

Jefferson Health Plans Flex (PPO) offered by Jefferson Health Plans

Annual Notice of Change for 2026

You're enrolled as a member of Jefferson Health Plans Flex (PPO).

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

- **You have from October 15 until 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 Jefferson Health Plans Flex (PPO).
- To change to a **different plan**, visit 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.JeffersonHealthPlans.com/medicare or call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) to get a copy by mail.

More Resources

- Call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477.) Hours are 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and 8 a.m. to 8 p.m., Monday - Friday, April 1 - Sept. 30. This call is free. This information is available in alternate formats such as braille, large print, and audio versions.

About Jefferson Health Plans Flex (PPO)

- Jefferson Health Plans contracts with Medicare to offer HMO, HMO-DSNP, and PPO plans. Enrollment in our plans depends on contract renewal.
- When this material says "we," "us," or "our," it means Jefferson Health Plans. When it says "plan" or "our plan," it means Jefferson Health Plans Flex (PPO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Jefferson Health Plans Flex (PPO).** Starting January 1, 2026, you'll get your medical and drug coverage through Jefferson Health Plans Flex (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

Annual Notice of Changes for 2026

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	\$0	\$0
Deductible	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for your covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$7,000 From network and out-of-network providers combined: \$10,000	From network providers: \$7,000 From network and out-of-network providers combined: \$10,000
Primary care office visits	\$0 per visit	\$0 per visit
Specialist office visits	\$35 per visit	\$25 per visit
Inpatient hospital stays 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 the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	\$250 copayment per day for days 1 - 6 and a \$0 copayment per day for days 7 - 90.	\$250 copayment per day for days 1 - 6 and a \$0 copayment per day for days 7 - 90.
Part D drug coverage deductible (Go to Section 1.6 for details.)	Deductible: \$0	Deductible: \$0
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 copay • Drug Tier 2: \$5 copay	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 copay • Drug Tier 2: \$5 copay

	2025 (this year)	2026 (next year)
	• Drug Tier 3: 25% coinsurance You pay 0%-20% / \$35 max per month supply of each covered insulin product on this tier. • Drug Tier 4: 40% coinsurance • Drug Tier 5: 33% coinsurance Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs	• Drug Tier 3: 25% coinsurance • Drug Tier 4: 32% coinsurance • Drug Tier 5: 33% coinsurance You pay \$35 per month supply of each covered insulin product on tiers 3, 4, and 5. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

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 your Medicare drug coverage.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts

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 services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$7,000	\$7,000 Once you've paid \$7,000 out of pocket for covered services, you'll pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$10,000	\$10,000 Once you've paid \$10,000 out of pocket for covered services, you'll pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* <https://www.jeffersonhealthplans.com/medicare/find-a-doctor/> to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*.

- Visit our website at www.JeffersonHealthPlans.com/medicare
- Call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) to get current provider information or to ask us to mail you a *Provider 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 Member Service at 1-866-901-8000 (TTY users call 1-877-454-8477) 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 of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* <https://www.jeffersonhealthplans.com/medicare/find-a-doctor/> to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.JeffersonHealthPlans.com/medicare
- Call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) to get current pharmacy information or to ask us to mail you a *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 Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

	2025 (this year)	2026 (next year)
Ambulance	\$255 copayment per trip for emergency ambulance services or medically necessary non-emergent ambulance services (ground).	\$250 copayment per trip for emergency ambulance services or medically necessary non-emergent ambulance services (ground).
Dental services	\$35 copayment for Medicare covered services	\$25 copayment for Medicare covered services
Flex card	\$2,250 every year for additional vision, dental, and hearing services. See your <i>Evidence of Coverage</i> for further details.	\$3,500 every year for additional vision, dental, and hearing services. See your <i>Evidence of Coverage</i> for details.

	2025 (this year)	2026 (next year)
Hearing	\$35 copayment for Medicare-covered services. \$1,000 allowance toward hearing aids (all types), limited to every 2 years (both ears combined). Benefit does not roll over annually.	\$25 copayment for Medicare-covered services. \$500 - \$1,975 copayment for hearing aids, limited to every 2 years (both ears combined). The minimum copayment applies to entry-level hearing aids, while the maximum copay applies to premium-level options. See your Evidence of Coverage for further details.
Outpatient Surgery	\$375 copayment per outpatient hospital stay \$375 copayment for observation services \$245 copayment per ambulatory surgical center visit	\$300 copayment per outpatient hospital stay \$300 copayment for observation services \$200 copayment per ambulatory surgical center visit
Over-the-Counter (OTC) Items	\$150 per quarter for eligible over-the-counter items. Unused amounts will <i>not</i> be rolled over. See your <i>Evidence of Coverage</i> for details.	\$160 per quarter for eligible over-the-counter items. Unused amounts will <i>not</i> be rolled over. See your <i>Evidence of Coverage</i> for details.
Podiatry Services	\$35 copayment for Medicare-covered services \$35 copayment for routine foot care, limited to 4 visits per year	\$25 copayment for Medicare-covered services \$25 copayment for routine foot care, limited to 6 visits per year
Skilled nursing facility (SNF) care	Days 1 - 20: \$0 copayment per day Days 21 - 100: \$203 copayment per day	Days 1 - 20: \$0 copayment per day Days 21 - 100: \$175 copayment per day
Specialist Office Visit	\$35 copayment	\$25 copayment

	2025 (this year)	2026 (next year)
Vision care	\$35 copayment for Medicare-covered services. \$100 for routine eyewear (one pair of eyeglasses (lenses and frames) or unlimited contact lenses).	\$25 copayment for Medicare-covered services. \$0 - \$200 for routine eyewear (one pair of eyeglasses (lenses and frames) or unlimited contact lenses).
X-Ray Services (ultrasounds, other imaging/procedures, etc)	\$0 copayment	\$30 copayment

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, during the year, 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 Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) for more information.

Starting in 2026, we can immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

For example: if you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before

you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: <https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars>. You can also call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) or ask your health care provider, prescriber, or pharmacist 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 may 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 you about your drug costs. If you get Extra Help and you don't get this material by September 30th, 2025, call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) 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.

Stage	2025 (this year)	2026 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Drug Costs in Stage 2: Initial Coverage

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, 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).

Stage	2025 (this year)	2026 (next year)
Tier 1 - Preferred Generic:	\$0	\$0
Tier 2 - Generic:	\$5	\$5
Tier 3 - Preferred Brand:	25% of the total cost.	25% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.
Tier 4 - Non-Preferred Drug:	40% of the total cost.	32% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.
Tier 5 - Specialty:	33% of the total cost.	33% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.

Changes to the Catastrophic Coverage Stage

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

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a	If you're participating in the Medicare

Description	2025 (this year)	2026 (next year)
	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.	Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-866-901-8000 (TTY users call 1-877-454-8477 or visit Medicare.gov.

SECTION 3 How to Change Plans

To stay in Jefferson Health Plans Flex 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 Jefferson Health Plans Flex.

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 Jefferson Health Plans Flex.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Jefferson Health Plans Flex.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-866-901-8000 (TTY users call 1-877-454-8477) 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 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5.2), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Jefferson Health Plans offers other Medicare health 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, 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 Special Pharmaceutical Benefit Program (SPBP). 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 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 1-866-901-8000 (TTY users call 1-877-454-8477 or visit [Medicare.gov](https://www.Medicare.gov)).

SECTION 5 Questions?

Section 5.1 Get Help from Jefferson Health Plans Flex (PPO)

Get Help from Jefferson Health Plans Flex (PPO)

- Call Member Services at 1-866-901-8000. (TTY users call 1-877-454-8477.)

We're available for phone calls 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and 8 a.m. to 8 p.m., Monday - Friday, April 1 - Sept. 30. 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 Jefferson Health Plans Flex. 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.JeffersonHealthPlans.com/medicare or call Member Services 1-866-901-8000. (TTY users call 1-877-454-8477) to ask us to mail you a copy.

- **Visit** www.JeffersonHealthPlans.com/medicare

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).

Section 5.2 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.

Call Pennsylvania Medicare Education and Decision Insight to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Pennsylvania Medicare Education and Decision Insight at 1-800-783-7067. Learn more about Pennsylvania Medicare Education and Decision Insight by visiting www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx.

Section 5.3 Get Help from Medicare

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

You can chat live at 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

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 or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

