

2027 Summary of Benefits

Jefferson Health Plans (H1619)

Jefferson Health Plans Flex (PPO) (001)

Jefferson Health Plans Preferred (PPO) (004)

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

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of the services we cover, please see the *Evidence of Coverage*. View it online at www.JeffersonHealthPlans.com/medicare or get a copy by calling Member Relations at 1-866-901-8000 (TTY 877-454-8477). From **October 1 to March 31**, we're available 8 a.m. to 8 p.m., 7 days a week. And from **April 1 to September 30**, we're available 8 a.m. to 8 p.m., Monday to Friday. **This call is free.**

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

Jefferson Health Plans has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, 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 or by calling the plan at 1-866-901-8000 (TTY 877-454-8477).

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

Our service area for the Jefferson Health Plans Flex (001) and Jefferson Health Plans Preferred (004) includes the following counties in Pennsylvania: Adams, Berks, Bradford, Bucks, Carbon, Chester, Cumberland, Dauphin, Delaware, Franklin, Lancaster, Lebanon, Lehigh, Monroe, Montgomery, Northampton, Perry, Philadelphia, Schuylkill, and York counties.

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 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.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call Member Relations or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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.

Premiums, Deductibles, and Limits

	Jefferson Health Plans Flex (001)	Jefferson Health Plans Preferred (004)
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	\$0	\$40
Deductible	This plan does not have a deductible for medical services. There is a \$0 deductible for prescription drugs.	This plan does not have a deductible for medical services. There is a \$0 deductible for prescription drugs.
Maximum Out-of-Pocket Amount <i>(does not include prescription drugs)</i>	<u>In-Network:</u> \$8,000 <u>Combined:</u> \$10,000 The most you pay for copays, coinsurance and other costs for medical services for the year	<u>In-Network:</u> \$6,500 <u>Combined:</u> \$10,000 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 Flex (001)		Jefferson Health Plans Preferred (004)	
Stage 1: Deductible	There is no Rx deductible for 2027.		There is no Rx deductible 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)
Tier 1: Preferred Generic	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2: Generic	\$5 copay	\$15 copay	\$0 copay	\$0 copay

	Jefferson Health Plans Flex (001)		Jefferson Health Plans Preferred (004)	
Tier 3: Preferred Brand Insulins	25% coinsurance \$35 copay	25% coinsurance \$105 copay	25% coinsurance \$35 copay	25% coinsurance \$105 copay
Tier 4: Non-Preferred Drug Insulins	27% coinsurance \$35 copay	27% coinsurance \$105 copay	31% coinsurance \$35 copay	31% coinsurance \$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.

Catastrophic Coverage

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

Long-term care pharmacy and out-of-network pharmacy coverage

Your costs for a 30-day supply at an out-of-network pharmacy or a 31-day supply from a long-term care pharmacy are the same as those for a 30-day supply at a standard retail pharmacy, as shown above.

Extended supplies are not available from out-of-network or long-term care pharmacies.

For more information, please see the plan's *Evidence of Coverage* at www.JeffersonHealthPlans.com/medicare or call us at 1-866-901-8000 (TTY 877-454-8477).

Part C Benefits

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Hospital		
Inpatient hospital coverage[★]	For each hospital admission/stay you pay: \$300 copay each day for days 1 - 6 \$0 copay each day for days 7 - 90 Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra”	For each hospital admission/stay you pay: \$350 copay per stay Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra”
[★] Prior authorization is required. [☆] Prior authorization may be required.		

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
	days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.	days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.
Outpatient hospital coverage Outpatient surgery [☆] Observation services	 \$375 copay \$375 copay per stay	 \$250 copay \$250 copay per stay
Ambulatory surgery center[★]	\$250 copay	\$150 copay
Doctor Visits and Preventive Care		
Doctor visits Primary care provider Specialist	 \$0 copay \$40 copay	 \$0 copay \$20 copay
Preventive care Annual Physical Visit Annual Wellness Visit Barium Enemas Diabetes Self-management Training Digital Rectal Exams EKG Following Preventive Services Glaucoma Screening Other Medicare-covered Preventive Services	 \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay	 \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay
Emergency and Urgent Care		
Emergency care	\$100 copay for each Medicare-covered emergency room visit.	\$100 copay for each Medicare-covered emergency room visit.
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	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
	Copay is waived if you are admitted to the same facility within 24 hours for the same condition.	Copay is waived if you are admitted to the same facility within 24 hours for the same condition.
Urgently needed services	\$20 copay for each Medicare-covered urgent care visit. Copay is waived if admitted to the hospital within 24 hours for the same condition.	\$10 copay for each Medicare-covered urgent care visit. Copay is waived if admitted to the hospital within 24 hours for the same condition.
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs		
Diagnostic services/labs/imaging		
Diagnostic radiology services (e.g. MRI, CT, PET)★	\$350 copay	\$250 copay
Lab services★	\$0 copay	\$0 copay
Diagnostic tests and procedures★	\$13 copay	\$0 copay
Outpatient X-rays★	\$30 copay	\$35 copay
Therapeutic radiology★	20% coinsurance	20% coinsurance
Hearing / Dental / Vision		
Hearing services		
Diagnostic exam	\$25 copay for Medicare-covered services (Specialist copay may additionally apply)	\$20 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)
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.
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	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Dental services Preventive dental services Medicare-covered dental services [☆] Supplemental comprehensive dental services [★]	You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply). \$25 copay for Medicare-covered dental services Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays \$3,000 every year towards supplemental comprehensive dental services 50% coinsurance for out-of-network supplemental comprehensive dental services.	You pay a \$0 copay for 3 exams and cleanings every year. X-rays covered (limits apply). \$20 copay for Medicare-covered dental services Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays \$2,000 every year towards supplemental comprehensive dental services 50% coinsurance for out-of-network supplemental comprehensive dental services.
Vision services Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery Routine eye exam (Non-Medicare) Routine eyewear (Non-Medicare)	\$25 copay for Medicare-covered services (Specialist copay may additionally apply) \$0 copay for routine eye exams (limited to 1 visit every year) You pay a \$0 copay for your choice of one of the following, up to \$100 every year: • One pair of eyeglasses (lenses and frames) • Contact lenses (unlimited)	\$0 copay for Medicare-covered services (Specialist copay may additionally apply) \$0 copay for routine eye exams (limited to 1 visit every year) You pay a \$0 copay for your choice of one of the following, up to \$200 every year: • One pair of eyeglasses (lenses and frames) • Contact lenses (unlimited)
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	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Mental Health Services		
Inpatient visits[★]	For each hospital admission/stay you pay: • \$295 copay per day for days 1 through 7 • \$0 copay per day for days 8 through 90 Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plans also cover 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these “extra” days.	For each hospital admission/stay you pay: • \$350 copay per stay Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plans also cover 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these “extra” days.
Outpatient visits[☆]		
Individual and group therapy	\$40 copay	\$20 copay
Individual and group psychiatric services	\$40 copay	\$20 copay
Skilled Nursing Facility (SNF)		
Skilled nursing facility[★]	\$0 copay per day for days 1 through 20 \$175 copay per day for days 21 through 100 Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven’t received any inpatient hospital care or skilled care in a SNF.)	\$0 copay per day for days 1 through 20 \$203 copay per day for days 21 through 100 Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven’t received any inpatient hospital care or skilled care in a SNF.)
[★] Prior authorization is required. [☆] Prior authorization may be required.		

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Outpatient Rehabilitation Services		
Therapy[★] Occupational Therapy Physical, Speech and language therapy	\$35 copay \$40 copay	\$20 copay \$20 copay
Medical Transportation		
Ambulance Ground [☆] Air [☆]	\$250 copay This cost-sharing is not waived if you're admitted to the hospital. 20% coinsurance	\$250 copay This cost-sharing is not waived if you're admitted to the hospital. 20% coinsurance
Transportation	Not covered	\$0 copay/coinsurance for 50 one-way trips each year to plan-approved, health-related locations.
Medicare Part B Drugs		
Medicare Part B drugs Chemotherapy drugs [★] Other Part B drugs [☆] Insulin	0% - 20% coinsurance 0% - 20% coinsurance Step therapy may apply 0% - 20% coinsurance You pay no more than \$35 every month	0% - 20% coinsurance 0% - 20% coinsurance Step therapy may apply 0% - 20% coinsurance You pay no more than \$35 every month
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Additional Benefits

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Additional Benefits		
Acupuncture Medically necessary acupuncture for chronic low back pain 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. \$10 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. \$0 copay for each supplemental acupuncture visit, limited to 20 visits every year.
Cardiac rehabilitation services	\$0 copay	\$0 copay
Chiropractic services[★] Medically necessary: Manual manipulation of the spine to correct subluxation Routine visits:	\$15 copay \$20 copay for 6 visits every year	\$15 copay \$20 copay for 6 visits every year
Diabetic supplies[☆]	0% coinsurance for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers 20% coinsurance for all other Part B diabetic supplies/monitors	0% coinsurance for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for diabetic monitoring supplies from non-preferred manufacturers 20% coinsurance for all other Part B diabetic supplies/monitors
Durable medical equipment, prosthetic devices and medical supplies[★]	20% coinsurance 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 DME must be obtained from JHP network providers only. JHP will not reimburse purchases made at out-of-network retail or on-line stores
[★] Prior authorization is required. [☆] Prior authorization may be required.		

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
Fitness program	\$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia The plan provides up to a \$300 allowance per year for use at an approved out-of-network fitness facility that is not part of the Silver Sneakers® network.	\$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia The plan provides up to a \$300 allowance per year for use at an approved out-of-network fitness facility that is not part of the Silver Sneakers® network.
Home health care★	\$0 copay	\$0 copay
Opioid treatment program services	\$40 copay	\$20 copay
Over-The-Counter (OTC) items The benefit period corresponds to the quarters of the calendar year: 1st quarter: Jan - March 2nd quarter: April - June 3rd quarter: July - Sept 4th quarter: Oct - Dec	Not available.	\$0 copay for up to \$75 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.
Partial hospitalization★	\$70 copay per day	\$70 copay per day
Podiatry services Medicare-covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Foot care for members with certain medical conditions affecting the lower limbs Routine foot care, including corn/callus treatment, nail	\$35 copay for Medicare-covered services \$35 copay for routine foot care (limited to 6 visits every year)	\$20 copay for Medicare-covered services \$20 copay for routine foot care (limited to 6 visits every year)
★ Prior authorization is required. ☆ Prior authorization may be required.		

	Jefferson Health Plans Flex (001) In- and Out-of-Network	Jefferson Health Plans Preferred (004) In- and Out-of-Network
care and other preventive/ maintenance care.		
Pulmonary rehabilitation services	\$0 copay	\$0 copay
Supplemental Flex Card	Not available.	Members are able to receive \$1,450 every year for additional vision, dental and hearing spend. Unused amounts will not be rolled over.
Telehealth You have the option of receiving physician and certain other services either through an in-person visit or via telehealth using electronic audio-video technology. If you choose to receive one of these services via telehealth, then you must use a provider that is set up to provide the service through telehealth.	\$0 copay for each PCP telehealth service \$40 copay for each specialist telehealth service \$40 copay for each mental health specialty individual session \$40 copay for each psychiatric service individual session Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.	\$0 copay for each PCP telehealth service \$20 copay for each specialist telehealth service \$20 copay for each mental health specialty individual session \$20 copay for each psychiatric service individual session Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.
Telemonitoring An in-home telemonitoring program is covered for members who have congestive heart failure (CHF), hypertension or uncontrolled diabetes. Members will be provided access to clinical support while on the program.	\$0 copay for telemonitoring services	\$0 copay for telemonitoring services
Worldwide emergency/ urgent coverage	\$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/ 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 Flex (001):** 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 Preferred (004): In addition to your monthly plan premium, **you must continue to pay your Medicare Part B premium.** This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, deductibles and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ 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.