2025 Summary of Benefits

Jefferson Health Plans (H9207)

Jefferson Health Plans Prime (HMO) (plan 002)

Jefferson Health Plans Complete (HMO) (plan 012)

Jefferson Health Plans Giveback (HMO) (plan 015)

This is a summary of drug and medical services covered by Jefferson Health Plans Prime and Jefferson Health Plans Complete and Jefferson Health Plans Giveback for the plan year January 1, 2025 - December 31, 2025.

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

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

Jefferson Health Plans has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, 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 1-877-454-8477).

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: Philadelphia, Bucks, Montgomery, Chester, Delaware, Adams, Franklin, Lancaster, York, Cumberland, Dauphin, Lebanon, Perry, Carbon, Lehigh, Monroe, Northampton, Schuylkill, Berks, Bradford 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.

This information is not a complete description of benefits. Call 1-833-477-4773 (TTY 1-877-454-8477) 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.

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Monthly plan premium	$40.90 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.
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.	This plan does not have a deductible for medical services. There is a $590 deductible for prescription drugs.
Maximum out-of-pocket amount responsibility *(does not include prescription drugs)*	$6,400 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	$5,700 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	$8,300 annually The most you pay for copays, coinsurance and other costs for medical services for the year.

	Jefferson Health Plans Prime		Jefferson Health Plans Complete		Jefferson Health Plans Giveback	
Outpatient Prescription Drugs (Part D)						
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 100-day supply)	**Standard retail cost-sharing** (in-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 100-day supply)	**Standard retail cost-sharing** (in-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 100-day supply)
Deductible	There is no Rx deductible for the Prime or Complete plan for 2025. There is a $590 deductible on tiers 3, 4 and 5 on the Giveback plan for 2025.					
Tier 1 Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$10 copay	$20 copay	$10 copay	$20 copay	$10 copay	$20 copay
Tier 3 Preferred Brand Select Insulins (all covered insulins)	25% coinsurance $35 copay	25% coinsurance $35 copay	25% coinsurance $35 copay	25% coinsurance $35 copay	20% coinsurance $35 copay	20%c coinsurance $35 copay

	Jefferson Health Plans Prime		Jefferson Health Plans Complete		Jefferson Health Plans Giveback	
Outpatient Prescription Drugs (Part D)						
Tier 4 Non-Preferred Drug	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance	35% coinsurance
Tier 5 Specialty	33% coinsurance	A long-term supply is not available for Specialty drugs.	33% coinsurance	A long-term supply is not available for Specialty drugs.	25% coinsurance	A long-term supply is not available for Specialty drugs.

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Outpatient Prescription Drugs (Part D)			
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Inpatient hospital coverage★	For each hospital admission/stay you pay: • $235 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" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $250 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" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.	For each hospital admission/stay you pay: • $310 copay each day for days 1 - 5 • $0 copay each day for days 6 - 90 Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.
Outpatient hospital coverage			
Outpatient hospital visits★	$350 copay	$300 copay	$350 copay
Outpatient hospital observation services	$350 copay per stay	$300 copay per stay	$350 copay
Services provided at an ambulatory surgical center★	$300 copay	$200 copay	$300 copay
Doctor Visits			
Primary Care Providers	$0 copay	$0 copay	$0 copay
Specialists	$20 copay	$25 copay	$40 copay

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Medicare-covered preventive care			
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
Diabetes self-management training	$0 copay	$0 copay	$0 copay
Digital rectal exams	$0 copay	$0 copay	$0 copay
EKG following preventive services	$0 copay	$0 copay	$0 copay
Glaucoma screening	$0 copay	$0 copay	$0 copay
Other Medicare-covered preventive services	$0 copay	$0 copay	$0 copay
Emergency care	$100 copay each Medicare-covered emergency room visit. Copay is waived if you are admitted to the same facility within 24 hours for the same condition.	$100 copay each Medicare-covered emergency room visit. Copay is waived if you are admitted to the same facility within 24 hours for the same condition.	$100 copay each Medicare-covered emergency room visit. Copay is waived if you are admitted to the same facility within 24 hours for the same condition.
Urgent care	$5 copay each Medicare-covered urgent care visit. Copay is not waived if admitted to hospital.	$10 copay each Medicare-covered urgent care visit. Copay is not waived if admitted to hospital.	$15 copay each Medicare-covered urgent care visit. Copay is not waived if admitted to hospital.
Diagnostic services/labs/ imaging			
Diagnostic tests and procedures★	$10 copay	$5 copay	$20 copay
Lab services	$0 copay	$0 copay	$0 copay

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Advanced radiology services (such as MRI, PET, CT and nuclear medicine)★	$250 copay	$250 copay	$300 copay
Outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography)☆	$25 copay	$25 copay	$30 copay
Therapeutic radiology (such as radiation treatment for cancer)★	20% coinsurance	20% coinsurance	20% coinsurance
Hearing services			
Medicare-covered hearing exam	$35 copay Specialist copay may additionally apply.	$35 copay Specialist copay may additionally apply.	$40 copay Specialist copay may additionally apply.
Routine hearing exam	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year
Hearing aids	$0 copay Up to $1,500 every two years (both ears combined)	$0 copay Up to $1,000 every two years (both ears combined)	$0 copay Up to $1,500 every two years (both ears combined)
Dental services			
Preventive dental services	You pay $0 copay for 3 exams and cleanings per year. X-rays covered (limits apply).	You pay $0 copay for 3 exams and cleanings per year. X-rays covered (limits apply).	You pay $0 copay for 3 exams and cleanings per 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

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Supplemental comprehensive dental services★	Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays $2,000 a year toward supplemental comprehensive dental services	Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays $2,000 a year toward supplemental comprehensive dental services	Supplemental comprehensive dental services include: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery The plan pays $2,000 a year toward supplemental comprehensive dental services
Vision care			
Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery Routine eye exam Supplemental eyeglasses (frame and lenses) or contact lenses	$40 copay for Medicare-covered services (Specialist copay may additionally apply.) $0 copay for Medicare-covered eyewear $0 copay for routine eye exam (limited to 1 visit every year) You pay $0 copay for your choice of one of the following, up to $300 yearly: - One pair of eyeglasses (lenses and frames) - Contact lenses	$45 copay for Medicare-covered services (Specialist copay may additionally apply.) $0 copay for Medicare-covered eyewear $0 copay for routine eye exam (limited to 1 visit every year) You pay $0 copay for your choice of one of the following, up to $400 yearly: - One pair of eyeglasses (lenses and frames) - Contact lenses	$40 copay for Medicare-covered services (Specialist copay may additionally apply.) $0 copay for Medicare-covered eyewear $0 copay for routine eye exam (limited to 1 visit every year) You pay $0 copay for your choice of one of the following, up to $200 yearly: - One pair of eyeglasses (lenses and frames) - Contact lenses

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Mental health services			
Inpatient services in a psychiatric hospital★	For each hospital admission/stay you pay: • $235 copay per day for days 1 - 6 • $0 copay for days 7 - 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: • $250 copay per day for days 1 - 6 • $0 copay for days 7 - 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: • $310 copay per day for days 1 - 5 • $0 copay for days 6 - 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.
Outpatient group therapy visit☆	$20 copay	$25 copay	$40 copay
Outpatient individual therapy visit☆	$20 copay	$25 copay	$40 copay
Psychiatric services☆	$20 copay	$25 copay	$40 copay
Partial hospitalization★	$55 copay per day	$55 copay per day	$55 copay per day

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Skilled nursing facility★	Days 1 - 20 : $0 copay per day Days 21 - 100 : $203 copay each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)	Days 1 - 20 : $0 copay per day Days 21 - 100 : $203 copay each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)	Days 1 - 20 : $0 copay per day Days 21 - 100 : $203 copay each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven't received any inpatient hospital care or skilled care in a SNF.)
Physical/occupational/ speech & language therapy★	$20 copay	$25 copay	**Occupational Therapy** $35 **Physical, Speech and language therapy** $40
Ambulance services Ground ambulance☆	$250 copay	$250 copay	$275 copay
Air ambulance★	20% coinsurance	20% coinsurance	20% coinsurance
Medicare Part B prescription drugs Chemotherapy drugs★	0%-20% coinsurance	0%-20% coinsurance	0%-20% coinsurance
Other Part B drugs☆	20% coinsurance Step therapy may apply	20% coinsurance Step therapy may apply	20% coinsurance Step therapy may apply

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Acupuncture for chronic low back pain Medicare-covered acupuncture for chronic low back pain Supplemental acupuncture services	 $0 copay for each Medicare-covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions. $0 copay for each supplemental acupuncture visit, limited to 20 visits each year.	 $0 copay for each Medicare-covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions. $10 copay for each supplemental acupuncture visit, limited to 20 visits each year.	 $0 copay for each Medicare-covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions. $10 copay for each supplemental acupuncture visit, limited to 20 visits each year.
Cardiac rehabilitation services	$0 copay	$0 copay	$0 copay
Chiropractic services Medicare-covered services: • Manual manipulation of the spine to correct subluxation	 $15 copay	 $15 copay	 $15 copay
Diabetic supplies☆	20% coinsurance for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies	20% coinsurance for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies	20% coinsurance for diabetic monitoring supplies from preferred manufacturers 20% coinsurance for all other Part B diabetic supplies
Durable medical equipment (DME) and related supplies★	$0 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	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 Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Fitness program	$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia and PASSi Evergreen Center.	$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia and PASSi Evergreen Center.	$0 copay for SilverSneakers® membership or membership in the Salvation Army Kroc Center of Philadelphia and PASSi Evergreen Center.
Home health care★	$0 copay	$0 copay	$0 copay
Opioid treatment program services	$20 copay	$25 copay	$40 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	$0 copay for up to $165 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.	$0 copay for up to $150 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.	$0 copay for up to $30 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.
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	$20 copay for Medicare-covered services	$25 copay for Medicare-covered services	$40 copay for Medicare-covered services
Routine foot care, including corn/callus treatment, nail care and other preventive/ maintenance care.	$20 copay for routine foot care (limited to one visit every three months)	$25 copay for routine foot care (limited to one visit every three months)	$40 copay for routine foot care (limited to one visit every three months)
Prosthetics/Orthotics★	20% coinsurance	20% coinsurance	20% coinsurance

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
Pulmonary rehabilitation services	$0 copay	$0 copay	$0 copay
Supplemental Flexcard	$2,250 Members are able to receive $2,250 per year for additional vision, dental and hearing spend. Unused amounts will not be rolled over.	$2,250 Members are able to receive $2,250 per year for additional vision, dental and hearing spend. Unused amounts will not be rolled over.	$2,250 Members are able to receive $2,250 per 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 $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.	$0 copay for each PCP telehealth service $25 copay for each specialist telehealth service $25 copay for each mental health specialty individual session $25 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 $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.

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

	Jefferson Health Plans Prime	Jefferson Health Plans Complete	Jefferson Health Plans Giveback
Medical Benefits (Part C)			
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 via either the application, or phone calls with directions on accessing video chat with a provider. In addition, blood pressure cuffs will be offered to members with uncontrolled hypertension. A doctor must recommend that a member needs these items. Limitations may apply.	$0 copay for telemonitoring services.	$0 copay for telemonitoring services.	$0 copay for telemonitoring services.
Worldwide emergency/ urgent coverage	$0 copay up to $50,000 maximum per year.	$0 copay up to $50,000 maximum per year.	$0 copay up to $50,000 maximum per 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 1-877-454-8477).

Understanding the Benefits

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.JeffersonHealthPlans.com/medicare or call 1-866-901-8000 (TTY 1-877-454-8477) to view a copy of the EOC.

☐ Review the *Provider & Pharmacy Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor. However, the plans shown in this Summary of Benefits are point-of-service plans that allow you to obtain physician specialist and certain other services from out-of-network providers. Please contact the plan for more information.

☐ Review the *Provider & Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2025.

☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, 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 higher cost-sharing 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.

H9207_MCE-810MG-5979-002-012-015_M