

2027 Summary of Benefits

Jefferson Health Plans (H9207)

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

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

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

This is a summary of drug and medical services covered by Jefferson Health Plans Special, Jefferson Health Plans Dual Pearl, and Jefferson Health Plans Select for the plan year January 1, 2027 - December 31, 2027.

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 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 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 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, Armstrong, Beaver, Bedford, Berks, Bradford, Bucks, Butler, Carbon, Chester, Clarion, Crawford, Cumberland, Dauphin, Delaware, Erie, Forest, Franklin, Fulton, Greene, Huntingdon, Lancaster, Lebanon, Lehigh, Luzerne, Monroe, Montgomery, Montour, Northampton, Perry, Philadelphia, Schuylkill, Snyder, Sullivan, Susquehanna, Venango, Warren, Washington, Wayne, Wyoming, and York counties.

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

Premiums, Deductibles, and Limits

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Monthly Plan Premium You 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 \$12.80.	\$0 Note: If your level of “Extra Help” changes, you may be responsible for a monthly premium up to \$12.80.	\$0 Note: If your level of “Extra Help” changes, you may be responsible for a monthly premium up to \$12.80.
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 \$305. 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 \$700 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 \$305. 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 \$700 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 \$305. 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 \$700 deductible.
Maximum Out-of-Pocket Amount <i>(does not include prescription drugs)</i>	\$9,850 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	\$9,850 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	\$9,850 annually The most you pay for copays, coinsurance and other costs for medical services for the year.

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it's on, even if you haven't paid your deductible.

	Jefferson Health Plans Special (004)		Jefferson Health Plans Dual Pearl (016)		Jefferson Health Plans Select (017)	
Stage 1: Deductible	There is a \$700 deductible on tiers 2, 3, 4, and 5 for 2027.		There is a \$700 deductible on tiers 2, 3, 4, and 5 for 2027.		There is a \$700 deductible on tiers 1, 2, 3, 4, and 5 for 2027.	
Stage 2: Initial coverage						
	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)
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	24% coinsurance	24% coinsurance	24% coinsurance	24% coinsurance	25% coinsurance	25% coinsurance
Insulins	\$35 copay	\$105 copay	\$35 copay	\$105 copay	\$35 copay	\$105 copay
Tier 4: Non-Preferred Drug	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance	26% coinsurance	26% coinsurance
Insulins	\$35 copay	\$105 copay	\$35 copay	\$105 copay	\$35 copay	\$105 copay
Tier 5: Specialty Drugs	25% coinsurance	A long-term supply is not available for Specialty drugs.	25% coinsurance	A long-term supply is not available for Specialty drugs.	25% coinsurance	A long-term supply is not available for Specialty drugs.
Tier 6: Select Care Drugs	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,400, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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 877-454-8477).

Part C Benefits

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Hospital			
Inpatient hospital coverage[★]	For each hospital admission/stay you pay \$0. 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. 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. 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 surgery [☆] Observation services	 \$0 copay \$0 copay per stay	 \$0 copay \$0 copay per stay	 \$0 copay \$0 copay per stay
Ambulatory surgery center[★]	\$0 copay	\$0 copay	\$0 copay
Doctor Visits and Preventive Care			
Doctor visits Primary care provider Specialist	 \$0 copay \$0 copay	 \$0 copay \$0 copay	 \$0 copay \$0 copay
Preventive care Annual Physical Visit Annual Wellness Visit Barium Enemas	 \$0 copay \$0 copay \$0 copay	 \$0 copay \$0 copay \$0 copay	 \$0 copay \$0 copay \$0 copay
★ Prior authorization is required. ☆ Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Diabetes Self-management Training	\$0 copay	\$0 copay	\$0 copay
Digital Rectal Exams	\$0 copay	\$0 copay	\$0 copay
EKG Following Preventive Services	\$0 copay	\$0 copay	\$0 copay
Glaucoma Screening	\$0 copay	\$0 copay	\$0 copay
Other Medicare-covered Preventive Services	\$0 copay	\$0 copay	\$0 copay
Emergency and Urgent Care			
Emergency care	\$0 copay for each Medicare-covered emergency room visit.	\$0 copay for each Medicare-covered emergency room visit.	\$0 copay for each Medicare-covered emergency room visit.
Urgently needed services	\$0 copay for each Medicare-covered urgent care visit.	\$0 copay for each Medicare-covered urgent care visit.	\$0 copay for each Medicare-covered urgent care visit.
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs			
Diagnostic services/labs/imaging			
Diagnostic radiology services (e.g. MRI, CT, PET)★	\$0 copay	\$0 copay	\$0 copay
Lab services★	\$0 copay	\$0 copay	\$0 copay
Diagnostic tests and procedures★	\$0 copay	\$0 copay	\$0 copay
Outpatient X-rays★	\$0 copay	\$0 copay	\$0 copay
Therapeutic radiology★	\$0 copay	\$0 copay	\$0 copay
Hearing / Dental / Vision			
Hearing services			
Diagnostic exam	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services
Routine hearing exam	\$0 copay for routine hearing exams (limited to 1 visit every year)	\$0 copay for routine hearing exams (limited to 1 visit every year)	\$0 copay for routine hearing exams (limited to 1 visit every year)
★ Prior authorization is required. ☆ Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Hearing aids	\$0 - \$1,475 copay for hearing aids, limited to every year (both ears combined). Minimum copay applies to entry-level hearing aids, while the maximum copay applies to premium-level options.	\$0 - \$1,475 copay for hearing aids, limited to every year (both ears combined). Minimum copay applies to entry-level hearing aids, while the maximum copay applies to premium-level options.	See Supplemental Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items
Dental services Preventive dental services Medicare-covered dental services [☆] Supplemental comprehensive dental services [★]	You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply). \$0 copay for Medicare-covered dental services Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays \$5,000 every year towards supplemental comprehensive dental services	You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply). \$0 copay for Medicare-covered dental services Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery • Implant services The plan pays \$4,000 every year towards supplemental comprehensive dental services	You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply). \$0 copay for Medicare-covered dental services See Supplemental Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items
Vision services Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services
[★] Prior authorization is required. [☆] Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Eyewear after cataract surgery			
Routine eye exam (Non-Medicare)	\$0 copay for routine eye exams (limited to 1 visit every year)	\$0 copay for routine eye exams (limited to 1 visit every year)	\$0 copay for routine eye exams (limited to 1 visit every year)
Routine eyewear (Non-Medicare)	You pay a \$0 copay for your choice of one of the following, up to \$250 every year: - One pair of eyeglasses (lenses and frames) - Contact lenses	You pay a \$0 copay for your choice of one of the following, up to \$200 every year: - One pair of eyeglasses (lenses and frames) - Contact lenses	See Supplemental Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items
Mental Health Services			
Inpatient visits[★]	For each hospital admission/stay you pay \$0 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.” 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 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.” 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 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.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.
Outpatient visits[☆]			
Individual and group therapy	\$0 copay	\$0 copay	\$0 copay
Individual and group psychiatric services	\$0 copay	\$0 copay	\$0 copay
[★] Prior authorization is required. [☆] Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Skilled Nursing Facility (SNF)			
Skilled nursing facility *	\$0 copay per day for days 1 through 20 \$0 copay per day for days 21 through 100 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.)	\$0 copay per day for days 1 through 20 \$0 copay per day for days 21 through 100 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.)	\$0 copay per day for days 1 through 20 \$0 copay per day for days 21 through 100 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.)
Outpatient Rehabilitation Services			
Therapy *			
Occupational Therapy	\$0 copay	\$0 copay	\$0 copay
Physical, Speech and language therapy	\$0 copay	\$0 copay	\$0 copay
Medical Transportation			
Ambulance			
Ground [☆]	\$0 copay	\$0 copay	\$0 copay
Air [☆]	\$0 copay	\$0 copay	\$0 copay
Transportation	\$0 copay/coinsurance for 40 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
★ Prior authorization is required. ☆ Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Medicare Part B Drugs			
Medicare Part B drugs			
Chemotherapy drugs★	\$0 copay	\$0 copay	\$0 copay
Other Part B drugs☆	\$0 copay Step therapy may apply	\$0 copay Step therapy may apply	\$0 copay Step therapy may apply
Insulin	\$0 copay You pay no more than \$35 every month	\$0 copay You pay no more than \$35 every month	\$0 copay You pay no more than \$35 every month
★ Prior authorization is required. ☆ Prior authorization may be required.			

Additional Benefits

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Additional Benefits			
Acupuncture			
Medically necessary acupuncture for chronic low back pain	\$0 copay for each medically necessary 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 for each medically necessary 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 for each medically necessary 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 for each supplemental acupuncture visit, limited to 20 visits every year.	\$0 copay for each supplemental acupuncture visit, limited to 20 visits every year.	\$0 copay for each supplemental acupuncture visit, limited to 20 visits every year.
Cardiac rehabilitation services	\$0 copay	\$0 copay	\$0 copay
★ Prior authorization is required. ☆ Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Chiropractic services[★] Medically necessary: Manual manipulation of the spine to correct subluxation	\$0 copay	\$0 copay	\$0 copay
Diabetic supplies[☆]	\$0 copay for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies/monitors	\$0 copay for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies/monitors	\$0 copay for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies/monitors
Durable medical equipment, prosthetic devices and medical supplies[★]	\$0 copay DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores	\$0 copay DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores	\$0 copay DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores
Fitness program	\$0 copay for SilverSneakers [®] membership or membership in the Salvation Army Kroc Center of Philadelphia	\$0 copay for SilverSneakers [®] membership or membership in the Salvation Army Kroc Center of Philadelphia	Not covered
Home health care[★]	\$0 copay	\$0 copay	\$0 copay
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 for up to 28 days per year. Please contact the plan for more details.	\$0 copay for up to 28 days per year. Please contact the plan for more details.	Not covered.
[★] Prior authorization is required. [☆] Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Supplemental Flex Card (SSBCI) Food and utilities allowance will be combined with OTC allowance for those who qualify for SSBCI. For eligible members, this SSBCI benefit is combined with your OTC benefit. To see if you may qualify refer to page 14.	Members are able to receive \$215 every month toward covered utilities, produce and other food items. Must be used for items for the member only.	Members are able to receive \$100 every month toward covered utilities, produce and other food items. Must be used for items for the member only.	Members are able to receive \$315 every month toward covered utilities, produce and other food items. Must be used for items for the member only.
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 for each PCP telehealth service \$0 copay for each specialist telehealth service \$0 copay for each mental health specialty individual session \$0 copay for each psychiatric service individual session 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 for each PCP telehealth service \$0 copay for each specialist telehealth service \$0 copay for each mental health specialty individual session \$0 copay for each psychiatric service individual session 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 for each PCP telehealth service \$0 copay for each specialist telehealth service \$0 copay for each mental health specialty individual session \$0 copay for each psychiatric service individual session 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	\$0 copay for telemonitoring services	\$0 copay for telemonitoring services	\$0 copay for telemonitoring services
★ Prior authorization is required. ☆ Prior authorization may be required.			

	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
(CHF), hypertension or uncontrolled diabetes. Members will be provided access to clinical support while on the program.			
Worldwide emergency/urgent coverage	\$0 copay up to \$50,000 maximum every year	\$0 copay up to \$50,000 maximum every year	\$0 copay up to \$50,000 maximum every year
★ Prior authorization is required. ☆ Prior authorization may be required.			

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 include 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.

Summary of Medicaid-Covered Benefits Adult Benefit Package

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.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
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 each Medicare-covered specialist visit \$0 copay/ coinsurance for Medicare-covered dental benefits	\$0 copay/ coinsurance for each Medicare-covered specialist visit \$0 copay/ coinsurance for Medicare-covered dental benefits

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		\$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 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 \$4,000 plan coverage limit for supplemental comprehensive dental benefits every year	\$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 See Supplemental Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services.
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.
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

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
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 medically necessary visit	\$0 copay/ coinsurance for each medically necessary visit	\$0 copay/ coinsurance for each medically necessary 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
Dental Care Services	Diagnostic, preventive, restorative,	\$0 copay/ coinsurance for each	\$0 copay/ coinsurance for each	\$0 copay/ coinsurance for each

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
	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	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	Medicare-covered service \$0 copay/ coinsurance for three oral exams and three cleanings yearly \$0 copay/ coinsurance for x-rays (limits apply) \$4,000 allowance yearly for supplemental comprehensive dental services Two Implants covered per 2 year period	Medicare-covered service \$0 copay/ coinsurance for three oral exams and three cleanings yearly \$0 copay/ coinsurance for x-rays (limits apply) See Supplemental 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	No Limits	\$0 copay/ coinsurance for	\$0 copay/ coinsurance for	\$0 copay/ coinsurance for

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Surgical Center (ASC)		each Medicare-covered service	each Medicare-covered service	each Medicare-covered service
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 40 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
Inpatient Acute Hospital or	No Limits	Plan covers up to 90 days for each inpatient stay. In	Plan covers up to 90 days for each inpatient stay. In	Plan covers up to 90 days for each inpatient stay. In

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Inpatient Rehab Hospital		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.	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.	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.
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.	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.	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.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		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.	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.	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.
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	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	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

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	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
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.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
Nutritional Supplements	No Limits	\$0 copay/ coinsurance when obtained through the plan's Over-the-Counter benefit. \$215 monthly allowance applies.	\$0 copay/ coinsurance when obtained through the plan's Over-the-Counter benefit. \$100 monthly allowance applies.	\$0 copay/ coinsurance when obtained through the plan's Over-the-Counter benefit. \$315 monthly allowance applies.
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
Prosthetics and Orthotics	Orthopedic shoes and hearing aids are not covered.	\$0 - \$1,475 copay for hearing aids. The minimum copay applies to	\$0 - \$1,475 copay for hearing aids. The minimum copay applies to	See Supplemental Flex Card benefit (below) for yearly allowance that can

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
	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.	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	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	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
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	\$0 copay/ coinsurance for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery \$0 copay/ coinsurance for	\$0 copay/ coinsurance for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery \$0 copay/ coinsurance for	See Supplemental Flex Card benefit (below) for yearly allowance that can be used for dental, vision, and hearing related items and services.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
	individuals diagnosed with aphakia.	supplemental eyewear (your choice of one of the following, up to \$250 yearly): - one pair of eyeglasses (lenses and frames) - contact lenses	supplemental eyewear (your choice of one of the following, up to \$200 yearly): - one pair of eyeglasses (lenses and frames) - contact lenses	
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
Adult Daily Living Services Assistive Technology Behavior Therapy Benefits Counseling Career Assessment	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	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	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	Home Delivered Meals and Routine Transport not covered. See Adult Benefit Package section above for coverage information about these benefits: Home Health Care

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
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 Job Coaching Job Finding Non-Medical Transportation	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. 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	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.	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.	Durable Medical Equipment Medical Supplies Other services listed are not covered.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
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 Structured Day Habilitation TeleCare Vehicle Modifications	solutions (except wipes and barrier cream). Items covered under third party payer liability. 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.			
Acupuncture	Not covered	\$0 copay for each medically necessary visit for chronic low back pain.	\$0 copay for each medically necessary visit for chronic low back pain.	\$0 copay for each medically necessary visit for chronic low back pain.

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		\$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) \$4,000 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 Supplemental Flex 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
Supplemental Flex Card	Not covered.	Not covered.	Not covered.	\$550 allowance every year for additional vision, dental and hearing benefits.
Special Supplemental Benefits for the Chronically Ill (combined with OTC benefit)	Covered through the Supplemental Nutrition Assistance Program (SNAP) if eligible	For eligible members Supplemental Flex Card: \$215 per month toward covered utilities,	For eligible members Supplemental Flex Card: \$100 per month toward covered utilities,	For eligible members Supplemental Flex Card: \$315 per month toward covered utilities,

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		produce and other food items. Must be used for items for the member only. This allowance is combined with OTC benefit for SSBCI members.	produce and other food items. Must be used for items for the member only. This allowance is combined with OTC benefit for SSBCI members.	produce and other food items. Must be used for items for the member only. This allowance is combined with OTC benefit for SSBCI members.
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 Supplemental Flex Card benefit (above) for yearly allowance that can be used for dental, vision, and hearing related items and services.
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	\$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	Not Covered

	Medicaid	Jefferson Health Plans Special (004)	Jefferson Health Plans Dual Pearl (016)	Jefferson Health Plans Select (017)
		clinical care coordinator.	clinical care coordinator.	
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	\$215 monthly allowance (unused amounts cannot be carried over from month to month)	\$100 monthly allowance (unused amounts cannot be carried over from month to month)	\$315 monthly allowance (unused amounts cannot be carried over from month to month)
Transportation (Routine)	Available through Medical Assistance Transportation Program	\$0 copay/ coinsurance for 40 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
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 Supplemental Flex 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 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/find-a-doctor/ or call 1-866-901-8000 (TTY 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, deductibles and/or copayments/co-insurance may change on January 1, 2028.
- ☐ 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*).
- ☐ **Jefferson Health Plans Special (004):** 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.
- ☐ **Jefferson Health Plans Dual Pearl (016) and Jefferson Health Plans Select (017):** 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.
- ☐ 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.