Independence

Personal Choice 65℠ PPO

Personal Choice 65℠ Medical-Only (PPO) offered by QCC Insurance Company

Annual Notice of Changes for 2020

You are currently enrolled as a member of Personal Choice 65 Medical-Only. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you?

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider/Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out of pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices.

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."

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- Review the list in the back of your *Medicare & You* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan.
   - If you want to **keep** Personal Choice 65 Medical-Only, you don't need to do anything. You will stay in Personal Choice 65 Medical-Only.
   - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019.**
   - If you **don't join another plan by December 7, 2019**, you will stay in Personal Choice 65 Medical-Only.
   - If you join another plan by December 7, 2019, your new coverage will start on January 1, 2020.

Additional Resources

- To receive this document in an alternate format such as Braille, large print or audio, please contact our Member Help Team (phone numbers are in Section 6.1 of this booklet).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Personal Choice 65 Medical-Only

- Personal Choice 65 offers PPO plans with a Medicare contract. Enrollment in Personal Choice 65 Medicare Advantage plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means QCC Insurance Company. When it says "plan" or "our plan," it means Personal Choice 65 Medical-Only.
- This information is not a complete description of benefits. Call 1-888-718-3333 (TTY/TDD: 711) for more information.

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Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Personal Choice 65 Medical-Only in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at https://www.ibxmedicare.com. You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Monthly plan premium (See Section 1.1 for details.)	$184	$184
Maximum out-of-pocket amounts This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $5,500 From in-network and out-of-network providers combined: $10,000	From network providers: $5,500 From in-network and out-of-network providers combined: $10,000
Doctor office visits	Primary care visits: $5 per visit Specialist visits: $40 per visit	Primary care visits: $5 per visit Specialist visits: $40 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$275 copayment per day for days 1-6 per admission $1,650 maximum copayment per admission	$250 copayment per day for days 1-6 per admission $1,500 maximum copayment per admission

Annual Notice of Changes for 2020
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$184	$184
Choice Program – Optional Supplemental Benefits (For an additional monthly premium, you receive dental, hearing, and vision coverage.)	Not offered	$12
Choice Plus Program – Optional Supplemental Benefits (For an additional monthly premium, you receive dental, hearing, and vision coverage.)	$20	$25

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out of pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$5,500 Once you have paid $5,500 out of pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	$5,500 Once you have paid $5,500 out of pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2019 (this year)	2020 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$10,000 Once you have paid $10,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.	$10,000 Once you have paid $10,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2020. An updated *Provider/Pharmacy Directory* is located on our website at https://www.ibxmedicare.com. You may also call our Member Help Team for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good-faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Diabetic supplies	Prior authorization is not required for select diabetic supplies.	Prior authorization is required for select in-network diabetic supplies only.
Inpatient hospital stays	$275 copayment per day for days 1-6 per admission $1,650 maximum copayment per admission	$250 copayment per day for days 1-6 per admission $1,500 maximum copayment per admission
Inpatient mental health care	$225 copayment per day for days 1-6 per admission $1,350 maximum copayment per admission	$250 copayment per day for days 1-6 per admission $1,500 maximum copayment per admission
Medicare Part B prescription drugs	Covered Part B prescription drugs are not subject to step therapy.	Some covered Part B prescription drugs **may be** subject to step therapy.
Outpatient rehabilitation services	Prior authorization is not required for covered services (physical therapy, occupational therapy, and speech language therapy.)	Prior authorization is required for in-network covered services only (physical therapy, occupational therapy, and speech language therapy.)

Cost	2019 (this year)	2020 (next year)
Dental services (continued)	**Choice Program:** Not offered	Routine dental care is covered under the **Choice Program** for an additional premium**:** We cover: • One exam and cleaning every six months • One set of dental X-rays every year (bitewing X-rays) **In network:** $10 copayment for exams and cleanings $0 copayment for dental X-rays (bitewing X-rays) 50% coinsurance for restorative services, endodontics, periodontics, and extractions **Out of network:** 80% coinsurance for exams and cleanings 80% coinsurance for X-rays (bitewing X-rays) 80% coinsurance for restorative services, endodontics, periodontics, and extractions **In and out of network:** Combined $500 allowance every year for restorative services, endodontics, periodontics, and extractions Prosthodontics and other oral/maxillofacial surgery are not covered. Routine and non-Medicare-covered Comprehensive dental services do not count towards your annual out-of-pocket maximum.

Cost	2019 (this year)	2020 (next year)
Dental services (continued)	Routine dental care is covered under the **Choice Plus Program** for an additional premium**:** **In network:** $500 plan allowance per calendar year for restorative dental services $0 copayment for restorative dental services **Out of network:** 70% coinsurance Comprehensive dental for restorative dental services has a $500 out-of-network plan maximum benefit payable per year. (This is not combined with the in-network plan benefit maximum amount.) **In and out of network:** Copayments for dental services do not count toward your maximum out-of-pocket amount.	Routine dental care is covered under the **Choice Plus Program** for an additional premium**:** **In network:** 50% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery **Out of network:** 80% coinsurance for exams and cleanings 80% coinsurance for X-rays (bitewing X-rays) 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery **In and out of network:** Combined $1,500 allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery Routine and non-Medicare-covered Comprehensive dental services do not count towards your annual out-of-pocket maximum.

Cost	2019 (this year)	2020 (next year)
Hearing services	**Choice Program:** Not offered	Routine hearing care is covered under the **Choice Program** for an additional premium**:** All hearing services that are not covered by Medicare must be obtained by a TruHearing provider. Any care received from a non-participating provider will not be covered by the plan. Covered services include: • Routine hearing exams (not covered by Medicare), covered once every year • Fitting and evaluation for hearing aids, covered three times every year • Up to two hearing aids per year, per ear **In or out of network:** $10 copayment per visit with a TruHearing provider for each routine hearing exam There is no coinsurance, copayment, or deductible for hearing aid fitting and evaluation when obtained by a TruHearing provider. $699 copayment per year, per ear for standard digital hearing aid; or, $999 copayment per year, per ear for premium digital hearing aid when purchased through TruHearing Copayments for hearing services **do not** count toward your maximum out-of-pocket amount.

Cost	2019 (this year)	2020 (next year)
Vision care	**Choice Program:** Not offered	Routine eye examinations and eyeglasses are covered under the **Choice Program** for an additional premium**:** Covered services include: • One routine eye exam (not covered by Medicare) covered every year • Eyewear: one pair of eyeglass frames, eyeglass lenses or contact lenses (not covered by Medicare) covered every year **In network:** $10 copayment for routine eye exam every year If you purchase glasses (eyeglass frames and lenses) in the Davis Vision Collection, frames and lenses are covered in full (some restrictions may apply). If you purchase glasses (frames and lenses) outside of the Davis Vision Collection but at a Davis Vision provider, you are covered up to $150 (some restrictions may apply). If you purchase glasses (frames and lenses) from Visionworks, you are covered up to $200 (some restrictions may apply). You are covered up to $150 per year for contact lenses in lieu of routine eyewear (frames and lenses). **Out of network:** 80% coinsurance

(continued)

Cost	2019 (this year)	2020 (next year)
Vision care (continued)		**In and out of network:** Eyewear (frames and lenses or contact lenses) has a $150 combined in- and out-of-network maximum benefit payable per year. For national Visionworks providers there is a $200 combined maximum that applies when you are in or out of network. Routine vision services (exams and eyewear) do not count towards your annual out-of-pocket maximum.
	Routine eye examinations and eyeglasses are covered under the **Choice Plus Program** for an additional premium**:** **Out of network:** 70% coinsurance Eyewear (frames and lenses or contact lenses) has a $150 out-of-network plan maximum benefit payable per year. (This is not combined with the in-network plan benefit maximum amount.)	Routine eye examinations and eyeglasses are covered under the **Choice Plus Program** for an additional premium**:** **Out of network:** 80% coinsurance **In and out of network:** Eyewear (frames and lenses or contact lenses) has a $150 combined in- and out-of-network maximum benefit payable per year. For national Visionworks providers there is a $200 combined maximum that applies when you are in or out of network.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Personal Choice 65 Medical-Only

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely.
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, QCC Insurance Company offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Personal Choice 65 Medical-Only.
  - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Personal Choice 65 Medical-Only.
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact our Member Help Team if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
  - – or – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. APPRISE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call APPRISE at 1-800-783-7067.You can learn more about APPRISE by visiting their website (http://www.aging.pa.gov/aging-services/insurance/).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your state Medicaid office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Pennsylvania Office of Medical Assistance Programs (OMAP). Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Pennsylvania Office of Medical Assistance Programs (OMAP) at 1-800-922-9384.

SECTION 6 Questions?

Section 6.1 – Getting Help from Personal Choice 65 Medical-Only

Questions? We're here to help. Please call our Member Help Team at **1-888-718-3333**. (**TTY/TDD: 711)**. We are available for phone calls seven days a week from 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. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for Personal Choice 65 Medical-Only. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://www.ibxmedicare.com. You may also call our Member Help Team to ask us to mail you an *Evidence of Coverage.*

Visit our Website

You can also visit our website at https://www.ibxmedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.