Independence

Medical Benefit Highlights

Personal Choice 65 Standard Drexel- $10/$15

Covered Services	Your Costs (You pay)	
Benefits	**In-Network**	**Out-of-Network**
Maximum Out-of-Pocket (MOOP)[1] Individual Only *Out of network maximum includes combined in/out network*	$6,700	$10,000
Lifetime Maximum	Unlimited	
Plan Deductible Individual Only	$0	$250
Ambulance	**In-Network**	**Out-of-Network**
Ground	$0 copayment	$0 copayment no deductible
Air	$0 copayment	$0 copayment no deductible
Non-emergent requires prior authorization		
Chiropractic/Spinal Manipulations	**In-Network**	**Out-of-Network**
Medicare Covered Chiropractic Care	$10 copayment	20% after deductible
Routine Chiropractic Care 6 visits/calendar year[2]	$10 copayment	20% after deductible
Physician Office Visits	**In-Network**	**Out-of-Network**
Primary Care Services	$10 copayment	20% after deductible
Specialist Services	$15 copayment	20% after deductible
Virtual Care	**In-Network**	**Out-of-Network**
Telemedicine	$0 copayment	Refer to EOC
Durable Medical Equipment (DME)	**In-Network**	**Out-of-Network**
DME, Prosthetics and Orthotics	$0 copayment	20% after deductible
Liquid and Gas Oxygen	$0 copayment	20% after deductible
Diabetic Supplies	**In-Network**	**Out-of-Network**
Supplies and Monitors	$0 copayment	20% after deductible
Shoes and Inserts	$0 copayment	20% after deductible
Insulin Pump	$0 copayment	20% after deductible
Emergency Care	**In-Network**	**Out-of-Network**
Emergency Care (copay waived if admitted)	$40 copayment	$40 copayment no deductible
Worldwide Coverage (copay waived	$40 copayment	$40 copayment no deductible

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if admitted)[3]		
Hearing Services	**In-Network**	**Out-of-Network**
Hearing Aids		
Standard Digital	$699 copayment	Not covered
Premium Digital	$999 copayment	Not covered
Hearing Aids Fitting and Evaluation	$0 copayment	Not covered
Medicare Covered Hearing Exams	$15 copayment	20% after deductible
Routine Hearing Exam	$15 copayment	20% after deductible
Home Health Care	$0 copayment	20% after deductible
Inpatient Hospital *You are covered for unlimited days*	$0 copayment	20% after deductible
Inpatient Mental Health/Substance Abuse *190-day lifetime maximum applies to treatment received in a Medicare-approved mental health facility*	$0 copayment	20% after deductible
Medicare Part B Drugs *Prior authorization is required for certain Part B injectable drugs*	$0 copayment	20% after deductible
Medicare Preventive Care[4] *Please see your Evidence of Coverage (EOC)*	$0 copayment	20% no deductible
Outpatient Diagnostic Procedures/Lab	$0 copayment	20% after deductible
Outpatient Mental Health Services *Includes Partial Hospitalization*	$15 copayment	20% after deductible
Outpatient Radiology/X-ray Services	**In-Network**	**Out-of-Network**
Advanced Imaging (MRI/CT Scan)	$0 copayment	20% after deductible
Standard Imaging (Routine/Diagnostic)	$0 copayment	20% after deductible

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Outpatient Rehabilitation Therapy	In-Network	Out-of-Network
Physical, Speech, Occupational Therapy	$15 copayment	20% after deductible
Cardiac, Pulmonary Rehabilitation	$5 copayment	20% after deductible
Outpatient Substance Abuse	$15 copayment	20% after deductible

Outpatient Hospital	In-Network	Out-of-Network
Observation Stay	$0 copayment	20% after deductible
Outpatient Surgery	$0 copayment	20% after deductible
Outpatient Ambulatory Surgical Center	$0 copayment	20% after deductible

Podiatry Services	In-Network	Out-of-Network
Medicare Covered Podiatry	$15 copayment	20% after deductible
Routine Podiatry 6 visits/calendar year[2]	$15 copayment	20% after deductible
Radiation Therapy	$0 copayment	20% after deductible
Routine Dental	Not covered	Not covered
Routine Vision	Covered. See Vision detail.	Covered. See Vision detail.
Skilled Nursing Facility [5] 100 days/benefit period[6]	$0 copayment/Day	20% after deductible

Urgently Needed Services	In-Network	Out-of-Network
Retail Clinic	$10 copayment	$10 copayment no deductible
Urgent Care Center	$15 copayment	$15 copayment no deductible
Worldwide Coverage[3]	$40 copayment	$40 copayment no deductible

Vision Care	In-Network	Out-of-Network
Medicare Covered Exam	$15 copayment	20% after deductible
Medicare Covered Eyewear (refer to EOC)	$0 copayment	$0 copayment no deductible

1 In-network out-of-pocket maximum (MOOP) includes deductible, copays, and coinsurance. Combined in-network and out-of-network out-of-pocket maximum (MOOP) includes copay, deductible and coinsurance. Visit limits are combined across in-network and out-of-network benefits. Routine care does not count towards your out-of-pocket maximum (MOOP).

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[2] Combined in and out-of-network.

[3] Worldwide Emergency Coverage available. Amounts you pay for emergency and urgently needed care services received outside the United States do not count toward your maximum out-of-pocket amount (MOOP).

[4] For Preventive Services, if you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

[5] No prior hospitalization required in order to obtain services from a Skilled Nursing Facility. In-network and out-of-network maximum day period combined.

[6] A Medicare benefit period begins the day you go into a hospital or skilled nursing facility. The Medicare benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one Medicare benefit period has ended, a new Medicare benefit period begins. There is no limit to the number of Medicare benefit periods.

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

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Language Assistance Services

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Independence

Drug Benefit Highlights

PC65 Group MAPD - Unlimited Gap Coverage (EGWP w/ WRAP)

Covered Services	Your Costs (You pay)	
Benefit		
Deductible	$0	
Initial Coverage	After you pay your annual deductible, you pay the following copays until you reach the initial coverage limit (paid by member and plan)	
30-day supply at network retail pharmacy	**Preferred Pharmacy**	**Standard Pharmacy**
Tier 1 Generic Drugs	$5 copayment	$10 copayment
Tier 2 Preferred Brand Drugs	$15 copayment	$15 copayment
Tier 3 Non-Preferred Brand Drugs	$30 copayment	$30 copayment
90-day supply at network retail pharmacy	**Preferred Pharmacy**	**Standard Pharmacy**
Tier 1 Generic Drugs	$15 copayment	$30 copayment
Tier 2 Preferred Brand Drugs	$45 copayment	$45 copayment
Tier 3 Non-Preferred Brand Drugs	$90 copayment	$90 copayment
30-day supply at network mail-order pharmacy	**Preferred Pharmacy**	**Standard Pharmacy**
Tier 1 Generic Drugs	$5 copayment	Not applicable
Tier 2 Preferred Brand Drugs	$15 copayment	Not applicable
Tier 3 Non-Preferred Brand Drugs	$30 copayment	Not applicable
90-day supply at network mail-order pharmacy		
Tier 1 Generic Drugs	$5 copayment	Not applicable
Tier 2 Preferred Brand Drugs	$15 copayment	Not applicable
Tier 3 Non-Preferred Brand Drugs	$30 copayment	Not applicable
Coverage Gap		
Please see your Evidence of Coverage (EOC)	The coverage gap begins after the initial coverage limit cost has been reached (paid by member and plan)	
30-day supply at a network retail pharmacy		
Generic	Covered at initial Limit	
Brand	Covered at initial Limit	

Initial Coverage Limit	$4,130
True Out-of-Pocket Cost (TrOOP)	$6,550

Catastrophic Coverage	
	Once your annual out-of-pocket drugs cost has been reached, you pay the greater of:
Generics (including brand drugs treated as generic)	$3.70 or 5%
All other drugs	$9.20 or 5%

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Select Option PDP is a PDP plan with a Medicare contract. Enrollment in Select Option PDP depends on contract renewal.

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Independence

Vision Benefit Highlights

PPO Group MA Vision Benefit

Covered Services	Your Costs (You pay)	
Routine Vision	**In-Network**	**Out-of-Network**
Routine Eye Exam (1 exam/every 2 years)[1]	$0 copayment	$35 allowance
Eyewear		
Frames (1 pair/every 2 years)[1]		$100 allowance[2]
Vendor Specific Collection	$0 copayment	Not applicable
Preferred Provider	$65 copayment	Not applicable
Standard Provider	$65 copayment	Not applicable
Lenses (1 pair/every 2 years)[1]		$100 allowance[2]
Vendor Specific Collection	$0 copayment	Not applicable
Preferred Provider	$0 copayment	Not applicable
Standard Provider	$0 copayment	Not applicable
Lens Options		
Tints	Not covered	Not covered
Progressive	Not covered	Not covered
Transition	Not covered	Not covered
Polish	Not covered	Not covered
Insurance	Not covered	Not covered
Contacts in lieu of Frames/Lenses (1 pair/every 2 years)[1]	$100 allowance	$100 allowance

[1] Combined in and out-of-network.
[2] Out-of-network allowance applies to both Lenses and Frames combined.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discrimination is Against the Law

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

This Plan provides:

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

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

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