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	$4,660
True Out-of-Pocket Cost (TrOOP)	$7,400

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)	$4.15 or 5%
All other drugs	$10.35 or 5%

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.

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

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

Independence

Vision Benefit Highlights

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 allowance	Not applicable
Standard Provider	$65 allowance	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[2]

1 Combined in and out-of-network.

2 Out-of-network allowance applies to both Lenses and Frames combined.

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