Independence

2026 Summary of Benefits

Medicare Advantage Plans

Personal Choice 65℠ Achieve Rx PPO
Personal Choice 65℠ Plus Rx PPO
Personal Choice 65℠ Rx PPO
Personal Choice 65℠ Medical-Only PPO

January 1, 2026 – December 31, 2026

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1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not 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.* You can also see the *Evidence of Coverage* on our website, **ibxmedicare.com**.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare Advantage health plan (such as Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Rx PPO, and Personal Choice 65 Medical-Only PPO.)

Tips for comparing your Medicare choices

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

- If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits* booklets. Or, use the Medicare Plan Finder on **medicare.gov**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Rx PPO, and Personal Choice 65 Medical-Only PPO.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits (Part D).
- Other Medical Benefits.

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

Things to Know About Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Rx PPO, and Personal Choice 65 Medical-Only PPO

Hours of Operation & Contact Information

- If you are a member of this plan, call our Member Help Team at **1-888-718-3333** (TTY/TDD: **711**), seven days a week, 8 a.m. to 8 p.m.
- If you are not a member of this plan, call **1-877-393-6733** (TTY/TDD: **711**), seven days a week, 8 a.m. to 8 p.m. By calling this number you will be directed to a licensed sales agent.
- Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.
- Our website: **ibxmedicare.com**.

Who can join?

To join Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Rx PPO, and Personal Choice 65 Medical-Only PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.

The service area for Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, and Personal Choice 65 Rx PPO includes the following counties in Pennsylvania: Chester, Delaware, Montgomery, Philadelphia, and Bucks.

The service area for Personal Choice 65 Medical-Only PPO includes the following counties in Pennsylvania: Philadelphia, and Bucks.

Which doctors, hospitals, and pharmacies can I use?

Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, Personal Choice 65 Rx PPO, and Personal Choice 65 Medical-Only 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.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider/Pharmacy Directory* on our website (**ibxmedicare.com**).

Or, call us and we will send you a copy of the *Provider/Pharmacy Directory*.

What do we cover?

We cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

Personal Choice 65 Medical-Only PPO covers Part B drugs, including chemotherapy and some other drugs administered by your provider. However, the plan does not cover Part D prescription drugs.

Personal Choice 65 Achieve Rx PPO, Personal Choice 65 Plus Rx PPO, and Personal Choice 65 Rx PPO cover Part D prescription drugs. In addition, the plans cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan *Formulary (List of Covered Drugs)* and any restrictions on our website (**ibxmedicare.com**).
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, and Catastrophic Coverage.

If you have any questions about the plan's benefits or costs, please contact Independence Blue Cross.

2 SECTION II - SUMMARY OF BENEFITS

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	Personal Choice 65 Achieve Rx PPO	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Monthly Plan Premium	$0 per month.	$214 per month.	**Personal Choice 65 Rx PPO** (Philadelphia, Bucks): $227 per month. **Personal Choice 65 Rx PPO** (Chester, Delaware, Montgomery): $187 per month. **Personal Choice 65 Medical-Only PPO** (Philadelphia, Bucks): $119 per month.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $375 for Tiers 3, 4, and 5.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible (Personal Choice 65 Rx PPO Only): Not Applicable.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
	Personal Choice 65 Achieve Rx PPO	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Maximum Out-of-Pocket (MOOP) Amount (the amounts you pay for your premium, Part D prescription drugs, and some medical services do not count toward the annual MOOP amount)	Your yearly limit in this plan: • $6,750 for services you receive from in-network providers. • $10,100 for services you receive from in and out-of-network providers combined. Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	Your yearly limit in this plan: • $4,201 for services you receive from in-network providers. • $6,300 for services you receive from in and out-of-network providers combined. Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.	Your yearly limit in this plan: • $5,950 for services you receive from in-network providers. • $9,900 for services you receive from in and out-of-network providers combined. Our plan has a yearly coverage limit for certain in-network benefits. Contact us for the services that apply.

3 SECTION III - SUMMARY OF BENEFITS

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	Personal Choice 65 Achieve Rx PPO	Personal Choice 65 Plus Rx PPO	Personal Choice 65 PPO
Inpatient Hospital Coverage (1)	**In-Network:** $390 copay per day for days 1-7 per admission. $0 copay per day for days 8 and beyond per admission. $0 copay on day of discharge. $2,730 maximum copay per admission. The plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 50% of the total cost per stay.	**In-Network:** $400 copay per stay. $0 copay per day for additional days per admission. $0 copay on day of discharge. The plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 35% of the total cost per stay.	**In-Network:** $270 copay per day for days 1-6 per admission. $0 copay per day for days 7 and beyond per admission. $0 copay on day of discharge. $1,620 maximum copay per admission. The plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 50% of the total cost per stay.
Outpatient Hospital Coverage (1)	**In-Network:** Outpatient hospital observation: $390 copay per stay. Outpatient hospital services: $540 copay. **Out-of-Network:** 50% of the total cost.	**In-Network:** Outpatient hospital observation: $310 copay per stay. Outpatient hospital services: $310 copay. **Out-of-Network:** 35% of the total cost.	**In-Network:** Outpatient hospital observation: $270 copay per stay. Outpatient hospital services: $350 copay. **Out-of-Network:** 50% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Ambulatory Surgical Center (ASC) Services (1)	**In-Network:** $350 copay. **Out-of-Network:** 50% of the total cost.	**In-Network:** $225 copay. **Out-of-Network:** 35% of the total cost.	**In-Network:** $200 copay. **Out-of-Network:** 50% of the total cost.
Doctor Visits (Primary Care Providers and Specialists)	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $55 copay per visit. **Out-of-Network:** 50% of the total cost.	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $0 copay per visit. **Out-of-Network:** 35% of the total cost.	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $40 copay per visit. **Out-of-Network:** 50% of the total cost.
Preventive Care (1)	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. 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 copay will apply. The copay amount depends on the provider type or place of service. **Out-of-Network:** 50% of the total cost.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. 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 copay will apply. The copay amount depends on the provider type or place of service. **Out-of-Network:** 35% of the total cost.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. 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 copay will apply. The copay amount depends on the provider type or place of service. **Out-of-Network:** 50% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Emergency Care Worldwide copay outside of the United States does not count toward the annual MOOP amount	**In-Network and Out-of-Network:** Emergency care: $130 copay per visit. Worldwide emergency coverage: $130 copay per visit. Not waived if admitted.	**In-Network and Out-of-Network:** Emergency care: $130 copay per visit. Worldwide emergency coverage: $130 copay per visit. Not waived if admitted.	**In-Network and Out-of-Network:** Emergency care: $130 copay per visit. Worldwide emergency coverage: $130 copay per visit. Not waived if admitted.
Urgently Needed Services Worldwide copay outside of the United States does not count toward the annual MOOP amount	**In-Network and Out-of-Network:** Retail clinic: $10 copay per visit. Urgent care center: $50 copay per visit. Worldwide urgent coverage: $130 copay per visit. Not waived if admitted.	**In-Network and Out-of-Network:** Retail clinic: $5 copay per visit. Urgent care center: $50 copay per visit. Worldwide urgent coverage: $130 copay per visit. Not waived if admitted.	**In-Network and Out-of-Network:** Retail clinic: $5 copay per visit. Urgent care center: $50 copay per visit. Worldwide urgent coverage: $130 copay per visit. Not waived if admitted.
Diagnostic Services, Labs, and Imaging (1)	**In-Network:** Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $0 copay - $500 copay. X-rays: $40 copay. Therapeutic radiology services (such as radiation therapy): $85 copay per visit.	**In-Network:** Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $0 copay - $275 copay. X-rays: $30 copay. Therapeutic radiology services (such as radiation therapy): $85 copay per visit.	**In-Network:** Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $0 copay - $175 copay. X-rays: $40 copay. Therapeutic radiology services (such as radiation therapy): $85 copay per visit.

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

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Diagnostic Services, Labs, and Imaging (1) (continued)	Radiation for breast cancer: $0 copay for members with a diagnosis of breast cancer. **Out-of-Network:** 50% of the total cost.	Radiation for breast cancer: $0 copay for members with a diagnosis of breast cancer. **Out-of-Network:** 35% of the total cost.	Radiation for breast cancer: $0 copay for members with a diagnosis of breast cancer. **Out-of-Network:** 50% of the total cost.
Hearing Services	**Medicare-covered Hearing Exams** **In-Network:** $55 copay. **Out-of-Network:** 50% of the total cost. **Routine Hearing Exams (up to 1 visit every year)** **In-Network and Out-of-Network:** $0 copay. **Routine Hearing Aids** **In-Network and Out-of-Network:** Advanced digital hearing aid: $699 copay per aid. Premium digital hearing aid: $999 copay per aid. Advanced and premium include a rechargeable hearing aid option.	**Medicare-covered Hearing Exams** **In-Network:** $0 copay. **Out-of-Network:** 35% of the total cost. **Routine Hearing Exams (up to 1 visit every year)** **In-Network and Out-of-Network:** $0 copay. **Routine Hearing Aids** **In-Network and Out-of-Network:** Advanced digital hearing aid: $499 copay per aid. Premium digital hearing aid: $799 copay per aid. Advanced and premium include a rechargeable hearing aid option.	**Medicare-covered Hearing Exams** **In-Network:** $40 copay. **Out-of-Network:** 50% of the total cost. **Routine Hearing Exams (up to 1 visit every year)** **In-Network and Out-of-Network:** $0 copay. **Routine Hearing Aids** **In-Network and Out-of-Network:** Advanced digital hearing aid: $499 copay per aid. Premium digital hearing aid: $799 copay per aid. Advanced and premium include a rechargeable hearing aid option.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Hearing Services (continued)	Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.	Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Dental Services	**Medicare-covered Dental Services** **In-Network:** $55 copay. **Out-of-Network:** 50% of the total cost. **Routine Dental Care** **In-Network:** $0 copay for one routine exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months. $0 copay for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months.	**Medicare-covered Dental Services** **In-Network:** $0 copay. **Out-of-Network:** 35% of the total cost. **Routine Dental Care** **In-Network:** $0 copay for one routine exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months. $0 copay for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months.	**Medicare-covered Dental Services** **In-Network:** $40 copay. **Out-of-Network:** 50% of the total cost. **Routine Dental Care** **In-Network:** $0 copay for one routine exam and cleaning every six months, two limited problem focused exams every 12 months, one comprehensive oral evaluation every 36 months, one detailed and extensive problem focused exam every 12 months, one comprehensive periodontal evaluation every 36 months, two dental consultations every 12 months, and one fluoride treatment every 12 months. $0 copay for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Dental Services (continued)	50% coinsurance for restorative services, endodontics, periodontics, and extractions. 50% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery. Member must use a participating IBX Medicare Dental Network provider for in-network coverage. **In-Network and Out-of-Network:** $1,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. **Out-of-Network:** 80% coinsurance for routine dental exam, and cleaning services. 80% coinsurance for dental X-ray.	0% coinsurance for restorative services, endodontics, periodontics, and extractions. 0% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery. Member must use a participating IBX Medicare Dental Network provider for in-network coverage. **In-Network and Out-of-Network:** $1,000 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. **Out-of-Network:** 80% coinsurance for routine dental exam, and cleaning services. 80% coinsurance for dental X-ray.	20% coinsurance for restorative services, endodontics, periodontics, and extractions. 40% coinsurance for prosthodontics, implants, and other oral/maxillofacial surgery. Member must use a participating IBX Medicare Dental Network provider for in-network coverage. **In-Network and Out-of-Network:** $1,500 combined plan allowance every year for restorative dental services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. **Out-of-Network:** 80% coinsurance for routine dental exam, and cleaning services. 80% coinsurance for dental X-ray.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Dental Services (continued)	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Routine dental services do not count toward the annual MOOP amount.	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Routine dental services do not count toward the annual MOOP amount.	80% coinsurance for restorative services, endodontics, periodontics, extractions, prosthodontics, implants, and other oral/maxillofacial surgery. Routine dental services do not count toward the annual MOOP amount.
Vision Services	**Medicare-covered Vision Services** **In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $55 copay. Medicare-covered glaucoma screening: $0 copay. **Out-of-Network:** 50% of the total cost. **Routine Vision Care** **In-Network:** $0 copay for one routine eye exam every year.	**Medicare-covered Vision Services** **In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $0 copay. Medicare-covered glaucoma screening: $0 copay. **Out-of-Network:** 35% of the total cost. **Routine Vision Care** **In-Network:** $0 copay for one routine eye exam every year.	**Medicare-covered Vision Services** **In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $40 copay. Medicare-covered glaucoma screening: $0 copay. **Out-of-Network:** 50% of the total cost. **Routine Vision Care** **In-Network:** $0 copay for one routine eye exam every year.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Vision Services (continued)	One pair of contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 allowance every year for eyewear (frames and lenses) purchased from Visionworks®. $150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider. $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear coverage does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider.	One pair of contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 allowance every year for eyewear (frames and lenses) purchased from Visionworks®. $150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider. $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear coverage does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider.	One pair of contact lenses or one pair of eyeglass frames and lenses are covered every year. If eyewear is purchased from the Davis Vision Collection, the eyeglass frames and lenses are covered in full. $250 allowance every year for eyewear (frames and lenses) purchased from Visionworks®. $150 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider. $150 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear coverage does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. Member must use a participating Davis Vision network provider.

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

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Vision Services (continued)	**Out-of-Network:** 80% of the total cost. Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $150 combined in-and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area.	**Out-of-Network:** 80% of the total cost. Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $150 combined in-and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area.	**Out-of-Network:** 80% of the total cost. Routine vision services do not count toward the annual MOOP amount. Eyewear (frames and lenses, or contact lenses) have a $150 combined in-and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to $250 combined maximum applies when in or out of the service area.
Mental Health Services (1)	**In-Network:** Outpatient mental health care: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Inpatient mental health care: • $330 copay per day for days 1-7 per admission. • $0 copay per day for days 8 and beyond per admission.	**In-Network:** Outpatient mental health care: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Inpatient mental health care: • $400 copay per stay. • $0 copay per day for additional days per admission.	**In-Network:** Outpatient mental health care: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Inpatient mental health care: • $270 copay per day for days 1-6 per admission. • $0 copay per day for days 7 and beyond per admission.

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

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Mental Health Services (1) (continued)	• $0 copay on day of discharge. • $2,310 maximum copay per admission. • 190-day lifetime maximum. Outpatient substance abuse services: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Partial hospitalization and intensive outpatient services: • $30 copay per day. **Out-of-Network:** 50% of the total cost.	• $0 copay on day of discharge. • 190-day lifetime maximum. Outpatient substance abuse services: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Partial hospitalization and intensive outpatient services: • $30 copay per day. **Out-of-Network:** 35% of the total cost.	• $0 copay on day of discharge. • $1,620 maximum copay per admission. • 190-day lifetime maximum. Outpatient substance abuse services: • Group therapy visit: $20 copay. • Individual therapy visit: $30 copay. Partial hospitalization and intensive outpatient services: • $30 copay per day. **Out-of-Network:** 50% of the total cost.
Skilled Nursing Facility (SNF) (1)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $218 copay per day. **Out-of-Network:** 50% of the total cost per stay. 100 days per benefit period.	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $218 copay per day. **Out-of-Network:** 35% of the total cost per stay. 100 days per benefit period.	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $218 copay per day. **Out-of-Network:** 50% of the total cost per stay. 100 days per benefit period.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Outpatient Rehabilitation Services (Physical therapy, occupational therapy, and speech therapy)	**In-Network:** $50 copay per visit. **Out-of-Network:** 50% of the total cost.	**In-Network:** $25 copay per visit. **Out-of-Network:** 35% of the total cost.	**In-Network:** $25 copay per visit. **Out-of-Network:** 50% of the total cost.
Ambulance (1) (Ground and air transportation)	**In-Network and Out-of-Network:** $310 copay per one-way trip. Not waived if admitted. In-network non-emergency ambulance services require prior authorization.	**In-Network and Out-of-Network:** $200 copay per one-way trip. Not waived if admitted. In-network non-emergency ambulance services require prior authorization.	**In-Network and Out-of-Network:** $195 copay per one-way trip. Not waived if admitted. In-network non-emergency ambulance services require prior authorization.
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	**In-Network:** For Part B drugs, including chemotherapy drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump. **Out-of-Network:** 50% of the total cost.	**In-Network:** For Part B drugs, including chemotherapy drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump. **Out-of-Network:** 35% of the total cost.	**In-Network:** For Part B drugs, including chemotherapy drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump. **Out-of-Network:** 50% of the total cost.

4 SECTION IV - SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS (PART D)

Deductible

Personal Choice 65 Achieve Rx PPO: $375 for Tiers 3, 4, and 5.
Personal Choice 65 Plus Rx PPO and Personal Choice 65 Rx PPO: No Part D deductible.

Initial Coverage

You pay no more than $2,100 in out-of-pocket costs for covered drugs. The cap does not apply to drugs covered under Medicare Part B.

Preferred Retail Cost-sharing			
	Personal Choice 65 Achieve Rx PPO	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 Rx PPO**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$35 copay	$35 copay	$35 copay
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$70 copay	$70 copay	$70 copay
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$105 copay	$105 copay	$105 copay

PRESCRIPTION DRUG BENEFITS (PART D)

Standard Retail Cost-sharing			
	Personal Choice 65 Achieve Rx PPO	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 Rx PPO**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
1 (Preferred Generic)	$9 copay	$9 copay	$9 copay
2 (Generic)	$20 copay	$20 copay	$20 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$35 copay	$35 copay	$35 copay
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
1 (Preferred Generic)	$18 copay	$18 copay	$18 copay
2 (Generic)	$40 copay	$40 copay	$40 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$70 copay	$70 copay	$70 copay
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
1 (Preferred Generic)	$18 copay	$18 copay	$18 copay
2 (Generic)	$40 copay	$40 copay	$40 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$105 copay	$105 copay	$105 copay

PRESCRIPTION DRUG BENEFITS (PART D)

Mail-order Cost-sharing			
	Personal Choice 65 Achieve Rx PPO	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 Rx PPO**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$35 copay	$35 copay	$35 copay
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$70 copay	$70 copay	$70 copay
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
2 (Generic)	$0 copay	$0 copay	$0 copay
3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
4 (Non-Preferred)	30% coinsurance	38% coinsurance	33% coinsurance
5 (Specialty)	28% coinsurance	33% coinsurance	33% coinsurance
Insulin (Tiers 3, 4, and 5)	$70 copay	$70 copay	$70 copay

You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have $0 copays when filled at preferred pharmacies or through mail order.

Your cost-sharing may change depending on the pharmacy you choose, if you purchase a long-term supply (up to 90 days) of a drug, when you move into each stage of your Part D benefits, or if you reside in a long-term care facility.

Please call us or see the plan's *Evidence of Coverage* on our website (**ibxmedicare.com**) for complete information about your costs for covered drugs.

Catastrophic Coverage Stage

After reaching the annual maximum of $2,100 in out-of-pockets costs, you pay $0 for covered drugs.

5 SECTION V - SUMMARY OF BENEFITS

OTHER MEDICAL BENEFITS

Benefits/Services	Personal Choice 65 Achieve Rx PPO	Personal Choice 65 Plus Rx PPO	Personal Choice 65 PPO
Over-the-Counter (OTC) Items	<u>**In-Network and Out-of-Network:**</u> $30 allowance every quarter. The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.	<u>**In-Network and Out-of-Network:**</u> $30 allowance every quarter. The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.	<u>**In-Network and Out-of-Network:**</u> $30 allowance every quarter. The quarterly (every three months) allowance is preloaded on the IBX Care Card. You must use the IBX Care Card to purchase OTC items at participating retailers. OTC items purchased from non-participating retailers will NOT be covered. OTC items can also be ordered with the IBX Care Card via website, phone, or catalog. Any unused balance will not roll over to the next quarter. OTC costs do not count toward the annual MOOP amount.

OTHER MEDICAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Telemedicine Visits	**<u>In-Network and Out-of-Network:</u>** $0 copay for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician. $0 copay for mental/behavioral health visits focused on depression, anxiety, stress, and more. $0 copay for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.	**<u>In-Network and Out-of-Network:</u>** $0 copay for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician. $0 copay for mental/behavioral health visits focused on depression, anxiety, stress, and more. $0 copay for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.	**<u>In-Network and Out-of-Network:</u>** $0 copay for medical visits focused on urgent care-like medical conditions by connecting to a state-licensed physician. $0 copay for mental/behavioral health visits focused on depression, anxiety, stress, and more. $0 copay for dermatology consultations focused on diagnosing and treating skin conditions like eczema, psoriasis, acne, and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.

OTHER MEDICAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Additional Telehealth (Primary care physician, specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $55 copay per visit. Physical, occupational, and speech therapy: $50 copay per visit. Other health care professional: $55 copay per visit. Not all telehealth services may be covered. **Out-of-Network:** Not covered.	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $0 copay per visit. Physical, occupational, and speech therapy: $25 copay per visit. Other health care professional: $0 copay per visit. Not all telehealth services may be covered. **Out-of-Network:** Not covered.	**In-Network:** Primary care physician: $0 copay per visit. Specialist: $40 copay per visit. Physical, occupational, and speech therapy: $25 copay per visit. Other health care professional: $40 copay per visit. Not all telehealth services may be covered. **Out-of-Network:** Not covered.
Dementia	**In-Network:** $0 copay for neurology, including telehealth neurology, physical therapy, speech therapy, individual mental health, individual psychiatric, and other health care professional visits. Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor. **Out-of-Network:** Not covered.	**In-Network:** $0 copay for neurology, including telehealth neurology, physical therapy, speech therapy, individual mental health, individual psychiatric, and other health care professional visits. Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor. **Out-of-Network:** Not covered.	**In-Network:** $0 copay for neurology, including telehealth neurology, physical therapy, speech therapy, individual mental health, individual psychiatric, and other health care professional visits. Members must be diagnosed with dementia. Members must be enrolled in the dementia support program provided through our specified vendor. **Out-of-Network:** Not covered.

OTHER MEDICAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Chiropractic Services	**Medicare-covered** **In-Network:** $15 copay per visit for spinal manipulations. **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 50% of the total cost. Routine visits do not count toward the annual MOOP amount.	**Medicare-covered** **In-Network:** $15 copay per visit for spinal manipulations. **Out-of-Network:** 35% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 35% of the total cost. Routine visits do not count toward the annual MOOP amount.	**Medicare-covered** **In-Network:** $15 copay per visit for spinal manipulations. **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 50% of the total cost. Routine visits do not count toward the annual MOOP amount.
Acupuncture	**Medicare-covered** **In-Network:** $15 copay per visit (up to 12 visits in 90 days; 8 additional if determined that progress is made). **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits each year). **Out-of-Network:** 50% of the total cost.	**Medicare-covered** **In-Network:** $15 copay per visit (up to 12 visits in 90 days; 8 additional if determined that progress is made). **Out-of-Network:** 35% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits each year). **Out-of-Network:** 35% of the total cost.	**Medicare-covered** **In-Network:** $15 copay per visit (up to 12 visits in 90 days; 8 additional if determined that progress is made). **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits each year). **Out-of-Network:** 50% of the total cost.

OTHER MEDICAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Acupuncture (continued)	Routine visits require a diagnosis of one of the eligible conditions. Routine visits do not count toward the annual MOOP amount.	Routine visits require a diagnosis of one of the eligible conditions. Routine visits do not count toward the annual MOOP amount.	Routine visits require a diagnosis of one of the eligible conditions. Routine visits do not count toward the annual MOOP amount.
Podiatry Services	**Medicare-covered** **In-Network:** $25 copay per visit. **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $25 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 50% of the total cost. Routine visits do not count toward the annual MOOP amount.	**Medicare-covered** **In-Network:** $15 copay per visit. **Out-of-Network:** 35% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 35% of the total cost. Routine visits do not count toward the annual MOOP amount.	**Medicare-covered** **In-Network:** $15 copay per visit. **Out-of-Network:** 50% of the total cost. **Routine Care** **In-Network:** $15 copay per visit (up to 6 visits combined in and out of network per year). **Out-of-Network:** 50% of the total cost. Routine visits do not count toward the annual MOOP amount.
Fitness Benefit	**In-Network and Out-of-Network:** $0 copay. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical	**In-Network and Out-of-Network:** $0 copay. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical	**In-Network and Out-of-Network:** $0 copay. The program includes access to a participating gym network, on-demand and livestreamed digital content, home kits, curated physical

OTHER MEDICAL BENEFITS			
Benefits/Services	**Personal Choice 65 Achieve Rx PPO**	**Personal Choice 65 Plus Rx PPO**	**Personal Choice 65 PPO**
Fitness Benefit (continued)	activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.	activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.	activities, and access to a complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises. Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program. Gym memberships and services received from non-One Pass fitness centers will be denied.
Caregiver Support Services	**<u>In-Network and Out-of-Network:</u>** $0 copay. Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	**<u>In-Network and Out-of-Network:</u>** $0 copay. Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.	**<u>In-Network and Out-of-Network:</u>** $0 copay. Includes support services (counseling, navigation, and support), digital coaching, and education for members and their caregivers.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Help Team representative at **1-888-718-3333 (TTY/TDD: 711)**.

Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **ibxmedicare.com** or call **1-888-718-3333 (TTY/TDD: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

DISCLAIMERS

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

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

TruHearing® is a registered trademark of TruHearing, Inc., an independent company.

Vision benefits are underwritten by QCC Insurance Company and administered by Davis Vision, an independent company.

An affiliate of Independence Blue Cross has a financial interest in Visionworks, an independent company.

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

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

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

One Pass is a voluntary program offered by an independent company. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

This information is not a complete description of benefits. Contact **1-877-393-6733** (TTY/TDD: **711**) for more information.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意：如果您说普通话，我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务，确保以无障碍格式传递信息。请致电 1-800-275-2583（TTY：711）或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ़्त में उपलब्ध हैं। सुलभ फ़ॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ़्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어를: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'anáawo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjį' bee adahodooníłí diné bich'į' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígíí ałdó' t'áá jiik'eh hǫlǫ. Kohjį' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'į' hanidziih.

Pennsilfaanisch-Deitsch: WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్‌కు కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtìlẹhìn èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna iráàyèsi kíka wà lárọwọ́tó bakanna lọ́fẹ̀ẹ́. Pe 1-800-275-2583 (TTY: 711) tàbi ki ó bá olùpèsè rẹ sọ̀rọ̀.

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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com**.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at the following website: **www.healthinsurancehosting.com/notices**.

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MA15590 (04/25)
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Independence

PO Box 13713

Philadelphia, PA 19101-3713

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THANK YOU