Independence

2025
Summary of Benefits

Effective January 1, 2025 through December 31, 2025

[redacted]

- Personal Choice 65℠ Elite Rx PPO
- Personal Choice 65℠ Plus 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 Plus 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 Plus 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 may 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 Plan Premium
- Plan Costs
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Personal Choice 65 Elite Rx PPO, Personal Choice 65 Plus 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 Plus 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 Plus 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 Plus 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...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$16.60

Personal Choice 65 Plus Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Plus Rx PPO
	You pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$164.00

Personal Choice 65 Prime Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Prime Rx PPO
	You pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$0.00

Personal Choice 65 Saver Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Saver Rx PPO
	You pay...
Philadelphia, Bucks, Chester, Delaware, or Montgomery County	$0.00

Personal Choice 65 Medical-Only PPO	
If you live in...	And you have...
	Personal Choice 65 Medical-Only PPO
	You pay...
Philadelphia or Bucks County	$102.50

Personal Choice 65 Rx PPO	
If you live in...	And you have...
	Personal Choice 65 Rx PPO
	You pay...
Philadelphia or Bucks County	$192.00
Chester, Delaware, or Montgomery County	$152.00

Plan Costs

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus 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.
Part B Premium Giveback*	This plan does not include a Part B Premium Giveback.	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: $7,000 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In Network and Out of Network: $10,000 each year	In Network: $4,151 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: $5,750 each year

*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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
This plan does not have a deductible for covered medical services or for Part D prescription drugs.	This plan does not have a deductible for covered medical services or for Part D prescription drugs.	Personal Choice 65 Medical-Only PPO does not have a deductible for covered medical services. Personal Choice 65 Rx PPO does not have a deductible for covered medical services or for Part D prescription drugs.
This plan will reduce your monthly Part B premium by $9.10.	This plan will reduce your monthly Part B premium by $96.	This plan does not include a Part B Premium Giveback.
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: $8,300 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: $5,500 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: $8,950 each year

Covered Medical and Hospital Benefits

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus 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 stay $0 copayment per day for additional days per admission $0 copayment on day of discharge Out of Network: 25% coinsurance
Outpatient Hospital Services (1)	In Network: $250 copayment per visit Out of Network: 30% coinsurance	In Network: $275 copayment per visit Out of Network: 25% coinsurance
Outpatient Observation Services	In Network: $250 copayment per visit Out of Network: 30% coinsurance	In Network: $275 copayment per visit Out of Network: 25% coinsurance
Ambulatory Surgical Services (1)	In Network: $150 copayment Out of Network: 30% coinsurance	In Network: $225 copayment Out of Network: 25% coinsurance
Doctor's Office Visits		
• **Primary Care Physician**	In Network: $0 copayment per visit Out of Network: 30% coinsurance	In Network: $0 copayment per visit Out of Network: 25% coinsurance
• **Specialist**	In Network: $30 copayment per visit Out of Network: 30% coinsurance	In Network: $0 copayment per visit Out of Network: 25% coinsurance

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

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $250 copayment per day for days 1–7 per admission $0 copayment per day for days 8 and beyond per admission $0 copayment on day of discharge $1,750 maximum copayment per admission Out of Network: 40% coinsurance	In Network: $375 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 $1,875 maximum copayment per admission Out of Network: 40% coinsurance	In Network: $240 copayment per day for days 1–6 per admission $0 copayment per day for days 7 and beyond per admission $0 copayment on day of discharge $1,440 maximum copayment per admission Out of Network: 30% coinsurance
In Network: $350 copayment per visit Out of Network: 40% coinsurance	In Network: 20% coinsurance per visit Out of Network: 40% coinsurance	In Network: $300 copayment per visit Out of Network: 30% coinsurance
In Network: $350 copayment per visit Out of Network: 40% coinsurance	In Network: 20% coinsurance per visit Out of Network: 40% coinsurance	In Network: $300 copayment per visit Out of Network: 30% coinsurance
In Network: $200 copayment Out of Network: 40% coinsurance	In Network: 20% coinsurance Out of Network: 40% coinsurance	In Network: $150 copayment Out of Network: 30% coinsurance
In Network: $0 copayment per visit Out of Network: 40% coinsurance	In Network: $10 copayment per visit Out of Network: 40% coinsurance	In Network: $0 copayment per visit Out of Network: 30% coinsurance
In Network: $30 copayment per visit Out of Network: 40% coinsurance	In Network: $50 copayment per visit Out of Network: 40% coinsurance	In Network: $35 copayment per visit Out of Network: 30% coinsurance

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus 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: 25% 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 of the U.S. does not count toward the annual MOOP amount	In Network and Out of Network: $100 copayment per visit Not waived if admitted	In Network and Out of Network: $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	In Network and Out of Network: $5 copayment in a retail clinic Not waived if admitted $45 copayment in an urgent care center Not waived if admitted $100 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 $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 (in-network only).

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $0 copayment Out of Network: 40% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.	In Network: $0 copayment Out of Network: 40% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.	In Network: $0 copayment Out of Network: 30% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
In Network and Out of Network: $100 copayment per visit Not waived if admitted	In Network and Out of Network: $110 copayment per visit Not waived if admitted	In Network and Out of Network: $125 copayment per visit Not waived if admitted
In Network and Out of Network: $10 copayment in a retail clinic Not waived if admitted $45 copayment in an urgent care center Not waived if admitted $100 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 $45 copayment in an urgent care center Not waived if admitted $110 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 $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)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
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 mammogram that results from a preventive mammogram) $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 mammogram that results from a preventive mammogram) $30 or $150 copayment depending on service Out of Network: 25% coinsurance
Diagnostic Procedures, Tests, and Lab Services (1)	In Network: $0 copayment Out of Network: 30% coinsurance	In Network: $0 copayment Out of Network: 25% coinsurance
Outpatient X-rays	In Network: $35 copayment for routine radiology Out of Network: 30% coinsurance	In Network: $30 copayment for routine radiology Out of Network: 25% coinsurance
Therapeutic Radiology (1) (Radiation Therapy)	In Network: $75 copayment per visit Out of Network: 30% coinsurance	In Network: $80 copayment per visit Out of Network: 25% coinsurance
Radiation for Breast Cancer (Uniform Flexibility)	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: 25% coinsurance

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

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
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) $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 mammogram that results from a preventive mammogram) $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 mammogram that results from a preventive mammogram) $40 or $175 copayment depending on service Out of Network: 30% coinsurance
In Network: $0 copayment Out of Network: 40% coinsurance	In Network: $0 copayment Out of Network: 40% coinsurance	In Network: $0 copayment Out of Network: 30% coinsurance
In Network: $40 copayment for routine radiology Out of Network: 40% coinsurance	In Network: $40 copayment for routine radiology Out of Network: 40% coinsurance	In Network: $40 copayment for routine radiology Out of Network: 30% coinsurance
In Network: $60 copayment per visit Out of Network: 40% coinsurance	In Network: $80 copayment per visit Out of Network: 40% coinsurance	In Network: $80 copayment per visit 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

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Hearing Services		
• **Medicare-covered Hearing Exams**	In Network: $30 copayment for Medicare-covered hearing exams Out of Network: 30% coinsurance	In Network: $0 copayment for Medicare-covered hearing exams Out of Network: 25% coinsurance
• **Routine Hearing Exams**	In Network and Out of Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In Network and Out of Network: $0 copayment for routine non-Medicare-covered hearing exams once every year
• **Routine Hearing Aids**	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 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.	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 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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $30 copayment for Medicare-covered hearing exams Out of Network: 40% coinsurance	In Network: $50 copayment for Medicare-covered hearing exams Out of Network: 40% coinsurance	In Network: $35 copayment for Medicare-covered hearing exams Out of Network: 30% coinsurance
In Network and Out of Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In Network and Out of Network: $0 copayment for routine non-Medicare-covered hearing exams once every year	In Network and Out of Network: $0 copayment for routine non-Medicare-covered hearing exams once every year
In Network and Out of Network: $699 copayment for an advanced digital hearing aid, per aid; or $999 copayment for a premium digital hearing aid, per aid. Advanced and premium include a rechargeable hearing aid option.	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.	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 for the first year; up to two hearing aids every year, one hearing aid per ear.	Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear.	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 and aids are covered when provided by a TruHearing® provider.	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 do not count toward the annual MOOP amount.	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 Plus Rx PPO
Dental Services		
• **Medicare-covered Dental Services**	In Network: $30 copayment for Medicare-covered dental services Out of Network: 30% coinsurance	In Network: $0 copayment for Medicare-covered dental services Out of Network: 25% coinsurance
• **Routine Dental Care** (includes preventive and comprehensive dental)	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 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: 80% coinsurance for routine dental exam and cleaning services; 80% coinsurance for dental X-ray; 80% 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.	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: $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery Out of Network: 80% coinsurance for routine dental exam and cleaning services; 80% coinsurance for dental X-ray; 80% 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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $30 copayment for Medicare-covered dental services Out of Network: 40% coinsurance	In Network: $50 copayment for Medicare-covered dental services Out of Network: 40% coinsurance	In Network: $35 copayment for Medicare-covered dental services Out of Network: 30% coinsurance
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	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	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
10% coinsurance for restorative services, endodontics, periodontics, and extractions; 10% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery	20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery	20% coinsurance for restorative services, endodontics, periodontics, and extractions; 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery
In Network and Out of Network: $2,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery	In Network and Out of Network: $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery	In Network and Out of Network: $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/ maxillofacial surgery
Out of Network: 80% coinsurance for routine dental exam and cleaning services; 80% coinsurance for dental X-ray; 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery	Out of Network: 80% coinsurance for routine dental exam and cleaning services; 80% coinsurance for dental X-ray; 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery	Out of Network: 80% coinsurance for routine dental exam and cleaning services; 80% coinsurance for dental X-ray; 80% 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.	Member must use a participating IBX Medicare Dental Network provider for in-network coverage.	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.	Routine and non-Medicare-covered comprehensive dental services do not count toward the annual MOOP amount.	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 Plus Rx PPO
Vision Services		
• **Medicare-covered Vision Services**	In Network: $30 copayment for Medicare-covered vision exams; no copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, or for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 30% coinsurance	In Network: $0 copayment for Medicare-covered vision exams; no copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, or for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 25% coinsurance
• **Routine Vision Care** (includes routine exam and eyewear)	In Network: $0 copayment for routine eye exam every year; contact lenses or one 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 (frames 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 Member must use a participating Davis Vision network provider. 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 copayment for routine eye exam every year; contact lenses or one 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 (frames 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 Member must use a participating Davis Vision network provider. 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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $30 copayment for Medicare-covered vision exams; no copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, or for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 40% coinsurance	In Network: $50 copayment for Medicare-covered vision exams; no copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, or for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 40% coinsurance	In Network: $35 copayment for Medicare-covered vision exams; no copayment for Medicare-covered diabetic or dilated retinal eye exam, for Medicare-covered glaucoma screenings, or for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery Out of Network: 30% coinsurance
In Network: $0 copayment for routine eye exam every year; contact lenses or one 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 (frames 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 Member must use a participating Davis Vision network provider. 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 copayment for routine eye exam every year; contact lenses or one 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 (frames 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 Member must use a participating Davis Vision network provider. 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 copayment for routine eye exam every year; contact lenses or one 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 (frames 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 Member must use a participating Davis Vision network provider. 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 Plus 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 stay $0 copayment per day for additional days per admission $0 copayment on day of discharge 190-day lifetime maximum Out of Network: 25% 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: 25% 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: 25% coinsurance
• **Partial Hospitalization and Intensive Outpatient Services (1)**	In Network: $30 copayment per day Out of Network: 30% coinsurance	In Network: $30 copayment per day Out of Network: 25% coinsurance
Skilled Nursing Facility (1)	In Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out of Network: 30% coinsurance 100 days per benefit period	In Network: $0 copayment per day for days 1–20 $214 copayment per day for days 21–100 Out of Network: 25% coinsurance 100 days per benefit period

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

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $250 copayment per day for days 1 through 7 per admission	In Network: $375 copayment per day for days 1–5 per admission	In Network: $240 copayment per day for days 1–6 per admission
$0 copayment per day for days 8 and beyond per admission	$0 copayment per day for days 6 and beyond per admission	$0 copayment per day for days 7 and beyond per admission
$0 copayment on day of discharge	$0 copayment on day of discharge	$0 copayment on day of discharge
$1,750 maximum copayment per admission	$1,875 maximum copayment per admission	$1,440 maximum copayment per admission
190-day lifetime maximum	190-day lifetime maximum	190-day lifetime maximum
Out of Network: 40% coinsurance	Out of Network: 40% coinsurance	Out of Network: 30% coinsurance
In Network: $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	In Network: $20 copayment per group therapy session; $30 copayment per individual therapy session
Out of Network: 40% coinsurance	Out of Network: 40% coinsurance	Out of Network: 30% coinsurance
In Network: $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	In Network: $20 copayment per group therapy session; $30 copayment per individual therapy session
Out of Network: 40% coinsurance	Out of Network: 40% coinsurance	Out of Network: 30% coinsurance
In Network: $30 copayment per day	In Network: $30 copayment per day	In Network: $30 copayment per day
Out of Network: 40% coinsurance	Out of Network: 40% coinsurance	Out of Network: 30% coinsurance
In Network: $0 copayment per day for days 1–20	In Network: $0 copayment per day for days 1–20	In Network: $0 copayment per day for days 1–20
$214 copayment per day for days 21–100	$214 copayment per day for days 21–100	$214 copayment per day for days 21–100
Out of Network: 40% coinsurance	Out of Network: 40% coinsurance	Out of Network: 30% coinsurance
100 days per benefit period	100 days per benefit period	100 days per benefit period

Covered Medical and Hospital Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Outpatient Rehabilitation Services (Physical therapy, occupational therapy, and speech therapy)	In Network: $30 copayment per visit Out of Network: 30% coinsurance	In Network: $15 copayment per visit Out of Network: 25% coinsurance
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: $150 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
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	In Network: 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*. Out of Network: 30% coinsurance	In Network: 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*. Out of Network: 25% coinsurance

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

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $25 copayment per visit Out of Network: 40% coinsurance	In Network: $35 copayment per visit Out of Network: 40% coinsurance	In Network: $20 copayment per visit Out of Network: 30% coinsurance
In Network and Out of Network: $240 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.
Not covered (offered under Uniform Flexibility; see page 35)	Not covered	Not covered (offered under Uniform Flexibility; see page 35)
In Network: 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*. Out of Network: 40% coinsurance	In Network: 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*. Out of Network: 40% coinsurance	In Network: 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*. Out of Network: 30% coinsurance

Prescription Drug Benefits (Part D)

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

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
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 Personal Choice 65 Rx PPO *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 Personal Choice 65 Rx PPO *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.	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.	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 Personal Choice 65 Medical-Only PPO.

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

	Personal Choice 65 Elite Rx PPO			Personal Choice 65 Plus 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
Tier 1 (Preferred Generic Drugs)						
• **Preferred Pharmacy**	$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
Tier 2 (Generic Drugs)						
• **Preferred Pharmacy**	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
• **Standard Pharmacy**	$20 copayment	$40 copayment	$60 copayment	$20 copayment	$40 copayment	$60 copayment
Tier 3 (Preferred Brand Drugs)						
• **Preferred Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
• **Standard Pharmacy**	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)						
• **Preferred Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
• **Standard Pharmacy**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)						
• **Preferred Pharmacy**	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
Insulin (Tier 3, Tier 4, and Tier 5)						
• **Preferred Pharmacy**	$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

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

Personal Choice 65 Prime Rx PPO			Personal Choice 65 Saver Rx PPO			Personal Choice 65 Rx PPO		
One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply	One-Month Supply	Two-Month Supply	Three-Month Supply
$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment	$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment	$0 copayment $9 copayment	$0 copayment $18 copayment	$0 copayment $27 copayment
$0 copayment $20 copayment	$0 copayment $40 copayment	$0 copayment $60 copayment	$0 copayment $10 copayment	$0 copayment $20 copayment	$0 copayment $30 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	23% coinsurance 23% coinsurance	23% coinsurance 23% coinsurance	23% coinsurance 23% 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	31% coinsurance 31% coinsurance	31% coinsurance 31% coinsurance	31% coinsurance 31% 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 Personal Choice 65 Elite Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Prime Rx PPO, Personal Choice 65 Saver Rx PPO, and Personal Choice 65 Rx PPO.

	Personal Choice 65 Elite Rx PPO			Personal Choice 65 Plus 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
Tier 1 (Preferred Generic Drugs)	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic Drugs)	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 3 (Preferred Brand Drugs)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs)	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tier 3, Tier 4, and Tier 5)	$35 copayment	$70 copayment	$70 copayment	$35 copayment	$70 copayment	$70 copayment

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

Personal Choice 65 Prime Rx PPO			Personal Choice 65 Saver Rx PPO			Personal Choice 65 Rx PPO		
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	23% coinsurance	23% coinsurance	23% 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	31% coinsurance	31% coinsurance	31% 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

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Over-the-Counter (OTC) Items	In Network and Out of Network: $125 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.	In Network and Out of Network: $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.
Dental, Vision, and Hearing Flex Benefit	In Network and Out of Network: $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 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 dental, vision, or hearing services or supplies. Any unused balance will not roll over to the next year.	Not covered

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network and Out of 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. OTC costs do not count toward the annual MOOP amount.	In Network and Out of Network: $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.	In Network and Out of Network: $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.
In Network and Out of Network: $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 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 dental, vision, or hearing services or supplies. Any unused balance will not roll over to the next year.	Not covered	Not covered

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Telemedicine Visits		
• **Telemedicine Visits***	In Network and Out of 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.	In Network and Out of 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.
• **Additional Telehealth** (Primary care physician (PCP), specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	In Network: $0 copayment per PCP visit; $30 copayment per specialist visit; $30 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	In Network: $0 copayment per PCP visit; $0 copayment per specialist visit; $15 copayment per physical therapy, occupational therapy, and speech therapy visit; $0 copayment per other health care professional visit Not all telehealth services may be covered. Out of Network: Not covered
Dementia (Uniform Flexibility)	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	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

*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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network and Out of 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.	In Network and Out of 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.	In Network and Out of 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.
In Network: $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. Out of Network: Not covered	In Network: $10 copayment per PCP visit; $50 copayment per specialist visit; $35 copayment per physical therapy, occupational therapy, and speech therapy visit; $50 copayment per other health care professional visit Not all telehealth services may be covered. 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 Not all telehealth services may be covered. Out of Network: Not 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	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	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

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Chiropractic Services		
• **Medicare-covered**	In Network: $15 copayment per visit for spinal manipulation Out of Network: 30% coinsurance	In Network: $15 copayment per visit for spinal manipulation Out of Network: 25% coinsurance
• **Routine Care*** (non-Medicare-covered)	In Network: $15 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 30% coinsurance	In Network: $15 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 25% coinsurance
Acupuncture		
• **Medicare-covered**	In Network: $15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 30% coinsurance	In Network: $15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 25% coinsurance
• **Routine Care*†** (non-Medicare-covered)	In Network: $15 copayment per visit (up to 6 visits per year) Out of Network: 30% coinsurance	In Network: $15 copayment per visit (up to 6 visits per year) Out of Network: 25% coinsurance
Podiatry Services		
• **Medicare-covered**	In Network: $25 copayment per visit Out of Network: 30% coinsurance	In Network: $15 copayment per visit Out of Network: 25% coinsurance
• **Routine Care*** (non-Medicare-covered)	In Network: $25 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 30% coinsurance	In Network: $15 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 25% coinsurance

*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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network: $15 copayment per visit for spinal manipulation Out of Network: 40% coinsurance	In Network: $15 copayment per visit for spinal manipulation Out of Network: 40% coinsurance	In Network: $20 copayment per visit for spinal manipulation Out of Network: 30% coinsurance
In Network: $15 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 40% coinsurance	In Network: $15 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 40% coinsurance	In Network: $20 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 30% coinsurance
In Network: $15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 40% coinsurance	In Network: $15 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 40% coinsurance	In Network: $20 copayment per visit, up to 12 visits in 90 days; 8 additional if determined that progress is made Out of Network: 30% coinsurance
In Network: $15 copayment per visit (up to 6 visits per year) Out of Network: 40% coinsurance	In Network: $15 copayment per visit (up to 6 visits per year) Out of Network: 40% coinsurance	In Network: $20 copayment per visit (up to 6 visits per year) Out of Network: 30% coinsurance
In Network: $25 copayment per visit Out of Network: 40% coinsurance	In Network: $25 copayment per visit Out of Network: 40% coinsurance	In Network: $20 copayment per visit Out of Network: 30% coinsurance
In Network: $25 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 40% coinsurance	In Network: $25 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 40% coinsurance	In Network: $20 copayment per visit (up to 6 visits combined in and out of network per year) Out of Network: 30% coinsurance

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Transportation Services (Uniform Flexibility)	In Network and Out of 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.	Not covered
Fitness Benefit	In Network and Out of 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.	In Network and Out of 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.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network and Out of 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.	Not covered	In Network and Out of 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.
In Network and Out of 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.	In Network and Out of 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.	In Network and Out of 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.

Other Medical Benefits (continued)

	Personal Choice 65 Elite Rx PPO	Personal Choice 65 Plus Rx PPO
Grocery Benefits*	In Network and Out of 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.	Not covered
Caregiver Support Services	In Network and Out of Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	In Network and Out of Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.

* The grocery benefit mentioned is part of a special supplemental program for the chronically ill. Members must be diagnosed with both Diabetes and Depression or Depressive Disorders to qualify. 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 this benefit.

Personal Choice 65 Prime Rx PPO	Personal Choice 65 Saver Rx PPO	Personal Choice 65 PPO
In Network and Out of 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.	Not covered	In Network and Out of 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.
In Network and Out of Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	In Network and Out of Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	In Network and Out of Network: No copayment or coinsurance Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.

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, 2026.

- [ ] 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.

- [ ] 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 **1-888-718-3333 (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.

Independence Blue Cross offers PPO Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross PPO 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.

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.

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

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.

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)

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 ដើម្បីឆ្លើយសំណួរណា
មួយដែលអ្នកប្រហែលជាមានអំពីគម្រោងសុខភាព 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.*

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Independence

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Philadelphia, PA 19101-3713
ibxmedicare.com

IBX14311 (07/24)
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