Independence

Personal Choice 65℠ PPO

2020

Summary of Benefits

Effective January 1, 2020 through December 31, 2020

[redacted]

- Personal Choice 65℠ Prime 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 **www.ibxmedicare.com**.

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

Personal Choice 65℠ Prime 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 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℠ Prime Rx PPO and Personal Choice 65℠ Rx PPO
- Optional Supplemental Benefits (Choice and Choice Plus Programs) You must pay an extra premium for these benefits.

Who can join?

To join Personal Choice 65℠ Prime Rx PPO, 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℠ Prime 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?

Personal Choice 65^{SM} Prime Rx PPO, Personal Choice 65^{SM} Medical-Only PPO, and Personal Choice 65^{SM} 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^{SM} Prime 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 www.ibxmedicare.com.

Personal Choice 65^{SM} Prime Rx PPO and Personal Choice 65^{SM} 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, www.ibxmedicare.com.

Personal Choice 65^{SM} 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℠ Prime Rx PPO			
If you live in...	And you have...		
	Personal Choice 65℠ Prime Rx PPO	Personal Choice 65℠ Prime Rx PPO with Choice	Personal Choice 65℠ Prime Rx PPO with Choice Plus
	You pay...		
Chester, Delaware, or Montgomery County	$0	$12	$25
Bucks or Philadelphia County	$0	$12	$25

Personal Choice 65℠ Medical-Only PPO			
If you live in...	And you have...		
	Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Medical-Only PPO with Choice	Personal Choice 65℠ Medical-Only PPO with Choice Plus
	You pay...		
Chester, Delaware, or Montgomery County	n/a	n/a	n/a
Bucks or Philadelphia County	$184	$196	$209

Personal Choice 65℠ Rx PPO			
If you live in...	And you have...		
	Personal Choice 65℠ Rx PPO	Personal Choice 65℠ Rx PPO with Choice	Personal Choice 65℠ Rx PPO with Choice Plus
	You pay...		
Chester, Delaware, or Montgomery County	$159	$171	$184
Bucks or Philadelphia County	$288	$300	$313

	Personal Choice 65℠ Prime Rx PPO
Deductible	This plan has a $1,000 deductible for covered medical services received from out-of-network providers. Does not apply to preventive services or supplemental benefits. This plan does not have a deductible for covered Part D drugs.
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: $6,700 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

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
This plan does not have a deductible for covered medical services.	This plan does not have a deductible for covered medical services or Part D prescription drugs.
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: $10,000 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: $10,000 each year

Covered Medical and Hospital Benefits

	Personal Choice 65℠ Prime Rx PPO
Inpatient Hospital Coverage (1)	In-Network: $250 copayment per day, days 1 through 7 per admission for Preferred Hospital $310 copayment per day,for days 1 through 7 per admission for Standard Hospital You pay nothing per day for days 8 and beyond per admission. No copayment on day of discharge. Out-of-Network: 30% coinsurance after deductible
Outpatient Hospital Coverage	
• Ambulatory Surgical Center (1)	In-Network: $250 copayment Out-of-Network: 30% coinsurance after deductible
• Outpatient Hospital Facility (1)	In-Network: $375 copayment for a Preferred Hospital $475 copayment for a Standard Hospital Out-of-Network: 30% coinsurance after deductible
• Observation Services	In-Network: $375 copayment per stay for a Preferred Hospital $475 copayment for a Standard Hospital Out-of-Network: 30% coinsurance per stay after deductible
Doctor's Office Visits	
• **Primary Care Physician**	In-Network: $5 copayment for Preferred primary care physician $20 copayment for Standard primary care physician Out-of-Network: 30% coinsurance after deductible
• **Specialist**	In-Network: $40 copayment for Preferred specialist $50 copayment for Standard specialist Out-of-Network: 30% coinsurance after deductible

Services with a (1) may require prior authorization.

Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Rx PPO
In-Network: $250 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission. No copayment on day of discharge. $1,500 maximum copayment per admission Out-of-Network: 30% coinsurance	In-Network: $250 copayment per day for days 1 through 6 per admission You pay nothing per day for days 7 and beyond per admission. No copayment on day of discharge. $1,500 maximum copayment per admission Out-of-Network: 30% coinsurance
In-Network: $150 copayment Out-of-Network: 30% coinsurance In-Network: $300 copayment Out-of-Network: 30% coinsurance In-Network: $300 copayment per stay Out-of-Network: 30% coinsurance per stay	In-Network: $150 copayment Out-of-Network: 30% coinsurance In-Network: $300 copayment Out-of-Network: 30% coinsurance In-Network: $300 copayment per stay Out-of-Network: 30% coinsurance per stay
In-Network: $5 copayment Out-of-Network: 30% coinsurance In-Network: $40 copayment Out-of-Network: 30% coinsurance	In-Network: $5 copayment Out-of-Network: 30% coinsurance In-Network: $40 copayment Out-of-Network: 30% coinsurance

	Personal Choice 65℠ Prime Rx PPO
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. If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.
Emergency Care — covered worldwide Worldwide copayment outside the U.S. does not count towards the annual MOOP	In-Network: $90 copayment Not waived if admitted Out-of-Network: $90 copayment Not waived if admitted
Urgently Needed Services — covered worldwide Worldwide copayment outside the U.S. does not count towards the annual MOOP	In-Network and Out-of-Network: $10 copayment in a retail clinic Not waived if admitted In-Network and Out-of-Network: $50 copayment in an urgent care center Not waived if admitted Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted
Diagnostic Services (1), Lab and Radiology Services (1), and X-rays	
• **Diagnostic Radiology Services**	In-Network: $45 or $225 copayment depending on service Out-of-Network: 30% coinsurance after deductible
• **Lab Services**	In-Network: You pay nothing Out-of-Network: 30% coinsurance after deductible
• **Diagnostic Tests and Procedures**	In-Network: You pay nothing Out-of-Network: 30% coinsurance after deductible
• **Outpatient X-rays**	In-Network: $45 copayment for routine radiology services Out-of-Network: 30% coinsurance after deductible for routine radiology services

Services with a (1) may require prior authorization.

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
In-Network: You pay nothing 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: You pay nothing 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: $90 copayment Not waived if admitted Out-of-Network: $90 copayment Not waived if admitted	In-Network: $90 copayment Not waived if admitted Out-of-Network: $90 copayment Not waived if admitted
In-Network: $5 copayment in a retail clinic Not waived if admitted Out-of-Network: $5 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: $90 copayment per visit outside of U.S. Not waived if admitted Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted	In-Network: $5 copayment in a retail clinic Not waived if admitted Out-of-Network: $5 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: $90 copayment per visit outside of U.S. Not waived if admitted Out-of-Network: $90 copayment per visit outside of U.S. Not waived if admitted
In-Network: $40 or $175 copayment depending on service Out-of-Network: 30% coinsurance In-Network: You pay nothing Out-of-Network: 30% coinsurance In-Network: You pay nothing Out-of-Network: 30% coinsurance In-Network: $40 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services	In-Network: $40 or $175 copayment depending on service Out-of-Network: 30% coinsurance In-Network: You pay nothing Out-of-Network: 30% coinsurance In-Network: You pay nothing Out-of-Network: 30% coinsurance In-Network: $40 copayment for routine radiology services Out-of-Network: 30% coinsurance for routine radiology services

Services with a (1) may require prior authorization.

	Personal Choice 65℠ Prime Rx PPO
Hearing Services	
• **Hearing Exam**	In-Network: $40 copayment for Medicare-covered hearing exams received from a Preferred specialist $50 copayment for Medicare-covered hearing exams received from a Standard specialist Out-of-Network: 30% coinsurance after deductible for Medicare-covered hearing exams **Available with Choice or Choice Plus:** In-Network and Out-of-Network: $10 copayment for routine non-Medicare-covered hearing exams once every year.
• **Hearing Aid**	**Available with Choice:** In-Network and Out-of-network: $699 standard digital hearing aid or $999 premium digital hearing aid copayment per year, per ear; 3 hearing aid fitting and evaluations every year; up to 2 hearing aids every year, one hearing aid per ear. **Available with Choice Plus:** In-Network and Out-of-Network: $499 standard digital hearing aid or $799 premium digital hearing aid copayment per year, per ear; 3 hearing aid fittings per year; up to 2 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 towards annual MOOP.

Services with a (1) may require prior authorization.

Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Rx PPO
In-Network: $40 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance for Medicare-covered hearing exams **Available with Choice or Choice Plus:** In-Network and Out-of-Network: $10 copayment for routine non-Medicare-covered hearing exams once every year. **Available with Choice:** In-Network and Out-of-network: $699 standard digital hearing aid or $999 premium digital hearing aid copayment per year, per ear; 3 hearing aid fittings per year; up to 2 hearing aids every year, one hearing aid per ear. **Available with Choice Plus:** In-Network and Out-of-Network: $499 standard digital hearing aid or $799 premium digital hearing aid copayment per year, per ear; 3 hearing aid fittings per year up to 2 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 towards annual MOOP.	In-Network: $40 copayment for Medicare-covered hearing exams Out-of-Network: 30% coinsurance for Medicare-covered hearing exams **Available with Choice or Choice Plus:** In-Network and Out-of-Network: $10 copayment for routine non-Medicare-covered hearing exams once every year. **Available with Choice:** In-Network and Out-of-Network: $699 standard digital hearing aid or $999 premium digital hearing aid copayment per year, per ear; 3 hearing aid fittings per year; up to 2 hearing aids every year, one hearing aid per ear. **Available with Choice Plus:** In-Network and Out-of-Network: $499 standard digital hearing aid or $799 premium digital hearing aid copayment per year, per ear; 3 hearing aid fittings per year; up to 2 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 towards annual MOOP.

	Personal Choice 65SM Prime Rx PPO
Dental Services	In-Network: $40 copayment for non-routine Medicare-covered dental services in a Preferred specialist office; $50 copayment for Medicare-covered dental services received from a Standard specialist Out-of-Network: 30% coinsurance after deductible for non-routine Medicare-covered dental services in a specialist office **Available through Choice:** In-Network: $10 copayment for routine non-Medicare-covered exam and cleaning every six months $0 copay for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered 50% coinsurance for restorative services, endodontics, periodontics, and extractions Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services 80% coinsurance for restorative services, endodontics, periodontics, and extractions $500 combined plan allowance every year for restorative dental services, endodontics, periodontics, and extractions. Prosthodontics and oral surgery are not covered **Available through Choice Plus:** In-Network: $0 copayment for routine non-Medicare-covered exam and cleaning every six months $0 copay for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered 50% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery $1500 combined in- and out-of-network plan allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services 80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
In-Network: $40 copayment for non-routine Medicare-covered dental services in a specialist office	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	Out-of-Network: 30% coinsurance for non-routine Medicare-covered dental services in a specialist office
Available through Choice: In-Network: $10 copayment for routine non-Medicare-covered exam and cleaning every six months	**Available through Choice:** In-Network: $10 copayment for routine non-Medicare-covered exam and cleaning every six months
$0 copayment for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered	$0 copayment for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered
50% coinsurance for restorative services, endodontics, periodontics, and extractions	50% coinsurance for restorative services, endodontics, periodontics, and extractions
Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services and dental X-rays	Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services and dental X-rays
80% coinsurance for restorative services, endodontics, periodontics, and extractions	80% coinsurance for restorative services, endodontics, periodontics, and extractions
$500 combined plan allowance every year for restorative dental services, endodontics, periodontics, and extractions.	$500 combined plan allowance every year for restorative dental services, endodontics, periodontics, and extractions.
Prosthodontics and oral surgery are not covered	Prosthodontics and oral surgery are not covered
Available through Choice Plus: In-Network: $0 copayment for routine non-Medicare-covered exam and cleaning every six months	**Available through Choice Plus:** In-Network: $0 copayment for routine non-Medicare-covered exam and cleaning every six months
$0 copay for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered	$0 copay for 1 set of dental bite-wing x-rays every year. Full mouth x-rays (panoramic) not covered
50% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery	50% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery
Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services	Out-of-Network: 80% coinsurance for routine non-Medicare-covered dental services
$1500 combined in- and out-of-network plan allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery	$1500 combined in- and out-of-network plan allowance every year for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery
80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, and oral surgery

	Personal Choice 65℠ Prime Rx PPO
Vision Services	In-Network: $40 copayment for Medicare-covered eye exams received from a Preferred specialist, $50 copayment for Medicare-covered eye exams received from a Standard specialist; $0 copayment for diabetic retinal eye exam and $0 copayment for Medicare-covered glaucoma screening; $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery Out-of-Network: 30% coinsurance after deductible for Medicare-covered eye exams, diabetic retinal exam, glaucoma screening and for one pair of eyeglasses or contact lenses after cataract surgery **Available through Choice or Choice Plus:** $10 copayment for routine eye exam every year; 1 pair of eyeglass frames and lenses or one pair of contact lenses are covered in full every year if purchased from the Davis Vision Collection; $150 combined in- and out-of-network plan allowance every year for all other eyewear (glasses, lenses or contacts) purchased at a Davis Vision provider. $200 combined in- and out-of-network allowance every year for eyewear (glasses and lenses) purchased from Visionworks. Routine vision services do not count towards the annual MOOP. Out-of-Network: 80% coinsurance

Services with a (1) may require prior authorization.

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
In-Network: $40 copayment for Medicare-covered eye exams; $0 copayment for diabetic retinal eye exam and $0 copayment for Medicare-covered glaucoma screening; $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery	In-Network: $40 copayment for Medicare-covered eye exams; $0 copayment for diabetic retinal eye exam and $0 copayment for Medicare-covered glaucoma screening; $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery
Out-of-Network: 30% coinsurance for Medicare-covered eye exams, diabetic retinal exam, glaucoma screening and for one pair of eyeglasses or contact lenses after cataract surgery	Out-of-Network: 30% coinsurance for Medicare-covered eye exams, diabetic retinal exam, glaucoma screening and for one pair of eyeglasses or contact lenses after cataract surgery
Available through Choice or Choice Plus: $10 copayment for routine eye exam every year; 1 pair of eyeglass frames and lenses or one pair of contact lenses are covered in full every year if purchased from the Davis Vision Collection; $150 combined in- and out-of-network plan allowance every year for all other eyewear (glasses, lenses or contacts) purchased at a Davis Vision provider.	**Available through Choice or Choice Plus:** $10 copayment for routine eye exam every year; 1 pair of eyeglass frames and lenses or one pair of contact lenses are covered in full every year if purchased from the Davis Vision Collection; $150 combined in- and out-of-network plan allowance every year for all other eyewear (glasses, lenses or contacts) purchased at a Davis Vision provider.
$200 combined in- and out-of-network plan allowance every year for eyewear (glasses and lenses) purchased from Visionworks.	$200 combined in- and out-of-network plan allowance every year for eyewear (glasses and lenses) purchased from Visionworks.
Routine vision services do not count towards the annual MOOP.	Routine vision services do not count towards the annual MOOP.
Out-of-Network: 80% coinsurance	Out-of-Network: 80% coinsurance

	Personal Choice 65℠ Prime Rx PPO
Mental Health Services	
• **Inpatient Mental Health Care (2)**	In-Network: $250 copayment per day for Preferred Hospital for days 1 through 5 per admission $310 copayment per day for Standard Hospital for days 1 through 5 per admission You pay nothing per day for days 6 and beyond Out-of-Network: 30% coinsurance after deductible 190-day lifetime maximum in a mental health facility
• Outpatient Therapy (Group and Individual)	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance after deductible
• Outpatient Substance Abuse Services (Group and Individual)	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance after deductible
• Partial Hospitalization (2)	In-Network: $40 copayment per visit Out-of-Network: 30% coinsurance after deductible
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 after deductible per day for days 1 through 100 100 days per benefit period
Physical Therapy	In-Network: $30 copayment per visit Out-of-Network: 30% coinsurance per visit after deductible
Ambulance (1)	$300 copayment for a one-way trip Not waived if admitted Non-emergency ambulance services require prior authorization
Transportation	Not covered

Services with a (1) may require prior authorization.
(2) Prior authorization is required by Magellan Behavioral Health.

Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Rx PPO
In-Network: $250 copayment per day for days 1 through 6 per admission. You pay nothing per day for days 7 and beyond Out-of-Network: 30% coinsurance $1,500 maximum copayment per admission 190-day lifetime maximum in a mental health facility	In-Network: $250 copayment per day for days 1 through 6 per admission. You pay nothing per day for days 7 and beyond Out-of-Network: 30% coinsurance $1,500 maximum copayment per admission 190-day lifetime maximum in a mental health facility
In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance	In-Network: $40 copayment per therapy session Out-of-Network: 30% coinsurance
In-Network: $40 copayment per visit Out-of-Network: 30% coinsurance	In-Network: $40 copayment per visit Out-of-Network: 30% coinsurance
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
In-Network: $20 copayment per visit Out-of-Network: 30% coinsurance per visit	In-Network: $20 copayment per visit Out-of-Network: 30% coinsurance per visit
$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
Not covered	Not covered

	Personal Choice 65℠ Prime 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*

Prescription Drug Benefits (Part D)

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

	Personal Choice 65℠ Prime Rx PPO
Initial Coverage Stage	You pay the following until your total yearly drug costs reach $4,020. "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℠ Prime Rx PPO *Evidence of Coverage*.

Services with a (1) may require prior authorization.

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
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*

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
Part D prescription drugs are not available with this plan.	You pay the following until your total yearly drug costs reach $4,020. "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 65SM Rx PPO *Evidence of Coverage*.

	Personal Choice 65℠ Prime Rx PPO		
Retail Cost-sharing (what you pay at a pharmacy location)	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)			
Preferred Pharmacy	$2 copayment	$4 copayment	$4 copayment
Standard Pharmacy	$9 copayment	$18 copayment	$27 copayment
Tier 2 (Generic Drugs)			
Preferred Pharmacy	$10 copayment	$20 copayment	$20 copayment
Standard Pharmacy	$20 copayment	$40 copayment	$60 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	33% coinsurance	33% coinsurance	33% coinsurance
Standard Pharmacy	33% coinsurance	33% coinsurance	33% coinsurance
Mail-Order Cost-sharing (what you pay when you order a prescription by mail)	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic Drugs)	$2 copayment	$4 copayment	$4 copayment
Tier 2 (Generic Drugs)	$10 copayment	$20 copayment	$20 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)	33% coinsurance	33% coinsurance	33% coinsurance

Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Rx PPO		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Part D prescription drugs are not available with this plan.	$1 copayment $9 copayment	$2 copayment $18 copayment	$2 copayment $27 copayment
Part D prescription drugs are not available with this plan.	$9 copayment $20 copayment	$18 copayment $40 copayment	$18 copayment $60 copayment
Part D prescription drugs are not available with this plan.	$47 copayment $47 copayment	$94 copayment $94 copayment	$141 copayment $141 copayment
Part D prescription drugs are not available with this plan.	$100 copayment $100 copayment	$200 copayment $200 copayment	$300 copayment $300 copayment
Part D prescription drugs are not available with this plan.	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance	33% coinsurance 33% coinsurance
	One-Month Supply	Two-Month Supply	Three-Month Supply
Part D prescription drugs are not available with this plan.	$1 copayment	$2 copayment	$2 copayment
Part D prescription drugs are not available with this plan.	$9 copayment	$18 copayment	$18 copayment
Part D prescription drugs are not available with this plan.	$47 copayment	$94 copayment	$94 copayment
Part D prescription drugs are not available with this plan.	$100 copayment	$200 copayment	$200 copayment
Part D prescription drugs are not available with this plan.	33% coinsurance	33% coinsurance	33% coinsurance

	Personal Choice 65SM Prime Rx PPO
Initial Coverage Stage	If you reside in a long-term care facility, you pay the same as at a Standard 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	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: • 5% of the costs, or; • $3.60 copayment for generic (including brand drugs tested as generic) and an $8.95 copayment for all other drugs
Other Medical Benefits	
Podiatry Services	
• Medical Condition	In-Network: $25 copayment per visit for condition treatment and $25 copayment per visit for Medicare-covered routine care Out-of-Network: 30% coinsurance per visit after deductible for condition treatment and Medicare-covered routine care
• Routine Foot Care (Medicare-covered)	
• Routine Foot Care (non-Medicare-covered)	In-Network: $25 copayment per visit for non-Medicare-covered routine care, up to 6 visits each year Out-of-Network: 30% coinsurance per visit after deductible for non-Medicare-covered routine care, up to 6 visits each year

Services with a (1) may require prior authorization.

Personal Choice 65SM Medical-Only PPO	Personal Choice 65SM Rx PPO
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 Standard 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.
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 $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.
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 $6,350, you pay the greater of: • 5% of the costs, or; • $3.60 copayment for generic (including brand drugs tested as generic) and an $8.95 copayment for all other drugs
In-Network: $20 copayment per visit for condition treatment and $20 copayment per visit for Medicare-covered routine care Out-of-Network: 30% coinsurance per visit for condition treatment and Medicare-covered routine care In-Network: $20 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: $20 copayment per visit for condition treatment and $20 copayment per visit for Medicare-covered routine care Out-of-Network: 30% coinsurance per visit for condition treatment and Medicare-covered routine care In-Network: $20 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

	Personal Choice 65℠ Prime Rx PPO
Over-the-Counter (OTC) Items	In-Network and Out-of-Network: $30 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our OTC vendor, Convey, to purchase items. Items purchased from pharmacies or other retailers will not be covered. Only one order can be placed per quarter. Each order cannot exceed the $30 quarterly allowance.
Telemedicine	In-network and Out-of-network: $5 copayment for telemedicine visits. Telemedicine physicians are available 24/7 365 days per year. MDLIVE must be used for telemedicine visits. MDLIVE doctors are state-licensed physicians. Telemedicine services rendered from other providers will not be covered.
Diabetic Supplies	No copayment for diabetic test strips and glucose monitors. You must use our preferred vendors Accu-Chek and OneTouch for test strips and monitors. Test strips and monitors from other vendors will not be covered. No copayment for lancets or solutions. No copayment for diabetic shoes and inserts. No copayment for insulin pumps and related supplies. Any network vendor may be used to purchase these supplies. Out-of-network: 30% coinsurance
Chiropractic Services	
• **Medical-covered (Medicare-covered)**	In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 30% coinsurance per visit after deductible for spinal manipulations
• **Routine Care (non-Medicare-covered)**	In-Network: $20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 30% coinsurance per visit after deductible for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year)

Personal Choice 65℠ Medical-Only PPO	Personal Choice 65℠ Rx PPO
In-Network and Out-of-Network: $30 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our OTC vendor, Convey, to purchase items. Items purchased from pharmacies or other retailers will not be covered. Only one order can be placed per quarter. Each order cannot exceed the $30 quarterly allowance.	In-Network and Out-of-Network: $30 allowance per quarter for over-the-counter (OTC) items. Allowance does not carry forward to the next quarter if not used. You must use our OTC vendor, Convey, to purchase items. Items purchased from pharmacies or other retailers will not be covered. Only one order can be placed per quarter. Each order cannot exceed the $30 quarterly allowance.
In-network and Out-of-network: $5 copayment for telemedicine visits. Telemedicine physicians are available 24/7 365 days per year. MDLIVE must be used for telemedicine visits. MDLIVE doctors are state-licensed physicians. Telemedicine services rendered from other providers will not be covered.	In-network and Out-of-network: $5 copayment for telemedicine visits. Telemedicine physicians are available 24/7 365 days per year. MDLIVE must be used for telemedicine visits. MDLIVE doctors are state-licensed physicians. Telemedicine services rendered from other providers will not be covered.
No copayment for diabetic test strips and glucose monitors. You must use our preferred vendors Accu-Chek and OneTouch for test strips and monitors. Test strips and monitors from other vendors will not be covered. No copayment for lancets or solutions. No copayment for diabetic shoes and inserts. No copayment for insulin pumps and related supplies. Any network vendor may be used to purchase these supplies. Out-of-network: 30% coinsurance	No copayment for diabetic test strips and glucose monitors. You must use our preferred vendors Accu-Chek and OneTouch for test strips and monitors. Test strips and monitors from other vendors will not be covered. No copayment for lancets or solutions. No copayment for diabetic shoes and inserts. No copayment for insulin pumps and related supplies. Any network vendor may be used to purchase these supplies. Out-of-network: 30% coinsurance
In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 30% coinsurance per visit for spinal manipulations In-Network: $20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year)	In-Network: $20 copayment per visit for spinal manipulations Out-of-Network: 30% coinsurance per visit for spinal manipulations In-Network: $20 copayment per visit for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year) Out-of-Network: 30% coinsurance per visit for non-Medicare-covered routine chiropractic care (up to 6 visits combined in- and out-of-network each year)

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.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.

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, 2021.

- ☐ 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.

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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 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 or 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. 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.

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.

The Independence Blue Cross Over the Counter benefit is underwritten by QCC Insurance Company and is administered by Convey Health Solutions, Inc., an independent company.

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 1-877-393-6733 for more information.

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

Out-of-network/non-contracted providers are under no obligation to treat Personal Choice 65 Prime Rx PPO, 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.

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

PC8888 (8/18)