

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 <i>Out of network maximum includes combined in/out network</i>	\$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
<i>Non-emergent requires prior authorization</i>		
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 Evidence of Coverage (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 if admitted) ³	\$40 copayment	\$40 copayment no deductible
Hearing Services	In-Network	Out-of-Network
Hearing Aids		
Advanced Digital	\$699 copayment	Refer to Evidence of Coverage (EOC)
Premium Digital	\$999 copayment	Refer to Evidence of Coverage (EOC)
Hearing Aids Fitting and Evaluation	\$0 copayment	Refer to Evidence of Coverage (EOC) 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 <i>You are covered for unlimited days</i>	\$0 copayment/Day	20% after deductible
Inpatient Mental Health/Substance Abuse <i>190-day lifetime maximum applies to treatment received in a Medicare-approved mental health facility</i>	\$0 copayment/Day	20% after deductible
Medicare Part B Drugs <i>Prior authorization is required for certain Part B injectable drugs</i>	\$0 copayment	20% after deductible
Medicare Preventive Care⁴ <i>Please see your Evidence of Coverage (EOC)</i>	\$0 copayment	20% no deductible
Outpatient Diagnostic Procedures/Lab	\$0 copayment	20% after deductible
Outpatient Mental Health Services <i>Includes Partial Hospitalization</i>	\$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
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 Facility⁵ 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).

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.

For updated information regarding plan providers, visit our website at www.ibxmedicare.com, or call the Member Help Team at **1-888-718-3333 (TTY/TDD: 711)**, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. This information is not a complete description of benefits. Contact **1-877-393-6733** for more information.

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

The BLUE CROSS and BLUE SHIELD names and symbols and BLUECARD are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Normal plan rules apply. Please refer to your Evidence of Coverage (EOC) for more information.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

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

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

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

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

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

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

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

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

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

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich epes 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 yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih kojì' 1-800-275-2583.

Urdu:

توجہ درکار ہے: 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 នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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: civilrightscordinator@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>.