

# 2027 Summary of Benefits

## Jefferson Health Plans (H9207)

### Jefferson Health Plans Prime (HMO) (002)

### Jefferson Health Plans Complete (HMO) (012)

### Jefferson Health Plans Giveback (HMO) (015)

This is a summary of drug and medical services covered by Jefferson Health Plans Prime, Jefferson Health Plans Complete and Jefferson Health Plans Giveback 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](http://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, you may pay more 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](http://www.JeffersonHealthPlans.com/medicare) or by calling the plan at 1-866-901-8000 (TTY 877-454-8477).

To join Jefferson Health Plans Prime, Jefferson Health Plans Complete or Jefferson Health Plans Giveback, you must be entitled to Medicare Part A and be enrolled in Medicare Part B.

**Our service area for the Jefferson Health Plans Prime (002), Jefferson Health Plans Complete (012) and Jefferson Health Plans Giveback (015)** 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](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven 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 (TTY 711) 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.

H9207\_MCE-810MR-9170\_M

## Premiums, Deductibles, and Limits

|                                                                                       | Jefferson Health<br>Plans Prime (002)                                                                           | Jefferson Health<br>Plans Complete (012)                                                                        | Jefferson Health<br>Plans Giveback (015)                                                                          |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Monthly Plan Premium</b><br>You must continue to pay your Medicare Part B premium. | \$12.80                                                                                                         | \$0                                                                                                             | \$0<br>For Jefferson Health Plans Giveback (HMO) members receive a \$132 Part B Premium reduction.                |
| <b>Deductible</b>                                                                     | This plan does not have a deductible for medical services.<br>There is a \$0 deductible for prescription drugs. | This plan does not have a deductible for medical services.<br>There is a \$0 deductible for prescription drugs. | This plan does not have a deductible for medical services.<br>There is a \$450 deductible for prescription drugs. |
| <b>Maximum Out-of-Pocket Amount</b><br><i>(does not include prescription drugs)</i>   | \$6,500 annually<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | \$7,500 annually<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | \$9,850 annually<br>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 on Tiers 3 and 4.

|                            | Jefferson Health Plans Prime (002)                                |                                                          | Jefferson Health Plans Complete (012)                             |                                                          | Jefferson Health Plans Giveback (015)                             |                                                          |
|----------------------------|-------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------|
| Stage 1: Deductible        | There is no Rx deductible for 2027.                               |                                                          | There is no Rx deductible for 2027.                               |                                                          | There is a \$450 deductible on tiers 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                                                | \$0 copay                                                         | \$0 copay                                                |
| Tier 2: Generic            | \$10 copay                                                        | \$20 copay                                               | \$5 copay                                                         | \$10 copay                                               | \$10 copay                                                        | \$20 copay                                               |
| Tier 3: Preferred Brand    | 25% coinsurance                                                   | 25% coinsurance                                          | 25% coinsurance                                                   | 25% coinsurance                                          | 20% coinsurance                                                   | 20% coinsurance                                          |
| Insulins                   | \$35 copay                                                        | \$105 copay                                              | \$35 copay                                                        | \$105 copay                                              | \$35 copay                                                        | \$105 copay                                              |
| Tier 4: Non-Preferred Drug | 28% coinsurance                                                   | 28% coinsurance                                          | 29% coinsurance                                                   | 29% coinsurance                                          | 29% coinsurance                                                   | 29% coinsurance                                          |
| Insulins                   | \$35 copay                                                        | \$105 copay                                              | \$35 copay                                                        | \$105 copay                                              | \$35 copay                                                        | \$105 copay                                              |
| Tier 5: Specialty Drugs    | 33% coinsurance                                                   | A long-term supply is not available for Specialty drugs. | 33% coinsurance                                                   | A long-term supply is not available for Specialty drugs. | 28% coinsurance                                                   | A long-term supply is not available for Specialty drugs. |
| Insulins                   | \$35 copay                                                        |                                                          | \$35 copay                                                        |                                                          | \$35 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](http://www.JeffersonHealthPlans.com/medicare) or call us at 1-866-901-8000 (TTY 877-454-8477).

## Part C Benefits

|                                                                                                 | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                                                                                                                                                                                                                             | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                                                                                                                                                                                                                          | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hospital</b>                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Inpatient hospital coverage</b> <sup>★</sup>                                                 | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$275 copay each day for days 1 - 7</li> <li>\$0 copay each day for days 8 - 90</li> </ul> <p>Our plan covers up to 90 days for an inpatient hospital stay.</p> <p>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.</p> | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$325 copay each day for days 1 - 6</li> <li>\$0 copay each day for days 7 - 90</li> </ul> <p>Our plan covers up to 90 days for an inpatient hospital stay.</p> <p>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.</p> | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$450 copay each day for days 1 - 5</li> <li>\$0 copay each day for days 6 - 90</li> </ul> <p>Our plan covers up to 90 days for an inpatient hospital stay.</p> <p>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.</p> |
| <b>Outpatient hospital coverage</b>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Outpatient surgery <sup>☆</sup>                                                                 | \$350 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$325 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$450 copay                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Observation services                                                                            | \$350 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                              | \$325 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                              | \$450 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Ambulatory surgery center</b> <sup>★</sup>                                                   | \$300 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$275 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$350 copay                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Doctor Visits and Preventive Care</b>                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Doctor visits</b>                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Primary care provider                                                                           | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Specialist                                                                                      | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                        | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                        | \$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Preventive care</b>                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Annual Physical Visit                                                                           | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Annual Wellness Visit                                                                           | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Barium Enemas                                                                                   | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <sup>★</sup> Prior authorization is required. <sup>☆</sup> Prior authorization may be required. |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                                                           | Jefferson Health<br>Plans Prime (002)                                                                                                                               | Jefferson Health<br>Plans Complete (012)                                                                                                                            | Jefferson Health<br>Plans Giveback (015)                                                                                                                            |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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                                                                                                                                                           |
| <b>Emergency and Urgent Care</b>                                          |                                                                                                                                                                     |                                                                                                                                                                     |                                                                                                                                                                     |
| <b>Emergency care</b>                                                     | \$100 copay for each Medicare-covered emergency room visit.<br><br>Copay is waived if you are admitted to the same facility within 24 hours for the same condition. | \$100 copay for each Medicare-covered emergency room visit.<br><br>Copay is waived if you are admitted to the same facility within 24 hours for the same condition. | \$100 copay for each Medicare-covered emergency room visit.<br><br>Copay is waived if you are admitted to the same facility within 24 hours for the same condition. |
| <b>Urgently needed services</b>                                           | \$5 copay for each Medicare-covered urgent care visit.<br><br>Copay is waived if admitted to the hospital within 24 hours for the same condition.                   | \$10 copay for each Medicare-covered urgent care visit.<br><br>Copay is waived if admitted to the hospital within 24 hours for the same condition.                  | \$15 copay for each Medicare-covered urgent care visit.<br><br>Copay is waived if admitted to the hospital within 24 hours for the same condition.                  |
| <b>Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs</b>    |                                                                                                                                                                     |                                                                                                                                                                     |                                                                                                                                                                     |
| <b>Diagnostic services/labs/imaging</b>                                   |                                                                                                                                                                     |                                                                                                                                                                     |                                                                                                                                                                     |
| Diagnostic radiology services (e.g. MRI, CT, PET)★                        | \$250 copay                                                                                                                                                         | \$295 copay                                                                                                                                                         | \$450 copay                                                                                                                                                         |
| Lab services★                                                             | \$0 copay                                                                                                                                                           | \$0 copay                                                                                                                                                           | \$0 copay                                                                                                                                                           |
| Diagnostic tests and procedures★                                          | \$0 copay                                                                                                                                                           | \$0 copay                                                                                                                                                           | \$25 copay                                                                                                                                                          |
| ★ Prior authorization is required. ☆ Prior authorization may be required. |                                                                                                                                                                     |                                                                                                                                                                     |                                                                                                                                                                     |

|                                                                           | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                             | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                          | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                          |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient X-rays★                                                        | \$25 copay                                                                                                                                                                                                                        | \$30 copay                                                                                                                                                                                                                        | \$40 copay                                                                                                                                                                                                                        |
| Therapeutic radiology★                                                    | 20% coinsurance                                                                                                                                                                                                                   | 20% coinsurance                                                                                                                                                                                                                   | 20% coinsurance                                                                                                                                                                                                                   |
| <b>Hearing / Dental / Vision</b>                                          |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| <b>Hearing services</b>                                                   |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| Diagnostic exam                                                           | \$35 copay for Medicare-covered services (Specialist copay may additionally apply)                                                                                                                                                | \$35 copay for Medicare-covered services (Specialist copay may additionally apply)                                                                                                                                                | \$40 copay for Medicare-covered services (Specialist copay may additionally apply)                                                                                                                                                |
| 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)                                                                                                                                                               |
| Hearing aids                                                              | \$500 - \$1,975 copay for hearing aids, limited to every two years (both ears combined). Minimum copay applies to entry-level hearing aids, while the maximum copay applies to premium-level options.                             | \$500 - \$1,975 copay for hearing aids, limited to every two years (both ears combined). Minimum copay applies to entry-level hearing aids, while the maximum copay applies to premium-level options.                             | \$500 - \$1,975 copay for hearing aids, limited to every two years (both ears combined). Minimum copay applies to entry-level hearing aids, while the maximum copay applies to premium-level options.                             |
| <b>Dental services</b>                                                    |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| Preventive dental services                                                | You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply).                                                                                                                                          | You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply).                                                                                                                                          | You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply).                                                                                                                                          |
| Medicare-covered dental services☆                                         | \$40 copay for Medicare-covered dental services                                                                                                                                                                                   | \$45 copay for Medicare-covered dental services                                                                                                                                                                                   | \$40 copay for Medicare-covered dental services                                                                                                                                                                                   |
| Supplemental comprehensive dental services★                               | Supplemental comprehensive dental services include: <ul style="list-style-type: none"> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> </ul> | Supplemental comprehensive dental services include: <ul style="list-style-type: none"> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> </ul> | Supplemental comprehensive dental services include: <ul style="list-style-type: none"> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> </ul> |
| ★ Prior authorization is required. ☆ Prior authorization may be required. |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |

|                                                                                                                                                                                                                                                                                                   | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                                                                                                                                                                                               | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                                                                                                                                                                                            | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                   | <ul style="list-style-type: none"> <li>Prosthodontics</li> <li>Oral/maxillofacial surgery</li> </ul> <p>The plan pays \$2,000 every year towards supplemental comprehensive dental services</p>                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li>Prosthodontics</li> <li>Oral/maxillofacial surgery</li> </ul> <p>The plan pays \$2,000 every year towards supplemental comprehensive dental services</p>                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li>Prosthodontics</li> <li>Oral/maxillofacial surgery</li> </ul> <p>The plan pays \$2,000 every year towards supplemental comprehensive dental services</p>                                                                                                                                                                                                     |
| <b>Vision services</b><br><br>Medicare-covered services include: <ul style="list-style-type: none"> <li>Exam to diagnose and treat diseases and conditions of the eye</li> <li>Eyewear after cataract surgery</li> </ul><br>Routine eye exam (Non-Medicare)<br><br>Routine eyewear (Non-Medicare) | <p>\$40 copay for Medicare-covered services (Specialist copay may additionally apply)</p><br><p>\$0 copay for routine eye exams (limited to 1 visit every year)</p><br><p>You pay a \$0 copay for your choice of one of the following, up to \$300 every year:</p> <ul style="list-style-type: none"> <li>One pair of eyeglasses (lenses and frames)</li> <li>Contact lenses (unlimited)</li> </ul> | <p>\$45 copay for Medicare-covered services (Specialist copay may additionally apply)</p><br><p>\$0 copay for routine eye exams (limited to 1 visit every year)</p><br><p>You pay a \$0 copay for your choice of one of the following, up to \$250 every year:</p> <ul style="list-style-type: none"> <li>One pair of eyeglasses (lenses and frames)</li> <li>Contact lenses (unlimited)</li> </ul> | <p>\$40 copay for Medicare-covered services (Specialist copay may additionally apply)</p><br><p>\$0 copay for routine eye exams (limited to 1 visit every year)</p><br><p>You pay a \$0 copay for your choice of one of the following, up to \$200 every year:</p> <ul style="list-style-type: none"> <li>One pair of eyeglasses (lenses and frames)</li> <li>Contact lenses (unlimited)</li> </ul> |
| <b>Mental Health Services</b>                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Inpatient visits<sup>★</sup></b>                                                                                                                                                                                                                                                               | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$295 copay per day for days 1 through 7</li> <li>\$0 copay per day for days 8 through 90</li> </ul>                                                                                                                                                                                                        | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$295 copay per day for days 1 through 7</li> <li>\$0 copay per day for days 8 through 90</li> </ul>                                                                                                                                                                                                        | <p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>\$415 copay per day for days 1 through 5</li> <li>\$0 copay per day for days 6 through 90</li> </ul>                                                                                                                                                                                                        |
| <sup>★</sup> Prior authorization is required. <sup>☆</sup> Prior authorization may be required.                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                                                           | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                                                                                                                                                                                                                            | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                                                                                                                                                                                                                         | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           | <p>Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies).</p> <p>Our plans also cover 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these “extra” days.</p>                                                                                                                                                   | <p>Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies).</p> <p>Our plans also cover 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these “extra” days.</p>                                                                                                                                                   | <p>Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies).</p> <p>Our plans also cover 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these “extra” days.</p>                                                                                                                                                   |
| <b>Outpatient visits</b> ☆                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Individual and group therapy                                              | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Individual and group psychiatric services                                 | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Skilled Nursing Facility (SNF)</b>                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Skilled nursing facility</b> ★                                         | <p>\$0 copay per day for days 1 through 20</p> <p>\$203 copay per day for days 21 through 100</p> <p>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.)</p> | <p>\$0 copay per day for days 1 through 20</p> <p>\$203 copay per day for days 21 through 100</p> <p>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.)</p> | <p>\$0 copay per day for days 1 through 20</p> <p>\$190 copay per day for days 21 through 100</p> <p>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.)</p> |
| ★ Prior authorization is required. ☆ Prior authorization may be required. |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                                                                                 | Jefferson Health<br>Plans Prime (002)                                                            | Jefferson Health<br>Plans Complete (012)                                               | Jefferson Health<br>Plans Giveback (015)                                               |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <b>Outpatient Rehabilitation Services</b>                                                       |                                                                                                  |                                                                                        |                                                                                        |
| <b>Therapy<sup>★</sup></b>                                                                      |                                                                                                  |                                                                                        |                                                                                        |
| Occupational Therapy                                                                            | \$20 copay                                                                                       | \$35 copay                                                                             | \$35 copay                                                                             |
| Physical, Speech and language therapy                                                           | \$20 copay                                                                                       | \$35 copay                                                                             | \$50 copay                                                                             |
| <b>Medical Transportation</b>                                                                   |                                                                                                  |                                                                                        |                                                                                        |
| <b>Ambulance</b>                                                                                |                                                                                                  |                                                                                        |                                                                                        |
| Ground <sup>☆</sup>                                                                             | \$240 copay<br><br>This cost-sharing is not waived if you're admitted to the hospital.           | \$250 copay<br><br>This cost-sharing is not waived if you're admitted to the hospital. | \$305 copay<br><br>This cost-sharing is not waived if you're admitted to the hospital. |
| Air <sup>☆</sup>                                                                                | 20% coinsurance                                                                                  | 20% coinsurance                                                                        | 20% coinsurance                                                                        |
| <b>Transportation</b>                                                                           | \$0 copay/coinsurance for 25 one-way trips each year to plan-approved, health-related locations. | Not covered                                                                            | Not covered                                                                            |
| <b>Medicare Part B Drugs</b>                                                                    |                                                                                                  |                                                                                        |                                                                                        |
| <b>Medicare Part B drugs</b>                                                                    |                                                                                                  |                                                                                        |                                                                                        |
| Chemotherapy drugs <sup>★</sup>                                                                 | 0% - 20% coinsurance                                                                             | 0% - 20% coinsurance                                                                   | 0% - 20% coinsurance                                                                   |
| Other Part B drugs <sup>☆</sup>                                                                 | 0% - 20% coinsurance<br>Step therapy may apply                                                   | 0% - 20% coinsurance<br>Step therapy may apply                                         | 0% - 20% coinsurance<br>Step therapy may apply                                         |
| Insulin                                                                                         | 0% - 20% coinsurance<br>You pay no more than \$35 every month                                    | 0% - 20% coinsurance<br>You pay no more than \$35 every month                          | 0% - 20% coinsurance<br>You pay no more than \$35 every month                          |
| <sup>★</sup> Prior authorization is required. <sup>☆</sup> Prior authorization may be required. |                                                                                                  |                                                                                        |                                                                                        |

## Additional Benefits

|                                                                                                                                                                                                                                                                                          | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                                                                                            | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                                                                                          | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Additional Benefits                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                   |
| <b>Acupuncture</b><br><br>Medically necessary acupuncture for chronic low back pain<br><br><br><br><br><br><br><br><br><br>Supplemental acupuncture services                                                                                                                             | \$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.<br><br>\$0 copay for each supplemental acupuncture visit, limited to 20 visits every year. | \$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.<br><br>\$10 copay for each supplemental acupuncture visit, limited to 10 visits every year. | \$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.<br><br>\$10 copay for each supplemental acupuncture visit, limited to 10 visits every year. |
| <b>Cardiac rehabilitation services</b>                                                                                                                                                                                                                                                   | \$0 copay                                                                                                                                                                                                                                                                                        | \$0 copay                                                                                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                                                                                         |
| <b>Chiropractic services<sup>★</sup></b><br><br>Medically necessary: <ul style="list-style-type: none"> <li>Manual manipulation of the spine to correct subluxation</li> </ul>                                                                                                           | \$15 copay                                                                                                                                                                                                                                                                                       | \$15 copay                                                                                                                                                                                                                                                                                        | \$15 copay                                                                                                                                                                                                                                                                                        |
| <b>Diabetic supplies<sup>☆</sup></b><br><br>0% coinsurance for diabetic monitoring supplies from preferred manufacturers<br><br>20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers<br><br>20% coinsurance for all other Part B diabetic supplies/monitors | 0% coinsurance for diabetic monitoring supplies from preferred manufacturers<br><br>20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers<br><br>20% coinsurance for all other Part B diabetic supplies/monitors                                                     | 0% coinsurance for diabetic monitoring supplies from preferred manufacturers<br><br>20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers<br><br>20% coinsurance for all other Part B diabetic supplies/monitors                                                      | 0% coinsurance for diabetic monitoring supplies from preferred manufacturers<br><br>20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers<br><br>20% coinsurance for all other Part B diabetic supplies/monitors                                                      |
| <sup>★</sup> Prior authorization is required. <sup>☆</sup> Prior authorization may be required.                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                   |

|                                                                                                                                                                                                                                                 | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                          | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                       | Jefferson Health<br>Plans Giveback (015)                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Durable medical equipment, prosthetic devices and medical supplies★</b>                                                                                                                                                                      | 20% coinsurance<br><br>DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores                                                  | 20% coinsurance<br><br>DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores                                                  | 15% coinsurance<br><br>DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores |
| <b>Fitness program</b>                                                                                                                                                                                                                          | \$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                                                                                                       | \$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia                                                      |
| <b>Home health care★</b>                                                                                                                                                                                                                        | \$0 copay                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                      | \$0 copay                                                                                                                                                     |
| <b>Opioid treatment program services</b>                                                                                                                                                                                                        | \$25 copay                                                                                                                                                                                                     | \$35 copay                                                                                                                                                                                                     | \$40 copay                                                                                                                                                    |
| <b>Over-The-Counter (OTC) items</b><br><br>The benefit period corresponds to the quarters of the calendar year:<br><br>1st quarter: Jan - March<br>2nd quarter: April - June<br>3rd quarter: July - Sept<br>4th quarter: Oct - Dec              | \$0 copay for up to \$85 every calendar quarter toward eligible OTC items.<br><br>Unused amounts will not be rolled over from quarter to quarter.<br><br>Allowance must be used for items for the member only. | \$0 copay for up to \$50 every calendar quarter toward eligible OTC items.<br><br>Unused amounts will not be rolled over from quarter to quarter.<br><br>Allowance must be used for items for the member only. | Not available.                                                                                                                                                |
| <b>Partial hospitalization★</b>                                                                                                                                                                                                                 | \$55 copay per day                                                                                                                                                                                             | \$55 copay per day                                                                                                                                                                                             | \$55 copay per day                                                                                                                                            |
| <b>Podiatry services</b><br><br>Medicare-covered services include:<br><ul style="list-style-type: none"> <li>Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> </ul> | \$25 copay for Medicare-covered services                                                                                                                                                                       | \$35 copay for Medicare-covered services                                                                                                                                                                       | \$40 copay for Medicare-covered services                                                                                                                      |

★ Prior authorization is required. ☆ Prior authorization may be required.

|                                                                                                                                                                                                                                                                                                                                               | Jefferson Health<br>Plans Prime (002)                                                                                                                                                                                                                                                                                                                                                                                                                                          | Jefferson Health<br>Plans Complete (012)                                                                                                                                                                                                                                                                                                                                                                                                                                       | Jefferson Health<br>Plans Giveback (015)                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Foot care for members with certain medical conditions affecting the lower limbs</li> </ul> <p>Routine foot care, including corn/callus treatment, nail care and other preventive/maintenance care.</p>                                                                                                 | \$25 copay for routine foot care (limited to 1 visit every three months)                                                                                                                                                                                                                                                                                                                                                                                                       | \$35 copay for routine foot care (limited to 1 visit every three months)                                                                                                                                                                                                                                                                                                                                                                                                       | \$40 copay for routine foot care (limited to 1 visit every three months)                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Pulmonary rehabilitation services</b>                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Supplemental Flex Card</b>                                                                                                                                                                                                                                                                                                                 | Members are able to receive \$1,000 every year for additional vision, dental and hearing spend. Unused amounts will not be rolled over.                                                                                                                                                                                                                                                                                                                                        | Members are able to receive \$250 every year for additional vision, dental and hearing spend. Unused amounts will not be rolled over.                                                                                                                                                                                                                                                                                                                                          | Not available.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Telehealth</b><br>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<br>\$25 copay for each specialist telehealth service<br>\$25 copay for each mental health specialty individual session<br>\$25 copay for each psychiatric service individual session<br>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<br>\$35 copay for each specialist telehealth service<br>\$35 copay for each mental health specialty individual session<br>\$35 copay for each psychiatric service individual session<br>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<br>\$50 copay for each specialist telehealth service<br>\$50 copay for each mental health specialty individual session<br>\$50 copay for each psychiatric service individual session<br>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. |
| ★ Prior authorization is required. ☆ Prior authorization may be required.                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                                                                                                                                                                                                                                    | Jefferson Health<br>Plans Prime (002)       | Jefferson Health<br>Plans Complete (012)    | Jefferson Health<br>Plans Giveback (015)    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------|---------------------------------------------|
| <b>Telemonitoring</b><br>An in-home telemonitoring program is covered for members who have congestive heart failure (CHF), hypertension or uncontrolled diabetes.<br><br>Members will be provided access to clinical support while on the program. | \$0 copay for telemonitoring services       | \$0 copay for telemonitoring services       | \$0 copay for telemonitoring services       |
| <b>Worldwide emergency/urgent coverage</b>                                                                                                                                                                                                         | \$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.                                                                                                                                                                          |                                             |                                             |                                             |

---

## 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/](http://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

- ☐ **Jefferson Health Plans Prime (002):** 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.  
  
**Jefferson Health Plans Complete (012):** In addition, **you must continue to pay your Medicare Part B premium.** This premium is normally taken out of your Social Security check each month.  
  
**Jefferson Health Plans Giveback (015):** In addition, **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.
- ☐ 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.