vision Services		
• **Medicare-covered Vision Services**	$30 copayment for Medicare-covered vision exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam; $0 copayment for Medicare-covered glaucoma screening; and $0 copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery	$25 copayment for Medicare-covered vision exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam; $0 copayment for Medicare-covered glaucoma screening; and $0 copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery
• **Routine Vision Care** (includes routine exam and eyewear)	$0 copayment for one routine eye exam every year Contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full; $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $150 allowance every year for all other eyewear (glasses and lenses) purchased at a network Davis Vision provider; $150 allowance every year for contact lenses in lieu of routine eyewear (glasses and lenses). Eyewear does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider. Routine vision services (exam and eyewear) do not count toward the annual MOOP amount.	$0 copayment for one routine eye exam every year Contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full; $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $150 allowance every year for all other eyewear (glasses and lenses) purchased at a network Davis Vision provider; $150 allowance every year for contact lenses in lieu of routine eyewear (glasses and lenses). Eyewear does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider. Routine vision services (exam and eyewear) do not count toward the annual MOOP amount.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $30 copayment for Medicare-covered vision exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam; $0 copayment for Medicare-covered glaucoma screening; and $0 copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 20% coinsurance	$40 copayment for Medicare-covered vision exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam; $0 copayment for Medicare-covered glaucoma screening; and $0 copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery	$40 copayment for Medicare-covered vision exams; $0 copayment for Medicare-covered diabetic or dilated retinal eye exam; $0 copayment for Medicare-covered glaucoma screening; and $0 copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery
In Network: $0 copayment for one routine eye exam every year Contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full; $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $150 allowance every year for all other eyewear (glasses and lenses) purchased at a network Davis Vision provider; $150 allowance every year for contact lenses in lieu of routine eyewear (glasses and lenses). Eyewear does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Out of Network: Not covered Member must use a participating Davis Vision network provider. Routine vision services (exam and eyewear) do not count toward the annual MOOP amount.	$0 copayment for one routine eye exam every year Contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full; $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $150 allowance every year for all other eyewear (glasses and lenses) purchased at a network Davis Vision provider; $150 allowance every year for contact lenses in lieu of routine eyewear (glasses and lenses). Eyewear does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider. Routine vision services (exam and eyewear) do not count toward the annual MOOP amount.	$0 copayment for one routine eye exam every year Contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full; $250 allowance every year for eyewear (glasses and lenses) purchased from Visionworks®; $150 allowance every year for all other eyewear (glasses and lenses) purchased at a network Davis Vision provider; $150 allowance every year for contact lenses in lieu of routine eyewear (glasses and lenses). Eyewear does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider. Routine vision services (exam and eyewear) do not count toward the annual MOOP amount.

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Mental Health Services		
• **Inpatient Mental Health Care (1)**	$250 copayment per day for days 1 through 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 190-day lifetime maximum	$525 copayment per stay $0 copayment per day for additional days per admission $0 copayment on day of discharge 190-day lifetime maximum
• **Outpatient Mental Health Care (1)** (Group and Individual)	$20 copayment per group therapy session; $30 copayment per individual therapy session	$20 copayment per group therapy session; $30 copayment per individual therapy session
• **Outpatient Substance Abuse Services** (Group and Individual)	$20 copayment per group therapy session; $30 copayment per individual therapy session	$20 copayment per group therapy session; $30 copayment per individual therapy session
• **Partial Hospitalization and Intensive Outpatient Services (1)**	$30 copayment per day	$30 copayment per day
Skilled Nursing Facility (1)	$0 copayment per day for days 1 through 20 $214 copayment per day for days 21 through 100 100 days per benefit period	$0 copayment per day for days 1 through 20 $214 copayment per day for days 21 through 100 100 days per benefit period

Services with a (1) may require prior authorization.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $210 copayment per day for days 1 through 6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,260 maximum copayment per admission 190-day lifetime maximum Out of Network: 20% coinsurance	$285 copayment per day for days 1 through 7 per admission $0 copayment per day for days 8 and beyond per admission $0 copayment on day of discharge $1,995 maximum copayment per admission 190-day lifetime maximum	$275 copayment per day for days 1 through 6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,650 maximum copayment per admission 190-day lifetime maximum
In Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out of Network: 20% coinsurance	$20 copayment per group therapy session; $30 copayment per individual therapy session	$20 copayment per group therapy session; $30 copayment per individual therapy session
In Network: $20 copayment per group therapy session; $30 copayment per individual therapy session Out of Network: 20% coinsurance	$20 copayment per group therapy session; $30 copayment per individual therapy session	$20 copayment per group therapy session; $30 copayment per individual therapy session
In Network: $30 copayment per day Out of Network: 20% coinsurance	$30 copayment per day	$30 copayment per day
In Network: $0 copayment per day for days 1 through 20 $214 copayment per day for days 21 through 100 100 days per benefit period Out of Network: 20% coinsurance	$0 copayment per day for days 1 through 20 $214 copayment per day for days 21 through 100 100 days per benefit period	$0 copayment per day for days 1 through 20 $214 copayment per day for days 21 through 100 100 days per benefit period

Covered Medical and Hospital Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Outpatient Rehabilitation Services (Physical therapy, occupational therapy, and speech therapy)	$25 copayment per visit	$25 copayment per visit
Ambulance (1) (Ground and air transportation)	$240 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization.	$220 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 36)	$0 copayment 12 one-way trips (or 6 round-trip rides) per year provided by Roundtrip to plan-approved medical facilities Modes of transportation include taxi, rideshare services, van, medical sedan, and wheelchair van. Maximum 80 miles per one-way trip.
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	0%-20% coinsurance for Part B drugs, including chemotherapy drugs $35 copayment for a one-month supply of insulin For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.	0%-20% coinsurance for Part B drugs, including chemotherapy drugs $35 copayment for a one-month supply of insulin For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.

Services with a (1) may require prior authorization.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $20 copayment per visit Out of Network: 20% coinsurance	$35 copayment per visit	$20 copayment per visit
In Network and Out of Network: $230 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization.	$260 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization.	$225 copayment per one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization.
Not covered (offered under Uniform Flexibility; see page 37)	Not covered	Not covered (offered under Uniform Flexibility; see page 37)
In Network: 0%-20% coinsurance for Part B drugs, including chemotherapy drugs $35 copayment for a one-month supply of insulin Out of Network: 20% coinsurance For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.	0%-20% coinsurance for Part B drugs, including chemotherapy drugs $35 copayment for a one-month supply of insulin For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.	0%-20% coinsurance for Part B drugs, including chemotherapy drugs $35 copayment for a one-month supply of insulin For a description of the types of drugs available under Part B, see your *Evidence of Coverage*.

Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO.

	Keystone 65 Basic Rx HMO
Prescription Drug Benefits	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 $0 copayments when 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 Keystone 65 Rx HMO *Evidence of Coverage*.
True Out-of-Pocket Limit	You pay no more than $2,000 in out-of-pocket costs for covered drugs. The cap does not apply to drugs covered under Medicare Part B.
Catastrophic Coverage Stage	After reaching the annual maximum of $2,000 in out-of-pocket costs, you pay $0 for covered drugs.

This benefit is not available for members of Keystone 65 Liberty Medical-Only HMO and Keystone 65 Select Medical-Only HMO.

Keystone 65 Essential Rx HMO-POS	Keystone 65 Focus Rx HMO-POS	Keystone 65 Select Rx HMO
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 $0 copayments when 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 Keystone 65 Rx HMO *Evidence of Coverage*.	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 $0 copayments when 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 Keystone 65 Rx HMO *Evidence of Coverage*.	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 $0 copayments when 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 Keystone 65 Rx HMO *Evidence of Coverage*.
You pay no more than $2,000 in out-of-pocket costs for covered drugs. The cap does not apply to drugs covered under Medicare Part B.	You pay no more than $2,000 in out-of-pocket costs for covered drugs. The cap does not apply to drugs covered under Medicare Part B.	You pay no more than $2,000 in out-of-pocket costs for covered drugs. The cap does not apply to drugs covered under Medicare Part B.
After reaching the annual maximum of $2,000 in out-of-pocket costs, you pay $0 for covered drugs.	After reaching the annual maximum of $2,000 in out-of-pocket costs, you pay $0 for covered drugs.	After reaching the annual maximum of $2,000 in out-of-pocket costs, you pay $0 for covered drugs.

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO.

	Keystone 65 Basic Rx HMO		
Retail Cost-sharing (what you pay at a pharmacy location)	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)			
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)			
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$20 copayment	$40 copayment	$60 copayment
Tier 3 (Preferred Brand Drugs)			
• **Preferred Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance
• **Standard Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)			
• **Preferred Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance
• **Standard Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)			
• **Preferred Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance
• **Standard Pharmacy**	33% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tier 3, Tier 4, and Tier 5)			
• **Preferred Pharmacy**	$35 copayment	$70 copayment	$105 copayment
• **Standard Pharmacy**	$35 copayment	$70 copayment	$105 copayment

This benefit is not available for members of Keystone 65 Liberty Medical-Only HMO and Keystone 65 Select Medical-Only HMO.

Keystone 65 Essential Rx HMO-POS			Keystone 65 Focus Rx HMO-POS			Keystone 65 Select Rx HMO		
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 $8 copayment	$0 copayment $16 copayment	$0 copayment $24 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
$0 copayment $20 copayment	$0 copayment $40 copayment	$0 copayment $60 copayment	$0 copayment $20 copayment	$0 copayment $40 copayment	$0 copayment $60 copayment	$0 copayment $20 copayment	$0 copayment $40 copayment	$0 copayment $60 copayment
25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance	25% coinsurance 25% coinsurance
50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% coinsurance	50% coinsurance 50% 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 33% coinsurance
$35 copayment $35 copayment	$70 copayment $70 copayment	$105 copayment $105 copayment	$35 copayment $35 copayment	$70 copayment $70 copayment	$105 copayment $105 copayment	$35 copayment $35 copayment	$70 copayment $70 copayment	$105 copayment $105 copayment

Prescription Drug Benefits (Part D) (continued)

Part D Prescription Drug Benefits are available for members of Keystone 65 Basic Rx HMO, Keystone 65 Essential Rx HMO-POS, Keystone 65 Focus Rx HMO-POS, and Keystone 65 Select Rx HMO.

	Keystone 65 Basic Rx HMO		
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)	$0 copayment	$0 copayment	$0 copayment
Tier 3 (Preferred Brand Drugs)	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tier 3, Tier 4, and Tier 5)	$35 copayment	$70 copayment	$70 copayment

This benefit is not available for members of Keystone 65 Liberty Medical-Only HMO and Keystone 65 Select Medical-Only HMO.

Keystone 65 Essential Rx HMO-POS			Keystone 65 Focus Rx HMO-POS			Keystone 65 Select Rx HMO		
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
$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment

Other Medical Benefits

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Over-the-Counter (OTC) Items	$70 allowance every quarter The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.	$100 allowance every quarter The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.
Medical, Dental, Vision, and Hearing Flex Benefit	$300 allowance every year The annual allowance is preloaded on the IBX Care Card. This allowance can be used to: 1. Cover cost-sharing for covered dental, vision, and hearing benefits. 2. Pay for covered medical, dental, vision, or hearing services or supplies provided by any provider who is a licensed professional who accepts the IBX Care Card. Allowance can be used for any combination of medical, dental, vision, or hearing services or supplies. Any unused balance will not roll over to the next year.	$300 allowance every year The annual allowance is preloaded on the IBX Care Card. This allowance can be used to: 1. Cover cost-sharing for covered dental, vision, and hearing benefits. 2. Pay for covered medical, dental, vision, or hearing services or supplies provided by any provider who is a licensed professional who accepts the IBX Care Card. Allowance can be used for any combination of medical, dental, vision, or hearing services or supplies. Any unused balance will not roll over to the next year.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $70 allowance every quarter The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. Out of Network: Not covered OTC costs do not count toward the annual MOOP amount.	$30 allowance every quarter The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.	$30 allowance every quarter The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.
Not covered	Not covered	Not covered

Other Medical Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Vital Care Program* (Uniform Flexibility)	$10 copayment for cardiology specialist visits; $10 copayment for endocrinology specialist visits; $5 copayment for Medicare-covered podiatry visits; $5 copayment for routine podiatry visits, up to 6 visits per year Members must be diagnosed with both diabetes and congestive heart failure to participate.	$10 copayment for cardiology specialist visits; $10 copayment for endocrinology specialist visits; $5 copayment for Medicare-covered podiatry visits; $5 copayment for routine podiatry visits, up to 6 visits per year Members must be diagnosed with both diabetes and congestive heart failure to participate.
Vital Care Plus Program* (Uniform Flexibility)	Not covered	Not covered
Caregiver Support Services	No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.

*Cardiology, endocrinology, pulmonology, and Medicare-covered podiatry visits apply toward the annual MOOP amount. Routine podiatry visits do not apply toward the annual MOOP amount.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
Not covered	$10 copayment for cardiology specialist visits; $10 copayment for endocrinology specialist visits; $5 copayment for Medicare-covered podiatry visits; $5 copayment for routine podiatry visits, up to 6 visits per year Members must be diagnosed with both diabetes and congestive heart failure to participate.	$10 copayment for cardiology specialist visits; $10 copayment for endocrinology specialist visits; $5 copayment for Medicare-covered podiatry visits; $5 copayment for routine podiatry visits, up to 6 visits per year Members must be diagnosed with both diabetes and congestive heart failure to participate.
In Network: $10 copayment for cardiology specialist visits; $10 copayment for endocrinology specialist visits; $10 copayment for pulmonology specialist visits; $5 copayment for Medicare-covered podiatry visits; $5 copayment for routine podiatry visits, up to 6 visits per year; $80 quarterly allowance for over-the-counter items Out of Network: Not covered Members must be diagnosed with diabetes to participate.	Not covered	Not covered
In Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers. Out of Network: Not covered	No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.

Other Medical Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Telemedicine Visits		
• **Telemedicine Visits***	$0 copayment for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician; $0 copayment for mental/behavioral health visits focused on depression, anxiety, stress, and more; $0 copayment for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.	$0 copayment for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician; $0 copayment for mental/behavioral health visits focused on depression, anxiety, stress, and more; $0 copayment for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.
• **Additional Telehealth** (Primary care physician (PCP), specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	$0 copayment per PCP visit; $30 copayment per specialist visit; $25 copayment per physical therapy, occupational therapy, and speech therapy visit; $30 copayment per other health care professional visit Not all telehealth services may be covered.	$0 copayment per PCP visit; $25 copayment per specialist visit; $25 copayment per physical therapy, occupational therapy, and speech therapy visit; $25 copayment per other health care professional visit Not all telehealth services may be covered.
Dementia (Uniform Flexibility)	$0 copayment for neurology visits, including telehealth neurology visits Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor.	$0 copayment for neurology visits, including telehealth neurology visits Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor.

*Members must complete a comprehensive electronic health record ("EHR"), either online or by telephone with a designated Teladoc Health representative prior to receiving telemedicine services. Mental/behavioral health visits must be scheduled via the online platform teladochealth.com/signin. Visits cannot be scheduled by phone. Members must complete a mental health assessment via the website platform prior to scheduling a mental health visit.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $0 copayment for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician; $0 copayment for mental/behavioral health visits focused on depression, anxiety, stress, and more; $0 copayment for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year. Out of Network: Not covered	$0 copayment for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician; $0 copayment for mental/behavioral health visits focused on depression, anxiety, stress, and more; $0 copayment for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.	$0 copayment for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician; $0 copayment for mental/behavioral health visits focused on depression, anxiety, stress, and more; $0 copayment for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.
In Network: $0 copayment per PCP visit; $30 copayment per specialist visit; $20 copayment per physical therapy, occupational therapy, and speech therapy visit; $30 copayment per other health care professional visit Not all telehealth services may be covered. Out of Network: Not covered	$0 copayment per PCP visit; $40 copayment per specialist visit; $35 copayment per physical therapy, occupational therapy, and speech therapy visit; $40 copayment per other health care professional visit Not all telehealth services may be covered.	$0 copayment per PCP visit; $40 copayment per specialist visit; $20 copayment per physical therapy, occupational therapy, and speech therapy visit; $40 copayment per other health care professional visit Not all telehealth services may be covered.
In Network: $0 copayment for neurology visits, including telehealth neurology visits Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor. Out of Network: Not covered	$0 copayment for neurology visits, including telehealth neurology visits Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor.	$0 copayment for neurology visits, including telehealth neurology visits Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor.

Other Medical Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Chiropractic Services		
Medicare-covered	$15 copayment per visit for spinal manipulations	$15 copayment per visit for spinal manipulations
• **Routine Care*** (non-Medicare-covered)	$15 copayment per visit (up to 6 visits each year)	$15 copayment per visit (up to 6 visits each year)
Acupuncture		
• **Medicare-covered**	$15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made	$15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made
• **Routine Care*†** (non-Medicare-covered)	$15 copayment per visit (up to 6 visits each year)	$15 copayment per visit (up to 6 visits each year)
Podiatry Services		
• **Medicare-covered**	$25 copayment per visit	$25 copayment per visit
• **Routine Care*** (non-Medicare-covered)	$25 copayment per visit (up to 6 visits each year)	$25 copayment per visit (up to 6 visits each year)

* Routine visits do not count toward the annual MOOP amount.

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

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $15 copayment per visit for spinal manipulations Out of Network: 20% coinsurance	$15 copayment per visit for spinal manipulations	$20 copayment per visit for spinal manipulations
In Network: $15 copayment per visit (up to 6 visits each year) Out of Network: Not covered	$15 copayment per visit (up to 6 visits each year)	$20 copayment per visit (up to 6 visits each year)
In Network: $15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 20% coinsurance	$15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made	$20 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made
In Network: $15 copayment per visit (up to 6 visits each year) Out of Network: Not covered	$15 copayment per visit (up to 6 visits each year)	$20 copayment per visit (up to 6 visits each year)
In Network: $25 copayment per visit Out of Network: 20% coinsurance	$25 copayment per visit	$20 copayment per visit
In Network: $25 copayment per visit (up to 6 visits each year) Out of Network: Not covered	$25 copayment per visit (up to 6 visits each year)	$20 copayment per visit (up to 6 visits each year)

Other Medical Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Transportation Services (Uniform Flexibility)	$0 copayment 24 one-way trips (or 12 round-trip rides) per year provided by 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 one-way trip.	Not covered (offered under Medical Benefits, see page 20)
Fitness Benefit	No copayment or coinsurance Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.	No copayment or coinsurance Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $0 copayment 24 one-way trips (or 12 round-trip rides) per year provided by 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 one-way trip. Out of Network: Not covered	Not covered	$0 copayment 24 one-way trips (or 12 round-trip rides) per year provided by 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 one-way trip.
In Network: No copayment or coinsurance Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied. Out of Network: Not covered	No copayment or coinsurance Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.	No copayment or coinsurance Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.

Other Medical Benefits (continued)

	Keystone 65 Basic Rx HMO	Keystone 65 Essential Rx HMO-POS
Grocery Benefits*	$0 copayment Grocery boxes containing food and produce will be provided for a maximum of 4 weeks per year, per member. Members must be diagnosed with both diabetes and depressive disorders to be eligible for the grocery benefit.	$0 copayment Grocery boxes containing food and produce will be provided for a maximum of 12 weeks per year, per member. Members must receive Low Income Subsidy (also known as LIS, or "Extra Help") and must have a diagnosis of one of the following conditions to be eligible for the grocery benefit: chronic and disabling mental health conditions, hypertension, diabetes, obesity, chronic kidney disease, or chronic heart failure (including ischemic heart disease, hyperlipidemia, and peripheral vascular disease).
Meals Program*†	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure

* For select plans, the grocery and meal benefits mentioned are part of a special supplemental program for the chronically ill. Members must be diagnosed with Diabetes, Depression or Depressive Disorders, Disabling Mental Health Conditions, Chronic Heart Failure, Hypertension, or other eligible conditions to qualify. Eligible conditions vary by benefit and plan. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. Contact us to confirm your eligibility for these benefits.

† Meals will be provided after discharge to the home following an inpatient acute hospital, skilled nursing facility, long-term acute care facility, acute rehabilitation facility, or rehabilitation facility stay. Participation in our medical management Transitions of Care Program is required.

Keystone 65 Focus Rx HMO-POS	Keystone 65 Liberty Medical-Only HMO	Keystone 65 Select HMO
In Network: $0 copayment Grocery boxes containing food and produce will be provided for a maximum of 4 weeks per year, per member. Members must be diagnosed with both diabetes and depressive disorders to be eligible for the grocery benefit. Out of Network: Not covered	Not covered	$0 copayment Grocery boxes containing food and produce will be provided for a maximum of 4 weeks per year, per member. Members must be diagnosed with both diabetes and depressive disorders to be eligible for the grocery benefit.
In Network: $0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure Out of Network: Not covered	Not covered	$0 copayment 3 meals per day, 7 days per week from MANNA Meals for up to 4 weeks, 2 times per year To qualify, members must fall into one of two groups: Group 1: Must have a new diagnosis of colorectal, endometrial, breast (male/female), lung, or prostate cancer Group 2: Must be diagnosed with both diabetes and congestive heart failure

Pre-Enrollment Checklist

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

Understanding the Benefits

- [ ] 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 **1-800-645-3965 (TTY/TDD: 711)** to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] 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, 2026.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- [ ] Our Keystone 65 Essential Rx HMO-POS and Keystone 65 Focus Rx HMO-POS plans allow you to see providers outside of the plan's network (non-contracted providers). However, while we pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- [ ] Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

For more information

For updated information regarding plan providers, visit our website at **ibxmedicare.com**, or call our 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 (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.

Independence Blue Cross offers HMO and HMO-POS Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross HMO and HMO-POS Medicare Advantage plans depends on contract renewal.

Benefits underwritten by Keystone Health Plan East, 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 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.

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

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

Teladoc Health and the practitioners accessible through Teladoc Health are independent companies and contractors not affiliated with Independence Blue Cross. Please consult a physician for personalized medical advice. Always seek the advice of a physician or other qualified health care provider with any questions regarding a medical condition.

Roundtrip is an independent company that administers our transportation benefit.

One Pass is a voluntary program offered by an independent company. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

MANNA is an independent company that 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 (TTY/TDD: 711)** (non-members) (by calling this number you will be directed to a licensed sales agent) or **1-800-645-3965 (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

Form Approved
OMB# 0938-1421

Multi-Language Insert

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. 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. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-275-2583。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-275-2583。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

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. 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. 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 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. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-275-2583 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

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 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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 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. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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. 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. 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. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-275-2583 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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Form CMS-10802
(Expires 12/31/25)

Multi-language Interpreter Services

Gujarati: અમારી આરોગ્ય અથવા દવા યોજના વિશે તમને હોય શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે નિ:શુલ્ક દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, અમને ફક્ત 1-800-275-2583 પર કૉલ કરો. ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ એક નિ:શુલ્ક સેવા છે.

Urdu: آپ کی صحت یا دوا کے متعلق کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمانی کی خدمات دستیاب ہیں۔ مترجم کی سہولت کے لیے، 1-800-275-2583 پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ مفت سروس ہے۔

Khmer: យើងមានផ្តល់សេវាកម្មអ្នកបកប្រែផ្ទាល់មាត់ឥតគិតថ្លៃ ដើម្បីឆ្លើយសំណួរណាមួយដែលអ្នកប្រហែលជាមានអំពីគម្រោងសុខភាព ឬឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ គ្រាន់តែហៅទូរសព្ទមកយើងតាមលេខ 1-800-275-2583 ។ អ្នកណាម្នាក់ដែលនិយាយភាសាអ៊ូឌូអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មឥតគិតថ្លៃ។

Telugu: మా ఆరోగ్యం లేదా ఔషధ ప్రణాళిక గురించి మీకు ఏవైనా ప్రశ్నలకు సమాధానం ఇవ్వడానికి మాకు ఉచిత ఇంటర్‌ప్రెటర్ సర్వీస్‌లు అందుబాటులో ఉన్నాయి. అనువాదకుడిని పొందడానికి, 1-800-275-2583 ద్వారా మాకు కాల్ చేయండి. తెలుగు మాట్లాడగలిగే ఎవరైనా మీకు సహాయం చేయగలరు. ఇది ఉచిత సర్వీస్.

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.*

PO Box 13713
Philadelphia, PA 19101-3713

ibxmedicare.com

IBX14310 (07/24)
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