Independence

Personal Choice 65℠ PPO

2018
Summary of Benefits

Effective January 1, 2018 through December 31, 2018

[redacted]

- **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***.

This *Summary of Benefits* booklet gives you a summary of what Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO cover and what you pay.

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 PCP and can go to doctors in or out of the plan's network. If members use out-of-network doctors, hospitals, or other health care providers, they will pay more for their services.

If you want to compare our plans with other available Medicare health plans, ask the other plan(s) for their *Summary of Benefits* booklet. Or, use the Medicare Plan Finder at www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections of this booklet

- Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits for Personal Choice 65 Rx PPO

Who can join?

To join Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO, 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 Rx PPO is Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania.

Which doctors, hospitals, and pharmacies can I use?

Personal Choice 65 Medical-Only PPO and Personal Choice 65 Rx PPO 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 Rx PPO has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy you use. To view our list of network providers and pharmacies (*Provider/ Pharmacy Directory*), please visit www.ibxmedicare.com.

Personal Choice 65 Rx PPO covers Part D drugs. In addition, the plan covers Part B drugs such as chemotherapy and some other drugs administered by your provider. You can see our complete plan *Formulary (List of Covered Drugs)* and any restrictions on our website, www.ibxmedicare.com.

Monthly Plan Premium

Personal Choice 65 PPO		
If You Live In...	And You Have...	
	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
	You Pay...	
Chester, Delaware, or Montgomery County	N/A	$160
Bucks or Philadelphia County	$214	$297
	You must continue to pay your Medicare Part B premium.	

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Deductible	This plan does not have a deductible for covered medical services.	This plan does not have a deductible for covered medical services. This plan has a $400 yearly deductible for Part D prescription drugs on Tier 3, Tier 4, and Tier 5
Maximum Out-of-Pocket (the amounts you pay for your premium, Part D prescription drugs and some medical services do not count toward your maximum out-of-pocket amount)	In-Network: $6,200 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: $6,200 each year Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply. Combined In-Network and Out-of-Network: $10,000 each year
Covered Medical and Hospital Benefits		
Inpatient Hospital Coverage (1)	In-Network: $300 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission $1,800 maximum copayment per admission Out-of-Network: 30% coinsurance	In-Network: $300 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission $1,800 maximum copayment per admission Out-of-Network: 30% coinsurance
Outpatient Hospital Coverage		
• **Ambulatory Surgical Center (1)**	In-Network: $200 copayment Out-of-Network: 30% coinsurance	In-Network: $200 copayment Out-of-Network: 30% coinsurance
• **Outpatient Hospital Facility (1)**	In-Network: $400 copayment Out-of-Network: 30% coinsurance	In-Network: $400 copayment Out-of-Network: 30% coinsurance
• **Observation Services**	In-Network: $400 copayment per stay Out-of-Network: 30% coinsurance per stay	In-Network: $400 copayment per stay Out-of-Network: 30% coinsurance per stay

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Doctor's Office Visits • **Primary Care Physician**	In-Network: $15 copayment Out-of-Network: 30% coinsurance	In-Network: $15 copayment Out-of-Network: 30% coinsurance
• **Specialist**	In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $40 copayment Out-of-Network: 30% coinsurance
Preventive Care	In-Network: You pay nothing Out-of-Network: 30% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. Any additional preventive services approved by Medicare during the contract year will be covered at the appropriate cost-share.	In-Network: You pay nothing Out-of-Network: 30% coinsurance Please refer to the *Evidence of Coverage* for a complete listing of services. Any additional preventive services approved by Medicare during the contract year will be covered at the appropriate cost-share.
Emergency Care — covered worldwide	In-Network: $80 copayment Not waived if admitted Out-of-Network: $80 copayment Not waived if admitted	In-Network: $80 copayment Not waived if admitted Out-of-Network: $80 copayment Not waived if admitted
Urgently Needed Services — covered worldwide	In-Network: $15 copayment in a retail clinic Not waived if admitted Out-of-Network: $15 copayment in a retail clinic Not waived if admitted In-Network: $40 copayment in an urgent care center Not waived if admitted Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network: $80 copayment per visit outside of U.S. Not waived if admitted Out-of-Network: $80 copayment per visit outside of U.S. Not waived if admitted	In-Network: $15 copayment in a retail clinic Not waived if admitted Out-of-Network: $15 copayment in a retail clinic Not waived if admitted In-Network: $40 copayment in an urgent care center Not waived if admitted Out-of-Network: $40 copayment in an urgent care center Not waived if admitted In-Network: $80 copayment per visit outside of U.S. Not waived if admitted Out-of-Network: $80 copayment per visit outside of U.S. Not waived if admitted

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Diagnostic Services (1), Lab and Radiology Services (1), and X-rays (1)		
• **Diagnostic Radiology Services**	In-Network: $50 or $175 copayment depending on service Out-of-Network: 30% coinsurance	In-Network: $50 or $175 copayment depending on service Out-of-Network: 30% coinsurance
• **Lab Services**	In-Network: You pay nothing Out-of-Network: 30% coinsurance	In-Network: You pay nothing Out-of-Network: 30% coinsurance
• **Diagnostic Tests and Procedures**	In-Network: You pay nothing Out-of-Network: 30% coinsurance	In-Network: You pay nothing Out-of-Network: 30% coinsurance
• **Outpatient X-rays**	In-Network: $50 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services	In-Network: $50 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services
Hearing Services		
• **Hearing Exam**	In-Network: $40 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance for Medicare-covered hearing exams $40 copayment for routine non-Medicare-covered hearing exams once every year Out-of-Network: 30% coinsurance for routine non-Medicare-covered hearing exams once every year	In-Network: $40 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance for Medicare-covered hearing exams $40 copayment for routine non-Medicare-covered hearing exams once every year Out-of-Network: 30% coinsurance for routine non-Medicare-covered hearing exams once every year
• **Hearing Aid**	In-Network: $699 or $999 copayment per year, per ear Out-of-Network: $699 or $999 copayment per year, per ear when purchased through TruHearing	In-Network: $699 or $999 copayment per year, per ear Out-of-Network: $699 or $999 copayment per year, per ear when purchased through TruHearing

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Dental Services	In-Network: $40 copayment for non-routine Medicare-covered dental services in a specialist office Out-of-Network: 30% coinsurance for non-routine Medicare-covered dental services in a specialist office In-Network: $0 copayment for non-routine Medicare-covered dental services in an inpatient facility Out-of-Network: 30% coinsurance for non-routine Medicare-covered dental services in an inpatient facility Routine dental services (such as cleanings) are not covered	In-Network: $40 copayment for non-routine Medicare-covered dental services in a specialist office Out-of-Network: 30% coinsurance for non-routine Medicare-covered dental services in a specialist office In-Network: $0 copayment for non-routine Medicare-covered dental services in an inpatient facility Out-of-Network: 30% coinsurance for non-routine Medicare-covered dental services in an inpatient facility Routine dental services (such as cleanings) are not covered

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Vision Services	In-Network: $40 copayment for Medicare-covered eye exams Out-of-Network: 30% coinsurance for Medicare-covered eye exams	In-Network: $40 copayment for Medicare-covered eye exams Out-of-Network: 30% coinsurance for Medicare-covered eye exams
	In-Network: $0 copayment for diabetic retinal eye exam Out-of-Network: 30% coinsurance for diabetic retinal exam	In-Network: $0 copayment for diabetic retinal eye exam Out-of-Network: 30% coinsurance for diabetic retinal exam
	In-Network: $0 copayment for Medicare-covered glaucoma screening Out-of-Network: 30% coinsurance for Medicare-covered glaucoma screening	In-Network: $0 copayment for Medicare-covered glaucoma screening Out-of-Network: 30% coinsurance for Medicare-covered glaucoma screening
	In-Network: $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery Out-of-Network: 30% coinsurance for one pair of eyeglasses or contact lenses after cataract surgery	In-Network: $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery Out-of-Network: 30% coinsurance for one pair of eyeglasses or contact lenses after cataract surgery
	Coverage for a pair of eyeglasses will include the allowance for a standard frame and lenses. A deluxe frame and/or progressive lens will be paid up to the allowance for the standard frame and/or lens.	Coverage for a pair of eyeglasses will include the allowance for a standard frame and lenses. A deluxe frame and/or progressive lens will be paid up to the allowance for the standard frame and/or lens.
	Routine (non-Medicare-covered) eye exams and eyewear are not covered	Routine (non-Medicare-covered) eye exams and eyewear are not covered

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Mental Health Services **• Inpatient Mental Health Care (1)**	In-Network: $225 copayment per day for days 1 through 7 You pay nothing per day for days 8 and beyond Out-of-Network: 30% coinsurance $1,575 maximum per admission 190-day lifetime maximum in a mental health facility	In-Network: $225 copayment per day for days 1 through 7 You pay nothing per day for days 8 and beyond Out-of-Network: 30% coinsurance $1,575 maximum per admission 190-day lifetime maximum in a mental health facility
• Outpatient Therapy (Group and Individual)	In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $40 copayment Out-of-Network: 30% coinsurance
• Outpatient Substance Abuse Services (Group and Individual)	In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $40 copayment Out-of-Network: 30% coinsurance
• Partial Hospitalization (1)	In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $40 copayment Out-of-Network: 30% coinsurance
Skilled Nursing Facility (1)	In-Network: You pay nothing per day for days 1 through 20 $165 copayment per day for days 21 through 100 per admission Out-of-Network: 30% coinsurance per day for days 1 through 100 100 days per benefit period	In-Network: You pay nothing per day for days 1 through 20 $165 copayment per day for days 21 through 100 per admission Out-of-Network: 30% coinsurance per day for days 1 through 100 100 days per benefit period
Physical Therapy	In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $40 copayment Out-of-Network: 30% coinsurance
Ambulance (1)	$175 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization	$175 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Transportation	Not covered	Not covered

Services with a (1) may require prior authorization.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Medicare Part B Drugs (1)	In-Network: 20% coinsurance for Part B drugs such as chemotherapy drugs Out-of-Network: 30% coinsurance for Part B drugs such as chemotherapy drugs For a description of the types of drugs available under Part B, see your *Evidence of Coverage*	In-Network: 20% coinsurance for Part B drugs such as chemotherapy drugs Out-of-Network: 30% coinsurance for Part B drugs such as chemotherapy drugs 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.

Prescription Drug Benefits (Part D)

Part D Prescription Drug Benefits are available for members of Personal Choice 65 Rx PPO. This benefit is not available for members of Personal Choice 65 Medical-Only PPO.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Initial Coverage Stage	Part D prescription drugs are not available with this plan.	You pay the following until your total yearly drug costs reach $3,750. "Total yearly drug costs" are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you move into each stage of your Part D benefits. You may fill your prescriptions at either a preferred or standard pharmacy. Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when you have them filled at preferred pharmacies. For information, please review the Personal Choice 65 Rx PPO *Evidence of Coverage*.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO		
		Retail Cost-sharing (what you pay at a pharmacy location)		
Tier		One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)				
Preferred Pharmacy		$3 copayment	$6 copayment	$9 copayment
Standard Pharmacy		$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)				
Preferred Pharmacy		$12 copayment	$24 copayment	$36 copayment
Standard Pharmacy		$18 copayment	$36 copayment	$54 copayment
Tier 3 (Preferred Brand Drugs)				
Preferred Pharmacy		$47 copayment	$94 copayment	$141 copayment
Standard Pharmacy		$47 copayment	$94 copayment	$141 copayment
Tier 4 (Non-Preferred Drugs)				
Preferred Pharmacy		$100 copayment	$200 copayment	$300 copayment
Standard Pharmacy		$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty Drugs)				
Preferred Pharmacy		25% coinsurance	25% coinsurance	25% coinsurance
Standard Pharmacy		25% coinsurance	25% coinsurance	25% coinsurance

Part D prescription drugs are not available with this plan.

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO		
		Mail-Order Cost-sharing (what you pay when you order a prescription by mail)		
Tier	Part D prescription drugs are not available with this plan.	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)		$3 copayment	$6 copayment	$6 copayment
Tier 2 (Generic Drugs)		$12 copayment	$24 copayment	$24 copayment
Tier 3 (Preferred Brand Drugs)		$47 copayment	$94 copayment	$94 copayment
Tier 4 (Non-Preferred Drugs)		$100 copayment	$200 copayment	$200 copayment
Tier 5 (Specialty Drugs)		25% coinsurance	25% coinsurance	25% coinsurance

	Personal Choice 65 Medical-Only PPO	Personal Choice 65 Rx PPO
Initial Coverage Stage	Part D prescription drugs are not available with this plan.	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. This plan has a preferred pharmacy network; cost-sharing for drugs may vary depending on the pharmacy used. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
Coverage Gap Stage	Part D prescription drugs are not available with this plan.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand-name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage Stage	Part D prescription drugs are not available with this plan.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the costs, or; • $3.35 copayment for generic (including brand drugs tested as generic) and an $8.35 copayment for all other drugs

Other Medical Benefits

Podiatry Services • **Medical Condition**	In-Network: $40 copayment per visit for condition treatment Out-of-Network: 30% coinsurance per visit for condition treatment	In-Network: $40 copayment per visit for condition treatment Out-of-Network: 30% coinsurance per visit for condition treatment
• **Routine Foot Care (Medicare-covered)**	In-Network: $40 copayment per visit for Medicare-covered routine care Out-of-Network: 30% coinsurance per visit for Medicare-covered routine care	In-Network: $40 copayment per visit for Medicare-covered routine care Out-of-Network: 30% coinsurance per visit for Medicare-covered routine care
• **Routine Foot Care (non-Medicare-covered)**	In-Network: $40 copayment per visit for non-Medicare-covered routine care, up to 6 visits each year Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine care, up to 6 visits each year	In-Network: $40 copayment per visit for non-Medicare-covered routine care, up to 6 visits each year Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine care, up to 6 visits each year
Durable Medical Equipment (1) and Prosthetic Devices and Related Supplies (1)	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance
Wellness Programs	SilverSneakers® included at no additional cost A toll-free hotline with nurses available 24 hours a day, 7 days a week Disease Management included at no additional cost Access to a health coach included at no additional cost	SilverSneakers® included at no additional cost A toll-free hotline with nurses available 24 hours a day, 7 days a week Disease Management included at no additional cost Access to a health coach included at no additional cost

Services with a (1) may require prior authorization.

Other Medical Benefits

Chiropractic Services • **Medical Condition**	In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 30% coinsurance per visit for spinal manipulations (up to 6 visits each year)	In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 30% coinsurance per visit for spinal manipulations (up to 6 visits each year)
• **Routine Care (non-Medicare-covered)**	In-Network: $20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year) Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine chiropractic care	In-Network: $20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits each year) Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine chiropractic care

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Independence

Personal Choice 65℠ PPO

PO Box 13713
Philadelphia, PA 19101-3713

www.ibxmedicare.com

For more information

For updated information regarding plan providers, visit our website at www.ibxmedicare.com, or call the 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 February 15 through September 30, your call may be sent to voicemail.

If you are not yet a member and have questions, please call 1-877-393-6733 or TTY/TDD: 711, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from February 15 through September 30, your call may be sent to voicemail. By calling this number you will be directed to a licensed sales agent.

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

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

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Personal Choice 65 Medical-Only PPO or Personal Choice 65 Rx PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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