



## Personal Choice 65<sup>SM</sup> Plus Rx (PPO) offered by QCC Insurance Company, a subsidiary of Independence Blue Cross, LLC (“IBX”)

### Annual Notice of Change for 2026

You’re enrolled as a member of Personal Choice 65 Plus Rx.

This material describes changes to our plan’s costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don’t join another plan by December 7, 2025, you’ll stay in Personal Choice 65 Plus Rx.
- To change to a **different plan**, visit [www.Medicare.gov](http://www.Medicare.gov) or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [www.ibxmedicare.com](http://www.ibxmedicare.com) or call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) to get a copy by mail. You can also review the separately mailed Evidence of Coverage to see if other benefit or cost changes affect you.

#### More Resources

- Call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711). Hours are 8 a.m. to 8 p.m., seven days a week. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. This call is free.
- To receive this document in an alternate format such as Braille, large print or audio, please contact our Member Help Team.

---

**About Personal Choice 65 Plus Rx**

- Independence Blue Cross offers PPO Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross PPO Medicare Advantage plans depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means QCC Insurance Company. When it says “plan” or “our plan,” it means Personal Choice 65 Plus Rx.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Personal Choice 65 Plus Rx.** Starting January 1, 2026, you'll get your medical and drug coverage through Personal Choice 65 Plus Rx. Go to Section 3 for more information about how to change plans and deadlines for making a change.

Y0041\_H3909\_PC\_26\_123678\_M

## Table of Contents

|                                                                      |           |
|----------------------------------------------------------------------|-----------|
| <b>Summary of Important Costs for 2026 .....</b>                     | <b>4</b>  |
| <b>SECTION 1 Changes to Benefits &amp; Costs for Next Year .....</b> | <b>7</b>  |
| Section 1.1 Changes to the Monthly Plan Premium .....                | 7         |
| Section 1.2 Changes to Your Maximum Out-of-Pocket Amount .....       | 7         |
| Section 1.3 Changes to the Provider Network .....                    | 9         |
| Section 1.4 Changes to the Pharmacy Network.....                     | 9         |
| Section 1.5 Changes to Benefits & Costs for Medical Services .....   | 10        |
| Section 1.6 Changes to Part D Drug Coverage .....                    | 14        |
| Section 1.7 Changes to Prescription Drug Benefits & Costs .....      | 15        |
| <b>SECTION 2 Administrative Changes .....</b>                        | <b>19</b> |
| <b>SECTION 3 How to Change Plans.....</b>                            | <b>21</b> |
| Section 3.1 Deadlines for Changing Plans.....                        | 21        |
| Section 3.2 Are there other times of the year to make a change?..... | 22        |
| <b>SECTION 4 Get Help Paying for Prescription Drugs .....</b>        | <b>22</b> |
| <b>SECTION 5 Questions? .....</b>                                    | <b>24</b> |
| Get Help from Personal Choice 65 Plus Rx .....                       | 24        |
| Get Free Counseling about Medicare .....                             | 24        |
| Get Help from Medicare .....                                         | 25        |

## Summary of Important Costs for 2026

|                                                                                                                                                                                                                                     | 2025<br>(this year)                                                                                  | 2026<br>(next year)                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>*Your premium can be higher or lower than this amount. Go to Section 1.1 for details.                                                                                                               | \$164                                                                                                | \$214                                                                                                                            |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)                                                                    | From network providers:<br>\$4,151<br>From network and out-of-network providers combined:<br>\$5,750 | <b>From network providers:</b><br><b>\$4,201</b><br><b>From network and out-of-network providers combined:</b><br><b>\$6,300</b> |
| <b>Primary care office visits</b>                                                                                                                                                                                                   | \$0 copayment per visit                                                                              | <b>\$0 copayment per visit</b>                                                                                                   |
| <b>Specialist office visits</b>                                                                                                                                                                                                     | \$0 copayment per visit                                                                              | <b>\$0 copayment per visit</b>                                                                                                   |
| <b>Inpatient hospital stays</b><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to | \$250 maximum copayment per admission                                                                | <b>\$400 maximum copayment per admission</b>                                                                                     |

|                                                                                                                                                  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| the hospital with a doctor's order. The day before you're discharged is your last inpatient day.                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Part D drug coverage deductible</b><br><br>(Go to Section 1.7 for details.)                                                                   | Deductible: \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Deductible: \$0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <p>Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy:</p> <p>Drug Tier 1: \$9</p> <p>Drug Tier 2: \$20</p> <p>Drug Tier 3: 25%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: 50%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 33%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> | <p><b>Copayment/Coinsurance during the Initial Coverage Stage at a standard pharmacy:</b></p> <p><b>Drug Tier 1: \$9</b></p> <p><b>Drug Tier 2: \$20</b></p> <p><b>Drug Tier 3: 25%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4: 38%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5: 33%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> |

|  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy:</p> <p>Drug Tier 1: \$0</p> <p>Drug Tier 2: \$0</p> <p>Drug Tier 3: 25%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: 50%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 33%</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <p><b>Copayment/Coinsurance during the Initial Coverage Stage at a preferred pharmacy:</b></p> <p><b>Drug Tier 1: \$0</b></p> <p><b>Drug Tier 2: \$0</b></p> <p><b>Drug Tier 3: 25%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4: 38%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5: 33%</b></p> <p><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Catastrophic Coverage Stage:</b></p> <p><b>During this payment stage, you pay nothing for your covered Part D drugs.</b></p> |

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

|                                                                                                  | 2025<br>(this year) | 2026<br>(next year) |
|--------------------------------------------------------------------------------------------------|---------------------|---------------------|
| <b>Monthly plan premium</b><br><br>(You must also continue to pay your Medicare Part B premium.) | \$164               | <b>\$214</b>        |

#### Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

|                                                                                                                                                                                                                                                                                                                                                                                      | 2025<br>(this year) | 2026<br>(next year)                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>In-network maximum out-of-pocket amount</b></p> <p>Your costs for covered medical services (such as copayments) from network providers <b>count</b> toward your in-network maximum out-of-pocket amount.</p> <p>Your plan premium and your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount.</p>                                       | \$4,151             | <p><b>\$4,201</b></p> <p>Once you've paid \$4,201 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.</p>                   |
| <p><b>Combined maximum out-of-pocket amount</b></p> <p>Your costs for covered medical services (such as copayments) from in-network and out-of-network providers <b>count</b> toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount for medical services.</p> | \$5,750             | <p><b>\$6,300</b></p> <p>Once you've paid \$6,300 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.</p> |

## Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider/Pharmacy Directory* [www.ibxmedicare.com/directory](http://www.ibxmedicare.com/directory) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at [www.ibxmedicare.com/directory](http://www.ibxmedicare.com/directory).
- Call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) to get current provider information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) for help.

## Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Provider/Pharmacy Directory* [www.ibxmedicare.com/directory](http://www.ibxmedicare.com/directory) to see which pharmacies are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at [www.ibxmedicare.com/directory](http://www.ibxmedicare.com/directory)
- Call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) to get current pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

|                                 | 2025<br>(this year)                                                                                                                                                                                                                                                                               | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Telehealth</b>    | \$20 copayment per Physical Therapy, Occupational Therapy, and Speech Therapy visit.                                                                                                                                                                                                              | <b>\$25 copayment per Physical Therapy, Occupational Therapy, and Speech Therapy visit.</b>                                                                                                                                                                                                                                                                                                                              |
| <b>Ambulance Services</b>       | \$150 copay for this benefit.                                                                                                                                                                                                                                                                     | <b>\$200 copay for this benefit.</b>                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Dementia Support Program</b> | <p>\$0 copayment for neurology visits, including telehealth neurology visits for members with a diagnosis of dementia.</p> <p>Members must be enrolled in the dementia support program provided from the plan-specified vendor. To find out if you're eligible, contact our Member Help Team.</p> | <p><b>\$0 copayment for neurology visits, including telehealth neurology visits, PT and SP, Individual MH Sessions, Individual Psychiatric Sessions, &amp; Other healthcare professional for members with a diagnosis of dementia.</b></p> <p><b>Members must be enrolled in the dementia support program provided from the plan-specified vendor. To find out if you're eligible, contact our Member Help Team.</b></p> |
| <b>Dental Services</b>          | <p>Non-Medicare-Covered Dental Services:</p> <p>\$1,500 combined in-and out-of-network annual plan maximum allowance every year for the defined comprehensive dental services.</p> <p>Once you reach the \$1,500 annual allowance, you must</p>                                                   | <p><b>Non-Medicare-Covered Dental Services:</b></p> <p><b>\$1,000 combined in-and out-of-network annual plan maximum allowance every year for the defined comprehensive dental services.</b></p> <p><b>Once you reach the \$1,000 annual allowance, you must</b></p>                                                                                                                                                     |

|                                   | 2025<br>(this year)                                                                                                                                                                                                                                                                             | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                   | <p>pay 100% of the cost of services for the rest of the year.</p> <p>Core buildup, including any pins when required – one per tooth every five years is <u>not</u> covered.</p> <p>Prefabricated post and core in addition to crown – one per tooth every five years is <u>not</u> covered.</p> | <p><b>pay 100% of the cost of services for the rest of the year.</b></p> <p><b>Core buildup, including any pins when required – one per tooth every five years is covered.</b></p> <p><b>Prefabricated post and core in addition to crown – one per tooth every five years is covered.</b></p>                                                  |
| <b>Diabetic Supplies</b>          | <p>0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors.</p> <p>Test strips and monitors must be obtained from preferred vendors Accu-Chek and OneTouch.</p> <p>Test strips and monitors from any other vendor will not be covered.</p>                       | <p><b>0% coinsurance for Medicare-covered diabetic test strips and diabetic glucose monitors.</b></p> <p><b>Test strips and monitors must be obtained from the preferred vendors Accu-Chek and Contour.</b></p> <p><b>OneTouch is <u>not</u> covered.</b></p> <p><b>Test strips and monitors from any other vendor will not be covered.</b></p> |
| <b>Emergency Care</b>             | \$110 copayment for this benefit.                                                                                                                                                                                                                                                               | <b>\$130 copayment for this benefit.</b>                                                                                                                                                                                                                                                                                                        |
| <b>Emergency Care - Worldwide</b> | \$110 copayment for this benefit.                                                                                                                                                                                                                                                               | <b>\$130 copayment for this benefit.</b>                                                                                                                                                                                                                                                                                                        |
| <b>Inpatient Hospital Care</b>    | \$250 maximum copayment per admission.                                                                                                                                                                                                                                                          | <b>\$400 maximum copayment per admission.</b>                                                                                                                                                                                                                                                                                                   |

|                                                              | 2025<br>(this year)                                                                                                                                                    | 2026<br>(next year)                                                                                                                                                                         |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Mental Health Care</b>                          | \$250 maximum copayment per admission.                                                                                                                                 | <b>\$400 maximum copayment per admission.</b>                                                                                                                                               |
| <b>Out-of-Network Coverage</b>                               | 25% of the total cost for the defined benefits out of network.                                                                                                         | <b>35% of the total cost for the defined benefits out of network.</b>                                                                                                                       |
| <b>Outpatient Diagnostic Radiology Services</b>              | \$150 copayment for complex radiology services (e.g., CT scans, MRI, MRA, Nuclear Cardiology Studies).                                                                 | <b>\$275 copayment for complex radiology services (e.g., CT scans, MRI, MRA, Nuclear Cardiology Studies).</b>                                                                               |
| <b>Outpatient Hospital Services</b>                          | \$275 copayment for this benefit.                                                                                                                                      | <b>\$310 copayment for this benefit.</b>                                                                                                                                                    |
| <b>Outpatient Observation Stays</b>                          | \$275 copayment for this benefit.                                                                                                                                      | <b>\$310 copayment for this benefit.</b>                                                                                                                                                    |
| <b>Outpatient Rehabilitation Services</b>                    | \$15 copayment for this benefit.                                                                                                                                       | <b>\$25 copayment for this benefit.</b>                                                                                                                                                     |
| <b>Outpatient Therapeutic Radiology (Radiation Services)</b> | \$80 copayment for this benefit.                                                                                                                                       | <b>\$85 copayment for this benefit.</b>                                                                                                                                                     |
| <b>Skilled Nursing Facility (SNF) Care</b>                   | \$0 copayment per day for days 1-20.<br>\$214 copayment per day for days 21-100.                                                                                       | <b>\$0 copayment per day for days 1-20.<br/>\$218 copayment per day for days 21-100.</b>                                                                                                    |
| <b>Telemedicine Visits</b>                                   | Teladoc Health must be used for telemedicine visits.<br><br>Telemedicine is offered through Teladoc Health.<br><br>Telemedicine for the following services is covered: | <b>Teladoc Health must be used for telemedicine visits.</b><br><br><b>Telemedicine is offered through Teladoc Health.</b><br><br><b>Telemedicine for the following services is covered:</b> |

|  | 2025<br>(this year)                                                                                                                                                                      | 2026<br>(next year)                                                                                                                                                                             |
|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | \$0 copayment for general medical visits focused on non-emergency conditions (e.g., flu, allergies, coughs, sore throats, rashes, and more) by connecting to a state-licensed physician. | <b>\$0 copayment for general medical visits focused on non-emergency conditions (e.g., flu, allergies, coughs, sore throats, rashes, and more) by connecting to a state-licensed physician.</b> |
|  | \$0 copayment for mental/behavioral health visits focused on therapy and counseling services by connecting a state-licensed therapist or psychiatrist.                                   | <b>\$0 copayment for mental/behavioral health visits focused on therapy and counseling services by connecting a state-licensed therapist or psychiatrist.</b>                                   |
|  | \$0 copayment for dermatology consultations focused on diagnosing and treating skin, hair, and nail conditions by connecting members to board-certified dermatologists.                  | <b>\$0 copayment for dermatology consultations focused on diagnosing and treating skin, hair, and nail conditions by connecting members to board-certified dermatologists.</b>                  |
|  | Access to the Teladoc platform and scheduling support available 24/7, 365 days per year.                                                                                                 | <b>Access to the Teladoc platform and scheduling support available 24/7, 365 days per year.</b>                                                                                                 |
|  | Members will access Teladoc by toll-free phone, secure video chat, or through a secure website/phone application.                                                                        | <b>Members will access Teladoc by toll-free phone, secure video chat, or through a secure website/phone application.</b>                                                                        |
|  | Members must complete a comprehensive medical                                                                                                                                            | <b>Members must complete a comprehensive medical</b>                                                                                                                                            |

|                                             | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                         | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                             | <p>history assessment, online with a designated Teladoc Health representative, prior to receiving telemedicine services.</p> <p>Mental/behavioral health visits must be scheduled via the online platform at <a href="http://www.teladochealth.com/signin">www.teladochealth.com/signin</a>. Visits cannot be scheduled by phone.</p> <p>Members must complete a mental health assessment via the website platform prior to scheduling.</p> | <p><b>history assessment, either online or by telephone with a designated Teladoc Health representative, prior to receiving telemedicine services.</b></p> <p><b>Mental/behavioral health visits must be scheduled via the online platform at <a href="http://www.teladochealth.com/signin">www.teladochealth.com/signin</a> or scheduled by phone.</b></p> <p><b>Members must complete a mental health assessment via the website platform or by phone prior to scheduling.</b></p> |
| <b>Urgently Needed Services</b>             | \$45 copayment for urgent care center.                                                                                                                                                                                                                                                                                                                                                                                                      | <b>\$50 copayment for urgent care center.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Urgently Needed Services - Worldwide</b> | \$110 copayment for this benefit.                                                                                                                                                                                                                                                                                                                                                                                                           | <b>\$130 copayment for this benefit.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |

## Section 1.6 Changes to Part D Drug Coverage

### Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call our Member Help Team 1-888-718-3333 (TTY/TDD users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

We have no deductible, so this payment stage doesn't apply to you.

- **Stage 2: Initial Coverage**

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

### Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

|                          | 2025<br>(this year)                                                     | 2026<br>(next year)                                                            |
|--------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | Because we have no deductible, this payment stage doesn't apply to you. | <b>Because we have no deductible, this payment stage doesn't apply to you.</b> |

### Drug Costs in Stage 2: Initial Coverage

For drugs on Preferred Brand Tier (Tier 3) and Non-Preferred Drug Tier (Tier 4), your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                                                                                                                                                                        | 2025<br>(this year)                                                                                                                                                                                                    | 2026<br>(next year)                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1 – Preferred Generic:</b><br><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. | <i>Standard cost sharing:</i><br>You pay \$9 per prescription.<br><br><i>Preferred cost sharing:</i><br>You pay \$0 per prescription.                                                                                  | <b><i>Standard cost sharing:</i></b><br><b>You pay \$9 per prescription.</b><br><br><b><i>Preferred cost sharing:</i></b><br><b>You pay \$0 per prescription.</b>                                                                                               |
| <b>Tier 2 – Generic:</b><br><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.           | <i>Standard cost sharing:</i><br>You pay \$20 per prescription.<br><br><i>Preferred cost sharing:</i><br>You pay \$0 per prescription.                                                                                 | <b><i>Standard cost sharing:</i></b><br><b>You pay \$20 per prescription.</b><br><br><b><i>Preferred cost sharing:</i></b><br><b>You pay \$0 per prescription.</b>                                                                                              |
| <b>Tier 3 – Preferred Brand:</b><br><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.   | <i>Standard cost sharing:</i><br>You pay 25% of the total cost.<br><br><i>Preferred cost sharing:</i><br>You pay 25% of the total cost.<br>You pay \$35 per month supply of each covered insulin product on this tier. | <b><i>Standard cost sharing:</i></b><br><b>You pay 25% of the total cost.</b><br><br><b><i>Preferred cost sharing:</i></b><br><b>You pay 25% of the total cost.</b><br><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b> |

|                                                                                                                                                                                     | 2025<br>(this year)                                                                                                                                                                                                                                                                               | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 4 – Non-Preferred Drug:</b><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. | <i>Standard cost sharing:</i><br>You pay 50% of the total cost.<br><i>Preferred cost sharing:</i><br>You pay 50% of the total cost.<br>You pay \$35 per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is 50% of the total cost. | <i>Standard cost sharing:</i><br><b>You pay 38% of the total cost.</b><br><i>Preferred cost sharing:</i><br><b>You pay 38% of the total cost.</b><br><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b><br><b>Your cost for a one-month mail-order prescription is 38% of the total cost.</b> |
| <b>Tier 5 – Specialty Tier:</b><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.     | <i>Standard cost sharing:</i><br>You pay 33% of the total cost.<br><i>Preferred cost sharing:</i><br>You pay 33% of the total cost.<br>You pay \$35 per month supply of each covered insulin product on this tier.                                                                                | <i>Standard cost sharing:</i><br><b>You pay 33% of the total cost.</b><br><i>Preferred cost sharing:</i><br><b>You pay 33% of the total cost.</b><br><b>You pay up to \$35 per month supply of each covered insulin product on this tier.</b>                                                                                       |

### Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

## SECTION 2 Administrative Changes

|                                                                         | 2025<br>(this year)                                                                                                                                                                                                                                                            | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>90-Day Supply for Tier 1 and Tier 2 Drugs at Standard Pharmacies</b> | 90-Day Supply of Tier 1 and Tier 2 drugs applies a three-month supply copayment at Standard Pharmacies.                                                                                                                                                                        | <b>90-Day Supply of Tier 1 and Tier 2 drugs applies a two-month supply copayment at Standard Pharmacies.</b>                                                                                                                                                                                                                                            |
| <b>Medicare Prescription Payment Plan</b>                               | The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option. | <p><b>If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.</b></p> <p><b>To learn more about this payment option, call us at 1-888-718-3333 (TTY/TDD users call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</b></p> |
| <b>Pharmacy Network Changes</b>                                         | <p>Rite Aid Pharmacy and some independent pharmacies are preferred pharmacies.</p> <p>Sam's Club is a standard pharmacy.</p>                                                                                                                                                   | <p><b>Rite Aid Pharmacy and some independent pharmacies are standard pharmacies.</b></p> <p><b>Sam's Club is a preferred pharmacy.</b></p>                                                                                                                                                                                                              |
| <b>Temporary Supply Coverage of your Drug</b>                           | Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives                                                                                                                                       | <b>Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives</b>                                                                                                                                                                                                         |

|  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>you time to talk with your provider about the change.</p> <p>To be eligible for a temporary supply, the drug you have been taking <b>must no longer be on the plan's Drug List OR is now restricted in some way.</b></p> <p><b>If you are a new member</b>, we will cover a temporary supply of your drug during the first <b>120 days</b> of your membership in the plan.</p> <p><b>If you were in the plan last year</b>, we will cover a temporary supply of your drug during the first <b>120 days</b> of the calendar year.</p> <p>This temporary supply will be for a maximum of a 30-day supply.</p> | <p><b>you time to talk with your provider about the change.</b></p> <p><b>To be eligible for a temporary supply, the drug you have been taking must no longer be on the plan's Drug List OR is now restricted in some way.</b></p> <p><b>If you are a new member, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.</b></p> <p><b>If you were in the plan last year, we will cover a temporary supply of your drug during the first 90 days of the calendar year.</b></p> <p><b>This temporary supply will be for a maximum of a 30-day supply.</b></p> |

## SECTION 3 How to Change Plans

---

**To stay in Personal Choice 65 Plus Rx, you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our Personal Choice 65 Plus Rx.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Personal Choice 65 Plus Rx.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Personal Choice 65 Plus Rx.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call our Member Help Team at 1-888-718-3333 (TTY/TDD users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 4).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [www.Medicare.gov](http://www.Medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, QCC Insurance Company offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

### Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

## Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## SECTION 4 Get Help Paying for Prescription Drugs

---

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday-Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.

- **Help from your state's pharmaceutical assistance program (SPAP).** 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 (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Pennsylvania Office of Medical Assistance Programs (OMAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the Pennsylvania Office of Medical Assistance Programs (OMAP) at 1-800-922-9384. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-888-718-3333 (TTY/TDD users should call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 5 Questions?

---

### Get Help from Personal Choice 65 Plus Rx

- **Call our Member Help Team at 1-888-718-3333. (TTY/TDD users call 711.)**

We're 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 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Personal Choice 65 Plus Rx. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [www.ibxmedicare.com/eoc](http://www.ibxmedicare.com/eoc) or call our Member Help Team 1-888-718-3333 (TTY/TDD users call 711) to ask us to mail you a copy.

- **Visit [www.ibxmedicare.com](http://www.ibxmedicare.com)**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

### Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

Call PA MEDI to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call PA MEDI at 1-800-783-7067. You can Learn more about PA MEDI by visiting website ([www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx](http://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx)).

## Get Help 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 can call 1-877-486-2048.

- **Chat live with [www.Medicare.gov](http://www.Medicare.gov)**

You can chat live at [www.Medicare.gov/talk-to-someone](http://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit [www.Medicare.gov](http://www.Medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [www.Medicare.gov](http://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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

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

Isaac Health, an independent company, provides assistance to Independence Blue Cross members with diagnosed dementia.

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