2026 Summary of Benefits

Jefferson Health Plans (H9207)

Jefferson Health Plans Special (HMO D-SNP) (plan 004)

Jefferson Health Plans Dual Pearl (HMO D-SNP) (plan 016)

Jefferson Health Plans Select (HMO D-SNP) (plan 017)

This is a summary of drug and medical services covered by Jefferson Health Plans Special and Jefferson Health Plans Dual Pearl and Jefferson Health Plans Select for the plan year January 1, 2026 - December 31, 2026.

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 the services we cover, please see the *Evidence of Coverage*. View it online at www.JeffersonHealthPlans.com/medicare or get a copy by calling Member Relations at 1-866-901-8000 (TTY 1-877-454-8477). From **October 1 to March 31**, we're available 8 a.m. to 8 p.m., 7 days a week. And from **April 1 to September 30**, we're available 8 a.m. to 8 p.m., Monday to Friday. **This call is free**.

This information is available for free in other languages. This document is available in other formats such as braille and large print. Please call Member Relations at 1-866-901-8000 (TTY 1-877-454-8477).

Jefferson Health Plans has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services.

For information about prescription drugs covered, please see the plan's *Formulary*. For information about providers and pharmacies in our network, see our *Provider & Pharmacy Directory*. These documents are available at www.JeffersonHealthPlans.com/medicare or by calling the plan at 1-866-901-8000 (TTY 1-877-454-8477).

To join Jefferson Health Plans Special you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for Medical Assistance (QMB+, SLMB+ or FBDE categories) from the Pennsylvania Department of Human Services and live in our service area.

To join Jefferson Health Plans Dual Pearl you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for Medical Assistance (QMB, QMB+, SLMB+ or FBDE categories) from the Pennsylvania Department of Human Services and live in our service area.

To join Jefferson Health Plans Select you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for Medical Assistance (QMB, QMB+, SLMB+ or FBDE categories) from the Pennsylvania Department of Human Services and live in our service area.

Our service area for Jefferson Health Plans Special (004) includes the following counties in Pennsylvania: Adams, Allegheny, Beaver, Berks, Bradford, Bucks, Carbon, Chester, Clarion, Crawford, Cumberland, Dauphin, Delaware, Erie, Forest, Franklin, Lancaster, Lebanon, Lehigh, Monroe, Montgomery, Northampton, Perry, Philadelphia, Schuylkill, Warren, Washington, York counties.

Our service area for Jefferson Health Plans Dual Pearl (016) includes the following counties in Pennsylvania: Philadelphia, Bucks, Montgomery, Chester, Delaware, Adams, Franklin, Lancaster, York, Cumberland, Dauphin, Lebanon, Perry, Carbon, Lehigh, Monroe, Northampton, Schuylkill, Berks, Bradford, Allegheny, Erie counties.

Our service area for Jefferson Health Plans Select (017) includes the following counties in Pennsylvania: Adams, Berks, Bradford, Bucks, Carbon, Chester, Cumberland, Dauphin, Delaware, Franklin, Lancaster, Lebanon, Lehigh, Monroe, Montgomery, Northampton, Perry, Philadelphia, Schuylkill, York counties.

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 www.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.

Jefferson Health Plans contracts with Medicare to offer HMO, HMO-DSNP, and PPO plans. Our HMO-DSNP also has a contract with the Pennsylvania State Medicaid program. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call 1-833-477-4773 for more information. From **October 1 to March 31**, we're available 8 a.m. to 8 p.m., 7 days a week. And from **April 1 to September 30**, we're available 8 a.m. to 8 p.m., Monday to Friday.

Premiums and prescription drug copayments, coinsurance, and deductibles may vary based on your eligibility for "Extra Help." Please contact the plan for further details.

Important: Enrollment in Jefferson Health Plans Special is limited to Medicare beneficiaries who also are eligible for Medicaid categories QMB+, SLMB+ or FBDE. Cost-sharing amounts for medical services in the following benefit chart assume active eligibility. Should you lose Medicaid eligibility and choose to remain in the Special plan for up to six months while attempting to regain eligibility, Medicaid will not pay your Medicare cost-sharing and you will be responsible for these amounts. In this case, your cost-sharing will be no more than 20%-30% coinsurance for most benefits. For additional information about cost-sharing during this period, please see the plan's Evidence of Coverage.

Enrollment in Jefferson Health Plans Dual Pearl Plan is limited to Medicare beneficiaries who also are eligible for Medicaid categories QMB, QMB+, SLMB+ or FBDE. Cost-sharing amounts for medical services in the following benefit chart assume active eligibility. Should you lose Medicaid eligibility and choose to remain in the Dual Pearl Plan for up to six months while attempting to regain eligibility, you will be responsible for paying the cost sharing amount. In this case, your cost-sharing will be no more than 20%-30% coinsurance for most benefits. For additional information about cost-sharing during this period, please see the plan's Evidence of Coverage.

Enrollment in Jefferson Health Plans Select Plan is limited to Medicare beneficiaries who also are eligible for Medicaid categories QMB, QMB+, SLMB+ or FBDE. Cost-sharing amounts for medical services in the following benefit chart assume active eligibility. Should you lose Medicaid eligibility and choose to remain in the Select Plan for up to six months while attempting to regain eligibility, you will be responsible for paying the cost sharing amount. In this case, your cost-sharing will be no more than 20%-30% coinsurance for most benefits. For additional information about cost-sharing during this period, please see the plan's Evidence of Coverage.

Even if you are otherwise eligible for 0% cost-sharing, remember that you generally must obtain services only from Jefferson Health Plans providers who also participate in the Medical Assistance program; if not, Medical Assistance may not pay the provider and you will be responsible for the higher cost-sharing amount.

Please contact the Medical Assistance program for additional information about your level of cost-sharing.

Prescription Drug Coverage Note:

Members in the above Medicaid categories are automatically deemed to have eligibility for Medicare's Low Income Subsidy, also known as "Extra Help." The cost-sharing for prescription drugs in this Summary of Benefits assumes this eligibility.

Should you lose "Extra Help" and choose to remain in the Special, Select or Dual Pearl plan, your costs will change. For additional information about cost-sharing in this situation, please call the plan.

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	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Monthly plan premium	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $32.70. You also must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $32.70. You also must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $32.70. You also must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.
Deductible	The Part B deductible is $0. Note: If you lose Medicaid eligibility, you can remain in the plan for up to six months, but will be responsible for a Part B deductible of $257. There is a $0 deductible for prescription drugs while you receive "Extra Help." If you lose eligibility for "Extra Help," you may be responsible for up to a $615 deductible.	The Part B deductible is $0. Note: If you lose Medicaid eligibility, you can remain in the plan for up to six months, but will be responsible for a Part B deductible of $257. There is a $0 deductible for prescription drugs while you receive "Extra Help." If you lose eligibility for "Extra Help," you may be responsible for up to a $615 deductible.	The Part B deductible is $0. Note: If you lose Medicaid eligibility, you can remain in the plan for up to six months, but will be responsible for a Part B deductible of $257. There is a $0 deductible for prescription drugs while you receive "Extra Help." If you lose eligibility for "Extra Help," you may be responsible for up to a $615 deductible.
Maximum out-of-pocket amount responsibility *(does not include prescription drugs)*	$9,250 annually The most you pay for copay, coinsurance and other costs for medical services for the year.	$9,250 annually The most you pay for copay, coinsurance and other costs for medical services for the year.	$9,250 annually The most you pay for copay, coinsurance and other costs for medical services for the year.

	Jefferson Health Plans Special		Jefferson Health Plans Dual Pearl		Jefferson Health Plans Select	
Outpatient Prescription Drugs (Part D)						
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Mail order cost-sharing (up to a 100-day supply)**	**Standard retail cost-sharing (in-network) (up to a 30-day supply)**	**Mail order cost-sharing (up to a 100-day supply)**	**Standard retail cost-sharing (in-network) (up to a 30-day supply)**	**Mail order cost-sharing (up to a 100-day supply)**
Deductible	There is a $615 deductible on tiers 2, 3, 4, and 5 for 2026. Deductible applies to Select and Dual Pearl plans only.					
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay	25% coinsurance	25% coinsurance
Tier 2 Generic	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance
Tier 3 Preferred Brand **Select Insulins (all covered insulins in tiers 3, 4 and 5)**	24% coinsurance $35 copay	24% coinsurance $105 copay	24% coinsurance $35 copay	24% coinsurance $105 copay	25% coinsurance $35 copay	25% coinsurance $105 copay
Tier 4 Non-Preferred Drug **Select Insulins (all covered insulins in tiers 3, 4 and 5)**	28% coinsurance $35 copay	28% coinsurance $105 copay	28% coinsurance $35 copay	28% coinsurance $105 copay	25% coinsurance $35 copay	25% coinsurance $105 copay
Tier 5 Specialty **Select Insulins (all covered insulins in**	25% coinsurance $35 copay	A long-term supply is not available for Specialty drugs.	25% coinsurance $35 copay	A long-term supply is not available for Specialty drugs.	25% coinsurance $35 copay	A long-term supply is not available for Specialty drugs.

	Jefferson Health Plans Special		Jefferson Health Plans Dual Pearl		Jefferson Health Plans Select	
Outpatient Prescription Drugs (Part D)						
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Mail order cost-sharing (up to a 100-day supply)**	**Standard retail cost-sharing (in-network) (up to a 30-day supply)**	**Mail order cost-sharing (up to a 100-day supply)**	**Standard retail cost-sharing (in-network) (up to a 30-day supply)**	**Mail order cost-sharing (up to a 100-day supply)**
tiers 3, 4 and 5)						
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Outpatient Prescription Drugs (Part D)			
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Outpatient Prescription Drugs (Part D)			
Long-term care pharmacy and out-of-network pharmacy coverage	Your costs for a 30-day supply at an out-of-network pharmacy or a 31-day supply from a long-term care pharmacy are the same as those for a 30-day supply at a standard retail pharmacy, as shown above. Extended supplies are not available from out-of-network or long-term care pharmacies. For more information, please see the plan's *Evidence of Coverage* at www.JeffersonHealthPlans.com/medicare or call us at 1-866-901-8000 (TTY 1-877-454-8477).	Your costs for a 30-day supply at an out-of-network pharmacy or a 31-day supply from a long-term care pharmacy are the same as those for a 30-day supply at a standard retail pharmacy, as shown above. Extended supplies are not available from out-of-network or long-term care pharmacies. For more information, please see the plan's *Evidence of Coverage* at www.JeffersonHealthPlans.com/medicare or call us at 1-866-901-8000 (TTY 1-877-454-8477).	Your costs for a 30-day supply at an out-of-network pharmacy or a 31-day supply from a long-term care pharmacy are the same as those for a 30-day supply at a standard retail pharmacy, as shown above. Extended supplies are not available from out-of-network or long-term care pharmacies. For more information, please see the plan's *Evidence of Coverage* at www.JeffersonHealthPlans.com/medicare or call us at 1-866-901-8000 (TTY 1-877-454-8477).

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Inpatient hospital coverage★	For each hospital admission/stay you pay: • $0 deductible; • $0 copay/coinsurance each day for days 1 - 60 • $0 copay/coinsurance each day for days 61 - 90 • $0 copay/coinsurance each day for days 91+ Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $0 deductible; • $0 copay/coinsurance each day for days 1 - 60 • $0 copay/coinsurance each day for days 61 - 90 • $0 copay/coinsurance each day for days 91+ Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $0 deductible; • $0 copay/coinsurance each day for days 1 - 60 • $0 copay/coinsurance each day for days 61 - 90 • $0 copay/coinsurance each day for days 91+ Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.
Outpatient hospital coverage			
Outpatient hospital visits☆	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Outpatient hospital observation services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Ambulatory surgical center (ASC) services			
Services provided at an ambulatory surgical center★	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Doctor visits			
Primary Care Provider	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Specialists	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Medicare-covered preventive care			
Annual Wellness Exam	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Barium Enemas	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Diabetes Self-management Training	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Digital Rectal Exams	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
EKG Following Preventive Services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Glaucoma Screening	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Other Medicare-covered Preventive Services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Emergency care	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Urgently needed services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Diagnostic services/labs/ imaging			
Diagnostic tests and procedures★ Lab services Advanced radiology services (such as MRI, PET, CT and nuclear medicine)★ Outpatient diagnostic imaging tests (such as x-rays, ultrasound and mammography)☆ Therapeutic radiology (such as radiation treatment for cancer)★	$0 copay/coinsurance for diagnostic services/labs/ imaging	$0 copay/coinsurance for diagnostic services/labs/ imaging	$0 copay/coinsurance for diagnostic services/labs/ imaging

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Hearing services			
Medicare-covered hearing exam	$0 copay/coinsurance for Medicare-covered exam (limited to one every year)	$0 copay/coinsurance for Medicare-covered exam (limited to one every year)	$0 copay/coinsurance for Medicare-covered exam (limited to one every year)
Routine hearing exam	$0 copay/coinsurance for routine hearing exam (limited to one every year)	$0 copay/coinsurance for routine hearing exam (limited to one every year)	$0 copay/coinsurance for routine hearing exam (limited to one every year)
Hearing aids	$0 - $1,475 copayment for hearing aids, limited to every 2 years (both ears combined). Minimum copayment applies to entry-level hearing aids, while the maximum copay applies to premium-level options.	$0 - $1,475 copayment for hearing aids, limited to every 2 years (both ears combined). Minimum copayment applies to entry-level hearing aids, while the maximum copay applies to premium-level options.	See Flexible Spending Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items
Dental Services			
Preventive dental services	You pay $0 copay/ coinsuance for 3 exams and cleanings per year. x-rays covered (limits apply).	You pay $0 copay/ coinsuance for 3 exams and cleanings per year. x-rays covered (limits apply).	You pay $0 copay/ coinsuance for 3 exams and cleanings per year. x-rays covered (limits apply).
Medicare-covered dental services★	$0 copay/coinsuance for Medicare-covered dental services	$0 copay/coinsuance for Medicare-covered dental services	$0 copay/coinsuance for Medicare-covered dental services
Supplemental comprehensive dental services★	Supplemental comprehensive dental services coverage (up to a maximum of $5,000 per year) includes: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery	Supplemental comprehensive dental services coverage (up to a maximum of $10,000 per year) includes: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery	See Flexible Spending Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Vision care			
Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery • Routine eye exam	$0 copay/coinsurance for Medicare-covered services $0 copay/coinsurance for Medicare-covered eyewear $0 copay/coinsurance for routine eye exam (limited to one every year)	$0 copay/coinsurance for Medicare-covered services $0 copay/coinsurance for Medicare-covered eyewear $0 copay/coinsurance for routine eye exam (limited to one every year)	$0 copay/coinsurance for Medicare-covered services $0 copay/coinsurance for routine eye exam (limited to one every year)
Supplemental eyeglasses (frame and lenses) or contact lenses	$0 copay/coinsurance for your choice of one of the following, up to $0 - $250 yearly: - one pair of eyeglasses (lenses and frames) - contact lenses up to the allowance	$0 copay/coinsurance for your choice of one of the following, up to $0 - $200 yearly: - one pair of eyeglasses (lenses and frames) - contact lenses up to the allowance	See Flexible Spending Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Mental health services			
Inpatient services in a psychiatric hospital★	For each hospital admission/stay you pay: • $0 deductible • $0 copay/coinsurance per day for days 1 - 60 • $0 copay/coinsurance per day for days 61 - 90 • $0 copay/coinsurance per day for days 91+ (lifetime reserve days) Our plan covers up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plan also covers 60 "lifetime reserve days." If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $0 deductible • $0 copay/coinsurance per day for days 1 - 60 • $0 copay/coinsurance per day for days 61 - 90 • $0 copay/coinsurance per day for days 91+ (lifetime reserve days) Our plan covers up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plan also covers 60 "lifetime reserve days." If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $0 deductible • $0 copay/coinsurance per day for days 1 - 60 • $0 copay/coinsurance per day for days 61 - 90 • $0 copay/coinsurance per day for days 91+ (lifetime reserve days) Our plan covers up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plan also covers 60 "lifetime reserve days." If your hospital stay is longer than 90 days, you can use these extra days.
Outpatient group therapy visit☆	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Outpatient individual therapy visit☆	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Psychiatric services☆	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Partial hospitalization★	$0 copay/coinsurance per day	$0 copay/coinsurance per day	$0 copay/coinsurance per day

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Skilled nursing facility★	Days 1 - 20 : $0 copay/ coinsurance per day Days 21 - 100 : $218 copay/coinsurance each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)	Days 1 - 20 : $0 copay/ coinsurance per day Days 21 - 100 : $218 copay/coinsurance each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)	Days 1 - 20 : $0 copay/ coinsurance per day Days 21 - 100 : $218 copay/coinsurance each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)
Physical/occupational/ speech & language therapy★	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Ambulance services Ground Ambulance☆ Air ambulance★	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Transportation (routine) Transportation is covered using taxi, rideshare services, van or medical transport. Members are required to coordinate trips with Jefferson Health Plans's vendor at least two business days in advance. Mileage restrictions apply. See Evidence of Coverage for full details and restrictions related to benefit.	$0 copay/coinsurance for 65 one-way trips each year to plan-approved, health-related locations.	$0 copay/coinsurance for 25 one-way trips each year to plan-approved, health-related locations.	Not Covered

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Medicare Part B prescription drugs Chemotherapy drugs★ Other Part B drugs☆	0% copay/coinsurance **Note:** Step therapy may apply for other Part B drugs.	0% copay/coinsurance **Note:** Step therapy may apply for other Part B drugs.	0% copay/coinsurance **Note:** Step therapy may apply for other Part B drugs.
Acupuncture for chronic low back pain Medicare-covered acupuncture for chronic low back pain	$0 copay/coinsurance for each Medicare- covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions.	$0 copay/coinsurance for each Medicare- covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions.	$0 copay/coinsurance for each Medicare- covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions.
Supplemental acupuncture services	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year
Cardiac rehabilitation services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Chiropractic services★ Medicare-covered services include: Manual manipulation of the spine to correct subluxation	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Diabetic supplies☆ Members will be responsible for 20% coinsurance for non-preferred diabetic monitoring supplies if they do not provide their Medicaid or Community HealthChoices card at the pharmacy.	$0 copay/coinsurance for diabetic monitoring supplies from preferred manufacturers 20% copay/coinsurance for all other Part B diabetic supplies	$0 copay/coinsurance for diabetic monitoring supplies from preferred manufacturers 20% copay/coinsurance for all other Part B diabetic supplies	$0 copay/coinsurance for diabetic monitoring supplies from preferred manufacturers 20% copay/coinsurance for all other Part B diabetic supplies

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Durable medical equipment (DME) and related supplies☆	0% copay/coinsurance	0% copay/coinsurance	0% copay/coinsurance
Fitness program	$0 copay/coinsurance for SilverSneakers® membership or membership to the Salvation Army Kroc Center of Philadelphia and PASSi Evergreen Center.	$0 copay/coinsurance for SilverSneakers® membership or membership to the Salvation Army Kroc Center of Philadelphia and PASSi Evergreen Center.	Not Covered
Home health care	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Meal benefit Covers up to four weeks, once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or JHP clinical care coordinator.	$0 copay/coinsurance for up to 28 days per year. Please contact the plan for more details.	$0 copay/coinsurance for up to 28 days per year. Please contact the plan for more details.	$0 copay/coinsurance for up to 28 days per year. Please contact the plan for more details.
Opioid treatment program services	$0 copay/coinsurance for each opioid treatment service	$0 copay/coinsurance for each opioid treatment service	$0 copay/coinsurance for each opioid treatment service
Over-the-counter (OTC) items The benefit period corresponds to the quarters of the calendar year: 1st quarter: Jan. - March 2nd quarter: April - June 3rd quarter: July - Sept. 4th quarter: Oct. - Dec.	$0 copay/coinsurance for up to $250 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.	$0 copay/coinsurance for up to $200 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.	$0 copay/coinsurance for up to $300 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Podiatry services Medicare-covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Foot care for members with certain medical conditions affecting the lower limbs.	$0 copay/coinsurance for Medicare-covered services	$0 copay/coinsurance for Medicare-covered services	$0 copay/coinsurance for Medicare-covered services
Routine foot care, including corn/callus treatment, nail care and other preventive/ maintenance care.	$0 copay/coinsurance for routine foot care (limited to one visit every three months)	$0 copay/coinsurance for routine foot care (limited to one visit every three months)	$0 copay/coinsurance for routine foot care (limited to one visit every three months)
Prosthetics/orthotics★	0% copay/coinsurance	0% copay/coinsurance	0% copay/coinsurance
Pulmonary rehabilitation services	$0 copay/coinsurance	$0 copay/coinsurance	$0 copay/coinsurance
Remote Access Technology (Teladoc®) Members have 24/7/365 access to credentialed doctors by phone or video. This service will not replace the role of the member's PCP and is a convenient option that allows members to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many non-emergent medical issues, including: bronchitis/ sinus problems, allergies, cold and flu symptoms, respiratory infections and ear infections.	$0 copay/coinsurance for Teladoc services.	$0 copay/coinsurance for Teladoc services.	$0 copay/coinsurance for Teladoc services.

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Telehealth You have the option of receiving physician and certain other services either through an in-person visit or via telehealth using electronic audio-video technology. If you choose to receive one of these services via telehealth, then you must use a provider that is set up to provide the service through telehealth.	$0 copay/coinsurance for these telehealth services: PCP services Specialist services Mental health specialty Individual and group sessions Psychiatric service Individual and group sessions Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.	$0 copay/coinsurance for these telehealth services: PCP services Specialist services Mental health specialty Individual and group sessions Psychiatric service Individual and group sessions Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.	$0 copay/coinsurance for these telehealth services: PCP services Specialist services Mental health specialty Individual and group sessions Psychiatric service Individual and group sessions Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.
Telemonitoring An in-home telemonitoring program is covered for members who have congestive heart failure (CHF), hypertension or uncontrolled diabetes. Members will be provided access to clinical support while on the program.	$0 copay/coinsurance for telemonitoring services	$0 copay/coinsurance for telemonitoring services	$0 copay/coinsurance for telemonitoring services
Worldwide emergency/ urgent coverage	$0 copay/coinsurance up to $50,000 maximum per year	$0 copay/coinsurance up to $50,000 maximum per year	$0 copay/coinsurance up to $50,000 maximum per year

	Jefferson Health Plans Special	Jefferson Health Plans Dual Pearl	Jefferson Health Plans Select
Medical Benefits (Part C)			
Special Supplemental Benefits for the Chronically Ill (SSBCI) Members with a qualifying chronic health condition may be eligible for SSBCI benefits and have access to flexible spending card benefit. Qualifying conditions range from chronic alcohol use disorder and other substance use disorders (SUDs), autoimmune disorders, cancer, cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, overweight/obesity/metabolic syndrome, chronic gastrointestinal disease, chronic kidney disease (CKD), severe hematologic disorders, HIV/AIDS, chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, conditions associated with cognitive impairment, and conditions with functional challenges. For requirements on accessing these benefits please see your *Evidence of Coverage* for further details. Jefferson Health Plans offers Special Supplemental Benefit for the Chronically Ill (SSBCI). To be eligible for this SSBCI benefit, you must have at least one of the covered chronic conditions. You must also meet the plan's coverage criteria and be a chronically ill enrollee as defined by Medicare to receive this benefit. Not all members with the listed chronic conditions will be eligible to receive the benefit.			
Flexible Spending Card:	**Flexible Spending Card:** $330 every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only.	**Flexible Spending Card:** $235 every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only.	**Flexible Spending Card:** $700 every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only. All members within plan qualify and have access to (regardless of qualifying chronic condition status): $800 per year (calendar year) toward dental, vision, and hearing related items and services.

Summary of Medicaid-Covered Benefits

To help you better understand your health care options, the following chart describes the costs for certain services as a Pennsylvania Medical Assistance (Medicaid) recipient and as a Jefferson Health Plans Special, Dual Pearl and Select member. To enroll in the Jefferson Health Plan Special, Dual Pearl and Select Plan, you must be a full or partial dual eligible, meaning that you qualify for both Medicare Part A and Part B and also receive full Medicaid benefits.

Medicare cost-sharing includes copayments, coinsurance and deductibles. As a full or partial dual eligible member, your cost-sharing for Medicare Part A and B services is paid for you by the Medicaid program. This is reflected in the tables that follow. (Please see the Evidence of Coverage for details about your cost-sharing responsibility should you lose Medicaid eligibility and remain on this plan, which you may do for up to six months.)

Medicare coverage must be used first. Medicaid will then cover payment of your cost-sharing for Medicare Part A and Part B services.

Medicaid will cover cost-sharing amounts only when your primary care doctor and other providers participate in the Medicaid program. Both our print and online provider directories include information to help you choose network providers who also accept Medicaid. To help avoid errors, always show both your Jefferson Health Plans member card and your Community HealthChoices and/or ACCESS card anytime you receive health care services.

It is important to know that Medicaid benefits and eligibility may change throughout the year. Please contact your Community HealthChoices plan, the Pennsylvania Medicaid program or your County Assistance Office for the most current and accurate information regarding your eligibility and benefits.

The benefits described in the preceding sections of the Summary of Benefits are covered by Jefferson Health Plans Special, Dual Pearl and Select. The benefits described in the following section are covered by Medicaid. For each benefit listed, you can compare what the Medical Assistance program covers and what our plan covers.

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Primary Care visit	No limits	$0 copay/coinsurance for each Medicare-covered primary care visit	$0 copay/coinsurance for each Medicare-covered primary care visit	$0 copay/coinsurance for each Medicare-covered primary care visit
Physician Services and Medical and Surgical Services provided by a Dentist	No limits	$0 copay/coinsurance for each Medicare-covered specialist visit $0 copay/coinsurance for Medicare-covered dental benefits $0 copay/coinsurance for the following preventive dental benefits: • up to 3 oral exams every year • up to 3 cleanings every year • 1 set of dental x-rays every year $5,000 plan coverage limit for supplemental comprehensive dental benefits every year	$0 copay/coinsurance for each Medicare-covered specialist visit $0 copay/coinsurance for Medicare-covered dental benefits $0 copay/coinsurance for the following preventive dental benefits: • up to 3 oral exams every year • up to 3 cleanings every year • 1 set of dental x-rays every year $10,000 plan coverage limit for supplemental comprehensive dental benefits every year	$0 copay/coinsurance for each Medicare-covered specialist visit $0 copay/coinsurance for Medicare-covered dental benefits $0 copay/coinsurance for the following preventive dental benefits: up to 3 oral exams every year up to 3 cleanings every year 1 set of dental x-rays every year
Certified Registered Nurse Practitioner	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Federally Qualified Health Center/Rural Health Clinic	No Limits except for Dental Care Services as described below	$0 copay/coinsurance for each Medicare-covered visit Also see Dental Care Services described below.	$0 copay/coinsurance for each Medicare-covered visit Also see Dental Care Services described below.	$0 copay/coinsurance for each Medicare-covered visit Also see Dental Care Services described below.

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Independent Clinic	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Outpatient Hospital Clinic	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Podiatrist Services	No Limits	$0 copay/coinsurance for each Medicare-covered visit $0 copay/coinsurance for routine foot care visits (limited to one every three months)	$0 copay/coinsurance for each Medicare-covered visit $0 copay/coinsurance for routine foot care visits (limited to one every three months)	$0 copay/coinsurance for each Medicare-covered visit $0 copay/coinsurance for routine foot care visits (limited to one every three months)
Chiropractor Services	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Optometrist Services	2 visits (exams) yearly	$0 copay/coinsurance for each Medicare-covered visit (limited to one yearly) $0 copay/coinsurance for routine exam (limited to one yearly)	$0 copay/coinsurance for each Medicare-covered visit (limited to one yearly) $0 copay/coinsurance for routine exam (limited to one yearly)	$0 copay/coinsurance for each Medicare-covered visit (limited to one yearly) $0 copay/coinsurance for routine exam (limited to one yearly)
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of five consecutive days in a 60-day certification period.	$0 copay/coinsurance (Hospice care is covered by Original Medicare.)	$0 copay/coinsurance (Hospice care is covered by Original Medicare.)	$0 copay/coinsurance (Hospice care is covered by Original Medicare.)
Radiology (including x-ray, MRIs and CTs)	No Limits	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation Key Limitations: Dentures – one upper arch (complete or partial) and one lower arch (complete or partial) per lifetime Denture relines – either full or partial, limited to one arch every two calendar years Oral exams – one every 180 days Dental prophylaxis – one every 180 days Panoramic maxilla or mandible single film is limited to one every five calendar years. Crowns, periodontics and endodontics only with an approved benefit limit exception	$0 copay/coinsurance for each Medicare-covered service $0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limits apply) $5,000 allowance yearly for supplemental comprehensive dental services	$0 copay/coinsurance for each Medicare-covered service $0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limits apply) $10,000 allowance yearly for supplemental comprehensive dental services Two Implants covered per 2 year period	$0 copay/coinsurance for each Medicare-covered service $0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limits apply) See Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services.
Outpatient Hospital Short Procedure Unit (SPU)	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Outpatient Ambulatory Surgical Center (ASC)	No Limits	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Non-Emergency Medical Transport	Only to and from Medicaid-covered services	$0 copay/coinsurance for each Medicare-covered service $0 copay/coinsurance for routine transportation to plan approved, health-related locations 65 one-way trips each year to plan-approved, health-related locations.	$0 copay/coinsurance for each Medicare-covered service $0 copay/coinsurance for routine transportation to plan approved, health-related locations. 25 one-way trips each year to plan-approved, health-related locations.	Not Covered.
Family Planning Clinic, Services and Supplies	No Limits	Not covered	Not covered	Not Covered.
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient yearly. Backup visits to the facility are limited to 75 visits yearly	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Emergency Room	No Limits	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit	$0 copay/coinsurance for each Medicare-covered visit
Ambulance (Emergency)	No Limits	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service	$0 copay/coinsurance for each Medicare-covered service

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Inpatient Acute Hospital or Inpatient Rehab Hospital	No Limits	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 copay/ coinsurance each day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 copay/ coinsurance each day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. The amounts for each inpatient stay are: Days 1–60: $0 deductible Days 61–90: $0 copay/ coinsurance each day $0 copay/coinsurance each day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Inpatient Psychiatric Hospital	No Limits	You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 each day for up to 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 each day for up to 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. The amounts for each inpatient stay are: Days 1–60: $0 deductible Days 61–90: $0 copay/ coinsurance each day $0 each day for up to 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Inpatient Drug & Alcohol	No Limits	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. 190-day lifetime limit applies if stay is in a psychiatric hospital. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 copay/ coinsurance each day for 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. 190-day lifetime limit applies if stay is in a psychiatric hospital. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 copay/ coinsurance each day • $0 copay/ coinsurance each day for 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. 190-day lifetime limit applies if stay is in a psychiatric hospital. The amounts for each inpatient stay are: Days 1–60: $0 deductible Days 61–90: $0 copay/ coinsurance each day $0 copay/coinsurance each day for 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Maternity (Physician, Certified Nurse Midwives, Birth Centers)	No Limits	$0 copay/coinsurance for each Medicare-covered physician and certified nurse midwife service; birth centers not covered	$0 copay/coinsurance for each Medicare-covered physician and certified nurse midwife service; birth centers not covered	$0 copay/coinsurance for each Medicare-covered physician and certified nurse midwife service; birth centers not covered

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Mental Health and Substance Abuse (Behavioral Health) including: **Outpatient Psychiatric Clinic, Mobile Mental Health Treatment, Outpatient Drug and Alcohol Treatment, Methadone Maintenance, Clozapine, Psychiatric Partial Hospital, Peer Support, Crisis, and Targeted Case Management.**	No limits except: Targeted case management for behavioral health only is limited to individual with serious mental illness. Targeted case management for other than behavioral health is limited to individuals identified in the target group.	$0 copay/coinsurance for each Medicare-covered individual therapy visit $0 copay/coinsurance for each Medicare-covered group therapy visit Also see Prescription Drugs coverage below.	$0 copay/coinsurance for each Medicare-covered individual therapy visit $0 copay/coinsurance for each Medicare-covered group therapy visit Also see Prescription Drugs coverage below.	$0 copay/coinsurance for each Medicare-covered individual therapy visit $0 copay/coinsurance for each Medicare-covered group therapy visit Also see Prescription Drugs coverage below.
Prescription Drugs	No Limits	For more detail on Part D prescription drugs, see your Evidence of Coverage and the included prescription drug costs chart previously listed in document.	For more detail on Part D prescription drugs, see your Evidence of Coverage and the included prescription drug costs chart previously listed in document.	For more detail on Part D prescription drugs, see your Evidence of Coverage and the included prescription drug costs chart previously listed in document.
Nutritional Supplements	No Limits	$0 copay/coinsurance when obtained through the plan's Over-the-Counter benefit. $250 quarterly allowance applies.	$0 copay/coinsurance when obtained through the plan's Over-the-Counter benefit. $200 quarterly allowance applies.	$0 copay/coinsurance when obtained through the plan's Over-the-Counter benefit. $300 quarterly allowance applies.

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Skilled Nursing Facility	365 days covered yearly	Plan covers up to 100 days each benefit period No prior hospital stay is required. The amounts for each inpatient stay are: • Days 1–20: $0 copay/ coinsurance each day • Days 21–100: $0 copay/ coinsurance each day	Plan covers up to 100 days each benefit period No prior hospital stay is required. The amounts for each inpatient stay are: • Days 1–20: $0 copay/ coinsurance each day • Days 21–100: $0 copay/ coinsurance each day	Plan covers up to 100 days each benefit period No prior hospital stay is required. The amounts for each inpatient stay are: • Days 1–20: $0 copay/ coinsurance each day • Days 21–100: $0 copay/ coinsurance each day
Home Health Care (includes nursing, nurse aide and therapy services)	Unlimited for first 28 days. Limited to 15 days every month thereafter.	$0 copay/coinsurance for Medicare-covered home health visits	$0 copay/coinsurance for Medicare-covered home health visits	$0 copay/coinsurance for Medicare-covered home health visits
Intermediate Care Facility (ICF/IID and ICF/ORC)	No limits but requires an institutional level of care.	Not covered	Not covered	Not Covered
Durable Medical Equipment	No limits	$0 copay/coinsurance for Medicare-covered durable medical equipment	$0 copay/coinsurance for Medicare-covered durable medical equipment	$0 copay/coinsurance for Medicare-covered durable medical equipment

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Prosthetics and Orthotics	Orthopedic shoes and hearing aids are not covered. Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications. Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint. Coverage for low vision aids and eye prostheses is limited to one every two years. Coverage for an eye ocular is limited to one yearly.	$0 - $1,475 copay for hearing aids. The minimum copay applies to entry-level hearing aids from a specific vendor, while the maximum copay applies to premium-level options. $0 copay/coinsurance for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts $0 copay/coinsurance for other Medicare-covered items Low vision aids not covered	$0 - $1,475 copay for hearing aids. The minimum copay applies to entry-level hearing aids from a specific vendor, while the maximum copay applies to premium-level options. $0 copay/coinsurance for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts $0 copay/coinsurance for other Medicare-covered items Low vision aids not covered	See Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services. $0 copay/coinsurance for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts $0 copay/coinsurance for other Medicare-covered items Low vision aids not covered

Summary of Medicaid-Covered Benefits Adult Benefit Package				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Eyeglasses and Contact Lenses	Eyeglasses limited to 4 lenses and 2 frames yearly for individuals diagnosed with aphakia. Deluxe frames not included Contact lenses limited to 4 lenses yearly for individuals diagnosed with aphakia.	$0 copay/coinsurance for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery $0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to $250 yearly): - one pair of eyeglasses (lenses and frames) - contact lenses	$0 copay/coinsurance for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery $0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to $200 yearly): - one pair of eyeglasses (lenses and frames) - contact lenses	See Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services.
Medical Supplies	No limits	$0 copay/coinsurance for Medicare-covered medical supplies	$0 copay/coinsurance for Medicare-covered medical supplies	$0 copay/coinsurance for Medicare-covered medical supplies
Therapy (Physical, Occupational, Speech)	Covered only when provided by a hospital, outpatient clinic or home health provider	$0 copay/coinsurance for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits	$0 copay/coinsurance for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits	$0 copay/coinsurance for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits
Laboratory Services	No limits	$0 copay/coinsurance for Medicare-covered lab services	$0 copay/coinsurance for Medicare-covered lab services	$0 copay/coinsurance for Medicare-covered lab services
Tobacco Cessation	70 15-minute units covered yearly	Two counseling quit attempts covered yearly	Two counseling quit attempts covered yearly	Two counseling quit attempts covered yearly

Summary of Medicaid-Covered Benefits Home and Community-Based Services				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Adult Daily Living Services **Assistive Technology** **Behavior Therapy** **Benefits Counseling** **Career Assessment** **Chore Services** **Cognitive Rehabilitation Therapy** **Community Integration** **Community Transition Services** **Counseling** **Employment Skills Development** **Home Adaptations** **Home Delivered Meals** **Home Health Aide** **Home Health – Nursing** **Home Health – Occupational Therapy** **Home Health – Physical Therapy** **Home Health – Speech and Language Therapy**	Under Community Integration: Each distinct goal may not be more than 26 weeks. No more than 32 units a week for one goal will be approved. If the participant has multiple goals, no more than 48 units a week will be approved. (The Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week. Up to 21 hours a week and periods longer than 26 weeks may be authorized.) Community Transition Services are limited to a combined $4,000 per participant, per lifetime, as preauthorized by the State Medicaid Agency program office.	Home Delivered Meals covered up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or JHP clinical care coordinator. See Adult Benefit Package section above for coverage information about these benefits: • Home Health Care • Non-Emergency Medical Transport • Durable Medical Equipment • Medical Supplies Other services listed are not covered.	Home Delivered Meals covered up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or JHP clinical care coordinator. See Adult Benefit Package section above for coverage information about these benefits: • Home Health Care • Non-Emergency Medical Transport • Durable Medical Equipment • Medical Supplies Other services listed are not covered.	Not Covered

Summary of Medicaid-Covered Benefits Home and Community-Based Services				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Job Coaching **Job Finding** **Non-Medical Transportation** **Nutritional Counseling** **Participant- Directed Community Supports** **Participant- Directed Goods and Services** **Personal Assistance Services** **Personal Emergency Response System** **Pest Eradication** **Residential Habilitation** **Respite** **Service Coordination** **Specialized Medical Equipment and Supplies**	Total combined hours for Employment Skills Development or Job Coaching services are limited to 50 hours in a calendar week. Prior approval is required to exceed this limit. Under Specialized Medical Equipment and Supplies, non-covered items include: All prescription and over-the- counter medications, compounds and solutions (except wipes and barrier cream). Items covered under third party payer liability.			

Summary of Medicaid-Covered Benefits Home and Community-Based Services				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Structured Day Habilitation **TeleCare** **Vehicle Modifications**	Items that do not provide direct medical or remedial benefit and/or are not directly related to a participant's disability. Food, food supplements, food substitutes (including formulas) and thickening agents. Eyeglasses, frames and lenses. Dentures. Any item that is experimental or has been denied by Medicare and/or Medicaid. Recreational or exercise equipment and adaptive devices for them.			

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Acupuncture	Not covered	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year.	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year.	$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year.
Dental	See Dental Care Services in earlier Adult Benefit Package section for coverage details.	$0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limited to 1 visit every year) $5,000 allowance yearly for supplemental comprehensive dental services	$0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limited to 1 visit every year) $10,000 allowance yearly for supplemental comprehensive dental services Two implants covered per 2 year period	$0 copay/coinsurance for three oral exams and three cleanings yearly $0 copay/coinsurance for x-rays (limited to 1 visit every year) See Flex Spending Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services.
Fitness	Not covered	$0 copay/coinsurance for SilverSneakers® fitness program membership	$0 copay/coinsurance for SilverSneakers® fitness program membership	Not Covered

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Flexible Spending Card	Covered through the Supplemental Nutrition Assistance Program (SNAP) if eligible	For eligible members **Flexible Spending Card:** $330 per quarter every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only.	For eligible members **Flexible Spending Card:** $235 per quarter every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only.	For eligible members **Flexible Spending Card:** $700 per quarter every calendar quarter toward covered utilities, produce and other food items. Must be used for items for the member only. $800 per year (calendar year) toward dental, vision, and hearing related items and services.
Hearing	Not covered	$0 copay/coinsurance for one routine hearing exam yearly $0 - $1,475 copayment. The minimum copay applies to entry-level hearing aids from a specific vendor, while the maximum copay applies to premium-level options. Please see Evidence of Coverage for further details.	$0 copay/coinsurance for one routine hearing exam yearly $0 - $1,475 copayment. The minimum copay applies to entry-level hearing aids from a specific vendor, while the maximum copay applies to premium-level options. Please see *Evidence of Coverage* for further details.	$0 copay/coinsurance for one routine hearing exam yearly See Flex Spending Card benefit (above) for yearly allowance that can be used for dental, vision, and hearing related items and services.

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Meals	Not covered	$0 copay/coinsurance for home-delivered meals for up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or JHP clinical care coordinator.	$0 copay/coinsurance for home-delivered meals for up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or JHP clinical care coordinator.	Not Covered
Podiatry (Routine)	No limits	$0 copay/coinsurance for each visit (limited to one visit every three months)	$0 copay/coinsurance for each visit (limited to one visit every three months)	$0 copay/coinsurance for each visit (limited to one visit every three months)
Over-the-Counter Items	Not covered	$250 quarterly allowance (unused amounts cannot be carried over from one calendar quarter to another)	$200 quarterly allowance (unused amounts cannot be carried over from one calendar quarter to another)	$300 quarterly allowance (unused amounts cannot be carried over from one calendar quarter to another)
Transportation (Routine)	Available through Medical Assistance Transportation Program	$0 copay/coinsurance for 65 one-way trips each year to plan-approved, health-related locations.	$0 copay/coinsurance for 25 one-way trips each year to plan-approved, health-related locations.	Not Covered

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)				
Benefit Category	**Medicaid**	**Jefferson Health Plans Special (HMO D-SNP) In-Network**	**Jefferson Health Plans Dual Pearl (HMO D-SNP) In-Network**	**Jefferson Health Plans Select (HMO D-SNP) In-Network**
Vision Care	Two exams covered yearly Eyeglasses and contacts limited to individuals diagnosed with aphakia (up to two frames and four lenses or four contact lenses yearly)	$0 copay/coinsurance for one routine exam yearly $0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to $250 yearly): • One pair of eyeglasses (lenses and frames) • Contact lenses	$0 copay/coinsurance for one routine exam yearly $0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to $200 yearly): • One pair of eyeglasses (lenses and frames) • Contact lenses	$0 copay/coinsurance for one routine exam yearly See Flex Spending Card benefit (above) for yearly allowance that can be used for dental, vision, and hearing related items and services.

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 Member Relations at 1-866-901-8000 (TTY 1-877-454-8477).

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 www.JeffersonHealthPlans.com/medicare or call 1-866-901-8000 (TTY 1-877-454-8477) to view a copy of the EOC.
- ☐ Review the *Provider & Pharmacy 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 *Provider & 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, 2026.
- ☐ Except in an emergency or urgent situation, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider & Pharmacy Directory*).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. You must have **full** Medicaid health coverage to enroll.
- ☐ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare 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.

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