



Start here for
a healthier you.

Individual and Family Plans

 **Jefferson**
Health Plans

1-866-599-0688
(TTY 711)

JeffersonHealthPlans.com/Individuals-Families

Budget-friendly plans for your best health.

Looking for low-cost health coverage?

With Jefferson Health Plans, you can choose from a range of plans that offer quality coverage and big savings.

We offer plans in your area, including **Lehigh** and **Northampton** counties.

Keep reading to learn more!



Why Choose Jefferson Health Plans?

Built on a foundation spanning nearly 40 years, we are committed to providing you with quality, affordable coverage. We connect you with top doctors and specialists — and provide you with benefits that go beyond the basics.

Count on us for:

Affordable plans

We offer a range of Bronze, Silver, and Gold Individual and Family Plans to fit every budget, including \$0 medical deductible plans at all metal levels.

Access to hundreds of trusted providers

Choose from our large provider network including Jefferson, Lehigh Valley Health Network, and other trusted providers located close to where you live.

Referral-free visits

Skip the hassle and find a specialist who meets your needs — no referral required.

Comprehensive care

Our plans cover the essentials: doctor's appointments, hospital visits, lab services — plus more:

- **Virtual care through JeffConnect**, so you have 24/7 access to virtual visits with a Jefferson provider.
- **Prescription drug coverage** for low-cost generic and brand name medications.
- **FREE** first primary care provider (PCP) visit!*

**For HMO plans, first free visit applies when seeing a Tier 1 provider.*

Questions?

Ready to enroll?

Call **1-866-599-0688 (TTY 711)**

Visit JeffersonHealthPlans.com/Individuals-Families

Work with a licensed broker for help choosing and enrolling in a plan.

Which Plan is Right for You?

We offer plans in three metal tiers: Bronze, Silver, and Gold. Choose a plan in a metal tier that best suits your healthcare needs and budget. No matter which plan and tier you choose, you can count on the same quality of coverage.

BRONZE

PREMIUM COSTS: \$

OUT-OF-POCKET: \$\$\$

- ✓ Advanced premium tax credits*
- ✗ Cost-sharing reductions*

★ **BEST IF:** You don't go to the doctor often and want lower premiums

SILVER

PREMIUM COSTS: \$\$

OUT-OF-POCKET: \$\$

- ✓ Advanced premium tax credits*
- ✓ Cost-sharing reductions*

★ **BEST IF:** You want to pay a lower premium and keep out-of-pocket costs lower

GOLD

PREMIUM COSTS: \$\$\$

OUT-OF-POCKET: \$

- ✓ Advanced premium tax credits*
- ✗ Cost-sharing reductions*



★ **BEST IF:** You go to the doctor often and want lower out-of-pocket costs

*If you are eligible for premium tax credits and/or cost-sharing reductions. See [page 4](#) for details.

HMO or PPO: How Do I Choose?



Deciding between a health maintenance organization (HMO) and preferred provider organization (PPO) plan can feel overwhelming, but we're here to help! Look at the chart below for a breakdown of the differences between HMO and PPO to help you choose the right type of plan. No matter which plan you choose, you get affordable, quality coverage.

HMO:

-  **Primary Care Provider (PCP):**
Choose your PCP (or we'll assign you one) to help coordinate your care
-  **Monthly premiums and out-of-pocket costs: LOWER \$**
- ✗ **Out-of-network coverage:**
Does not include out-of-network coverage, unless for a true medical emergency

BEST IF:
You care more about affordability or prefer using a PCP to manage your care

PPO:

-  **Primary Care Provider (PCP):**
Choosing a PCP is suggested, but not required
-  **Monthly premiums and out-of-pocket costs: HIGHER \$\$**
- ✓ **Out-of-network coverage:**
Allows the flexibility of out-of-network provider visits, but at a higher cost

BEST IF:
You care more about flexibility and more choice of both in and out of network providers.

HMO & PPO

- No referrals required!
- See leading Jefferson and Lehigh Valley Health Network doctors and other trusted providers!

Ways to Save

Need help paying for health insurance? We have good news!

Two types of financial assistance are available for those who qualify when you buy one of our plans through Pennie®, Pennsylvania's Official Health Insurance Marketplace¹:

- Advance Premium Tax Credits
- Cost-Sharing Reductions.

Even better, **9 out of 10 people qualify for savings.**²

See if you qualify

Your household income and size determine if you are eligible to save on your health insurance. Check your eligibility by calling us at **1-866-599-0688**, or by visiting www.pennie.com.



Understanding costs – we've got you covered.



Premiums

Monthly payments to maintain your coverage.



Deductibles

Fixed amount you pay for covered medical services before your insurance kicks in.



Coinsurance

Percentage of covered medical expenses you pay once you've met your deductible.



Copays

Fixed amount you pay for doctor visits, prescriptions, or other medical services.



Advanced Premium Tax Credits

Tax credit that lowers your monthly premium if you qualify.³



Cost-Sharing Reductions

Lower your out-of-pocket costs and can be combined with an Advance Premium Tax credit to save more.³

1. Learn more at www.pennie.com or call **1-844-844-8040** for assistance.

2. www.cms.gov press release 'Historic 21.3 Million People Choose ACA Coverage'; January 24, 2024

3. Federal financial assistance can only be applied to the purchase of a Qualified Health Plan (QHP), which is an insurance plan that's certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act.

		Jefferson Health Plans + \$0 Deductible + Bronze + HMO	
		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$0/\$0	\$2,000/\$4,000
Drug Deductible		\$5,000/\$10,000	\$5,000/\$10,000
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		\$95 No Deductible	\$150 No Deductible
Specialist Visit		\$150 No Deductible	\$175 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$95 No Deductible	\$150 No Deductible
Virtual Care - Specialist Visit		\$150 No Deductible	\$175 No Deductible
Inpatient Hospital Services	Acute stays	\$2,000 Per Day No Deductible (Max 5 copays per admit)	\$3,000 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$2,000 Per Day No Deductible (Max 5 copays per admit)	\$3,000 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$2,000 Per Day No Deductible (Max 5 copays per admit)	\$3,000 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance No Deductible	50% Coinsurance After Deductible
Lab Services		\$150 No Deductible	\$250 No Deductible
Emergency Room Services		\$1,200 No Deductible	\$1,200 After Deductible
Imaging (CT/PET Scans, MRIs)		\$600 No Deductible	\$750 After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$150 No Deductible	\$250 No Deductible
Urgent Care Centers or Facilities		\$150 No Deductible	\$175 No Deductible
Gender Affirming Care		\$2,000 No Deductible	\$3,000 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$35 No Deductible	\$35 No Deductible
	Generic Drugs Tier 2	\$35 No Deductible	\$35 No Deductible
	Preferred Brand Drugs	\$150 No Deductible	\$150 No Deductible
	Non-Preferred Brand Drugs	\$250 After Deductible	\$250 After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Total + Bronze + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$7,900/\$15,800	\$19,200/\$18,400
Drug Deductible		Combined	Combined
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		\$60 No Deductible	\$95 No Deductible
Specialist Visit		\$95 No Deductible	\$150 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care (other) - Primary Care Visit		\$60 No Deductible	\$95 No Deductible
Virtual Care (other) - Specialist Visit		\$95 No Deductible	\$150 No Deductible
Inpatient Hospital Services	Acute stays	\$850 Per Day After Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$850 Per Day After Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$850 Per Day After Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	0% Coinsurance After Deductible
Lab Services		\$75 No Deductible	\$150 No Deductible
Emergency Room Services		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Imaging (CT/PET Scans, MRIs)		\$300 No Deductible	\$350 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$135 No Deductible	\$150 No Deductible
Urgent Care Centers or Facilities		\$95 No Deductible	\$150 No Deductible
Gender Affirming Care		\$850 After Deductible	\$1,000 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$35 No Deductible	\$35 No Deductible
	Generic Drugs Tier 2	\$35 No Deductible	\$35 No Deductible
	Preferred Brand Drugs	\$150 No Deductible	\$150 No Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Value + Bronze + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$8,500/\$17,000	\$9,200/\$18,400
Drug Deductible		Combined	Combined
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		0% After Deductible	0% After Deductible
Specialist Visit		0% After Deductible	0% After Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care (other) - Primary Care Visit		0% After Deductible	0% After Deductible
Virtual Care (other) - Specialist Visit		0% After Deductible	0% After Deductible
Inpatient Hospital Services	Acute stays	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		0% After Deductible	0% After Deductible
Lab Services		0% Coinsurance After Deductible	0% Coinsurance After Deductible
Emergency Room Services		0% After Deductible	0% After Deductible
Imaging (CT/PET Scans, MRIs)		0% After Deductible	0% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		0% After Deductible	0% After Deductible
Urgent Care Centers or Facilities		0% After Deductible	0% After Deductible
Gender Affirming Care		0% After Deductible	0% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$35 No Deductible	\$35 No Deductible
	Generic Drugs Tier 2	\$35 No Deductible	\$35 No Deductible
	Preferred Brand Drugs	0% After Deductible	0% After Deductible
	Non-Preferred Brand Drugs	0% After Deductible	0% After Deductible
	Specialty Drugs	0% After Deductible	0% After Deductible

Jefferson Health Plans + \$0 Deductible + Silver + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$0/\$0	\$2,000/\$4,000
Drug Deductible		\$5,000/\$10,000	\$5,000/\$10,000
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		\$50 No Deductible	\$95 No Deductible
Specialist Visit		\$95 No Deductible	\$130 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$50 No Deductible	\$95 No Deductible
Virtual Care - Specialist Visit		\$95 No Deductible	\$130 No Deductible
Inpatient Hospital Services	Acute stays	\$595 Per Day No Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$595 Per Day No Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$595 Per Day No Deductible (Max 5 copays per admit)	\$1,000 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance No Deductible	50% Coinsurance After Deductible
Lab Services		\$60 No Deductible	\$100 No Deductible
Emergency Room Services		\$975 No Deductible	\$975 No Deductible
Imaging (CT/PET Scans, MRIs)		\$350 No Deductible	\$500 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	\$130 No Deductible
Urgent Care Centers or Facilities		\$95 No Deductible	\$130 No Deductible
Gender Affirming Care		\$595 No Deductible	\$1,000 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$5 No Deductible	\$5 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	\$100 No Deductible	\$100 No Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Balanced + Silver + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$2,500/\$5,000	\$6,900/\$13,800
Drug Deductible		\$600/\$1,200	\$600/\$1,200
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		\$45 No Deductible	\$90 No Deductible
Specialist Visit		\$90 No Deductible	\$130 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$45 No Deductible	\$90 No Deductible
Virtual Care - Specialist Visit		\$90 No Deductible	\$130 No Deductible
Inpatient Hospital Services	Acute stays	\$550 Per Day After Deductible (Max 5 copays per admit)	\$850 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$550 Per Day After Deductible (Max 5 copays per admit)	\$850 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$550 Per Day After Deductible (Max 5 copays per admit)	\$850 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$50 No Deductible	\$100 No Deductible
Emergency Room Services		\$950 No Deductible	\$950 No Deductible
Imaging (CT/PET Scans, MRIs)		\$300 No Deductible	\$450 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	\$100 No Deductible
Urgent Care Centers or Facilities		\$90 No Deductible	\$130 No Deductible
Gender Affirming Care		\$550 After Deductible	\$850 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$5 No Deductible	\$5 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Total + Silver + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$4,900/\$9,800	\$8,000/\$16,000
Drug Deductible		\$600/\$1,200	\$600/\$1,200
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		1/Benefit Year	0
PCP Visit		\$40 No Deductible	\$85 No Deductible
Specialist Visit		\$85 No Deductible	\$125 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$40 No Deductible	\$85 No Deductible
Virtual Care - Specialist Visit		\$85 No Deductible	\$125 No Deductible
Inpatient Hospital Services	Acute stays	\$500 Per Day After Deductible (Max 5 copays per admit)	\$800 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$500 Per Day After Deductible (Max 5 copays per admit)	\$800 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$500 Per Day After Deductible (Max 5 copays per admit)	\$800 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$50 No Deductible	\$100 No Deductible
Emergency Room Services		\$950 No Deductible	\$950 No Deductible
Imaging (CT/PET Scans, MRIs)		\$300 No Deductible	\$450 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	\$100 No Deductible
Urgent Care Centers or Facilities		\$85 No Deductible	\$125 No Deductible
Gender Affirming Care		\$500 After Deductible	\$800 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$5 No Deductible	\$5 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + \$0 Deductible + Gold + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$0/\$0	\$500/\$1,000
Drug Deductible		Combined	Combined
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		2/Benefit Year	0
PCP Visit		\$25 No Deductible	\$75 No Deductible
Specialist Visit		\$75 No Deductible	\$100 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$25 No Deductible	\$75 No Deductible
Virtual Care - Specialist Visit		\$75 No Deductible	\$100 No Deductible
Inpatient Hospital Services	Acute stays	\$350 Per Day No Deductible (Max 5 copays per admit)	\$550 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$350 Per Day No Deductible (Max 5 copays per admit)	\$550 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$350 Per Day No Deductible (Max 5 copays per admit)	\$550 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance No Deductible	50% Coinsurance After Deductible
Lab Services		\$5 No Deductible	\$65 No Deductible
Emergency Room Services		\$450 No Deductible	\$550 No Deductible
Imaging (CT/PET Scans, MRIs)		\$120 No Deductible	\$150 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$75 No Deductible	\$100 No Deductible
Urgent Care Centers or Facilities		\$75 No Deductible	\$100 No Deductible
Gender Affirming Care		\$350 After Deductible	\$550 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$5 No Deductible	\$5 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	\$100 No Deductible	\$100 No Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Total + Gold + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$100/\$500	\$1,000/\$2,000
Drug Deductible		\$1,000/\$2,000	\$1,000/\$2,000
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		2/Benefit Year	0
PCP Visit		\$20 No Deductible	\$60 No Deductible
Specialist Visit		\$65 No Deductible	\$100 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$20 No Deductible	\$60 No Deductible
Virtual Care - Specialist Visit		\$65 No Deductible	\$100 No Deductible
Inpatient Hospital Services	Acute stays	\$300 Per Day After Deductible (Max 5 copays per admit)	\$500 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$300 Per Day After Deductible (Max 5 copays per admit)	\$500 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$300 Per Day After Deductible (Max 5 copays per admit)	\$500 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		0%	20% Coinsurance After Deductible
Emergency Room Services		\$400 No Deductible	\$400 No Deductible
Imaging (CT/PET Scans, MRIs)		\$110 No Deductible	\$150 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$65 No Deductible	\$100 No Deductible
Urgent Care Centers or Facilities		\$65 No Deductible	\$100 No Deductible
Gender Affirming Care		\$300 After Deductible	\$500 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$0 No Deductible	\$0 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	\$100 No Deductible	\$100 No Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Value + Gold + HMO

		Tier 1	Tier 2
Medical Deductible - Individual/Family		\$1,500/\$3,000	\$2,000/\$4,000
Drug Deductible		\$500/\$1,000	\$1,000/\$2,000
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$9,200/\$18,400
No Cost Share PCP Visit		2/Benefit Year	0
PCP Visit		\$15 No Deductible	\$60 No Deductible
Specialist Visit		\$60 No Deductible	\$100 No Deductible
Virtual Care (JeffConnect)		No Charge	N/A
Virtual Care - Primary Care Visit		\$15 No Deductible	\$60 No Deductible
Virtual Care - Specialist Visit		\$60 No Deductible	\$100 No Deductible
Inpatient Hospital Services	Acute stays	\$250 Per Day After Deductible (Max 5 copays per admit)	\$500 Per Day After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$60 Per Day After Deductible (Max 5 copays per admit)	\$60 Per Day After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$250 Per Day After Deductible (Max 5 copays per admit)	\$500 Per Day After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$0	\$50 No Deductible
Emergency Room Services		\$300 No Deductible	\$500 No Deductible
Imaging (CT/PET Scans, MRIs)		\$100 No Deductible	\$150 No Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$60 No Deductible	\$100 No Deductible
Urgent Care Centers or Facilities		\$60 No Deductible	\$100 No Deductible
Gender Affirming Care		\$250 After Deductible	\$500 After Deductible
Pharmacy Services	Preventive Drugs	No Charge	No Charge
	Generic Drugs Tier 1	\$0 No Deductible	\$0 No Deductible
	Generic Drugs Tier 2	\$20 No Deductible	\$20 No Deductible
	Preferred Brand Drugs	\$100 No Deductible	\$100 No Deductible
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + \$0 Deductible + Bronze + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$0/\$0	\$10,000/\$20,000
Drug Deductible		\$5,000/\$10,000	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$100 No Deductible	50% After Deductible
Specialist Visit		\$150 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$100 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$150 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$2,000 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$2,000 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$2,000 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance No Deductible	50% Coinsurance After Deductible
Lab Services		\$100 No Deductible	50% After Deductible
Emergency Room Services		\$1,500 No Deductible	\$1,500
Imaging (CT/PET Scans, MRIs)		\$600 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$150 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$150 No Deductible	50% After Deductible
Gender Affirming Care		Not Covered	Not Covered
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$35 No Deductible	Not Covered
	Generic Drugs Tier 2	\$35 No Deductible	Not Covered
	Preferred Brand Drugs	\$200 After Deductible	Not Covered
	Non-Preferred Brand Drugs	\$250 After Deductible	Not Covered
	Specialty Drugs	50% After Deductible	Not Covered

		Jefferson Health Plans + Total + Bronze + PPO	
		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$7,450/\$14,900	\$14,900/\$29,800
Drug Deductible		Combined	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$60	50% After Deductible
Specialist Visit		\$95 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care (other) - Primary Care Visit		\$60 No Deductible	50% After Deductible
Virtual Care (other) - Specialist Visit		\$95 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$850 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$850 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$850 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$75 No Deductible	50% After Deductible
Emergency Room Services		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Imaging (CT/PET Scans, MRIs)		\$300 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$135 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$95 No Deductible	50% After Deductible
Gender Affirming Care		Not Covered	Not Covered
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$35 No Deductible	Not Covered
	Generic Drugs Tier 2	\$35 No Deductible	Not Covered
	Preferred Brand Drugs	\$150 No Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	50% Coinsurance After Deductible

Jefferson Health Plans + Value + Bronze + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$8,000/\$16,000	\$16,000/\$32,000
Drug Deductible		Combined	N/A
Out-of-Pocket Maximum - Individual/Family		\$8,000/\$16,000	\$16,000/\$32,000
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		0% After Deductible	0% After Deductible
Specialist Visit		0% After Deductible	0% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care (other) - Primary Care Visit		0% After Deductible	0% After Deductible
Virtual Care (other) - Specialist Visit		0% After Deductible	0% After Deductible
Inpatient Hospital Services	Acute Stays	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	0% After Deductible (Max 5 copays per admit)	0% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		0% After Deductible	0% After Deductible
Lab Services		0% Coinsurance After Deductible	0% Coinsurance After Deductible
Emergency Room Services		0% After Deductible	0% After Deductible
Imaging (CT/PET Scans, MRIs)		0% After Deductible	0% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		0% After Deductible	0% After Deductible
Urgent Care Centers or Facilities		0% After Deductible	0% After Deductible
Gender Affirming Care		0% After Deductible	0% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$35 No Deductible	Not Covered
	Generic Drugs Tier 2	\$35 No Deductible	Not Covered
	Preferred Brand Drugs	0% After Deductible	Not Covered
	Non-Preferred Brand Drugs	0% After Deductible	Not Covered
	Specialty Drugs	0% After Deductible	Not Covered

Jefferson Health Plans + \$0 Deductible + Silver + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$0/\$0	\$5,000/\$10,000
Drug Deductible		\$5,000/\$10,000	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$55 No Deductible	50% After Deductible
Specialist Visit		\$95 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$55 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$95 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$595 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$595 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$595 Per Day No Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance No Deductible	50% Coinsurance After Deductible
Lab Services		\$60 No Deductible	50% After Deductible
Emergency Room Services		\$975 No Deductible	\$975 No Deductible
Imaging (CT/PET Scans, MRIs)		\$350 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$95 No Deductible	50% After Deductible
Gender Affirming Care		\$595 No Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$10 No Deductible	Not Covered
	Generic Drugs Tier 2	\$30 No Deductible	Not Covered
	Preferred Brand Drugs	\$100 No Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered

Jefferson Health Plans + Balanced + Silver + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$2,900/\$5,800	\$10,000/\$20,000
Drug Deductible		\$600/\$1,200	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$45 No Deductible	50% After Deductible
Specialist Visit		\$90 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$45 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$90 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$550 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$550 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$550 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$60 No Deductible	50% After Deductible
Emergency Room Services		\$900 No Deductible	\$900 No Deductible
Imaging (CT/PET Scans, MRIs)		\$300 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$90 No Deductible	50% After Deductible
Gender Affirming Care		\$550 After Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$5 No Deductible	Not Covered
	Generic Drugs Tier 2	\$20 No Deductible	Not Covered
	Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered

Jefferson Health Plans + Total + Silver + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$4,900/\$9,800	\$10,000/\$20,000
Drug Deductible		\$600/\$1,200	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$40 No Deductible	50% After Deductible
Specialist Visit		\$90 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$40 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$90 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$50 No Deductible	50% After Deductible
Emergency Room Services		\$900 No Deductible	\$900 No Deductible
Imaging (CT/PET Scans, MRIs)		\$250 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$100 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$90 No Deductible	50% After Deductible
Gender Affirming Care		\$500 After Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$5 No Deductible	Not Covered
	Generic Drugs Tier 2	\$20 No Deductible	Not Covered
	Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered

Jefferson Health Plans + \$0 Deductible + Gold + PPO

		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$0/\$0	\$5,000/\$10,000
Drug Deductible		Combined	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$15,000/\$30,000
No Cost Share PCP Visit		1/Benefit Year	Not Covered
PCP Visit		\$25 No Deductible	50% After Deductible
Specialist Visit		\$65 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$25 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$65 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$600 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$600 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$600 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$25 No Deductible	50% After Deductible
Emergency Room Services		\$350 No Deductible	\$350 No Deductible
Imaging (CT/PET Scans, MRIs)		\$200 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$75 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$65 No Deductible	50% After Deductible
Gender Affirming Care		\$600 No Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$0 No Deductible	Not Covered
	Generic Drugs Tier 2	\$20 No Deductible	Not Covered
	Preferred Brand Drugs	\$50 No Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered

		Jefferson Health Plans + Total + Gold + PPO	
		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$500/\$1,000	\$10,000/\$20,000
Drug Deductible		\$1,000/\$2,000	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		2/Benefit year	Not Covered
PCP Visit		\$20 No Deductible	50% After Deductible
Specialist Visit		\$50 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$20 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$50 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$500 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$20 No Deductible	50% After Deductible
Emergency Room Services		\$300 No Deductible	\$300 No Deductible
Imaging (CT/PET Scans, MRIs)		\$125 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$60 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$50 No Deductible	50% After Deductible
Gender Affirming Care		\$500 After Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$0 No Deductible	Not Covered
	Generic Drugs Tier 2	\$20 No Deductible	Not Covered
	Preferred Brand Drugs	\$50 No Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered

Jefferson Health Plans + Value + Gold + PPO


		In-Network	Out-of-Network
Medical Deductible - Individual/Family		\$1,500/\$3,000	\$10,000/\$20,000
Drug Deductible		\$500/\$1,000	N/A
Out-of-Pocket Maximum - Individual/Family		\$9,200/\$18,400	\$18,400/\$36,800
No Cost Share PCP Visit		2/Benefit year	Not Covered
PCP Visit		\$15 No Deductible	50% After Deductible
Specialist Visit		\$45 No Deductible	50% After Deductible
Virtual Care (JeffConnect)		No Charge	Not Covered
Virtual Care - Primary Care Visit		\$15 No Deductible	50% After Deductible
Virtual Care - Specialist Visit		\$45 No Deductible	50% After Deductible
Inpatient Hospital Services	Acute Stays	\$400 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Mental/Behavioral Health/SUD	\$400 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
	Delivery and All Inpatient Services for Maternity Care	\$400 Per Day After Deductible (Max 5 copays per admit)	50% After Deductible (Max 5 copays per admit)
Durable Medical Equipment		50% Coinsurance After Deductible	50% Coinsurance After Deductible
Lab Services		\$0 No Deductible	50% After Deductible
Emergency Room Services		\$250 No Deductible	\$250 No Deductible
Imaging (CT/PET Scans, MRIs)		\$100 No Deductible	50% After Deductible
Occupational and Rehabilitative Physical Therapy (30 visits combined per year)		\$50 No Deductible	50% After Deductible
Urgent Care Centers or Facilities		\$45 No Deductible	50% After Deductible
Gender Affirming Care		\$400 After Deductible	50% After Deductible
Pharmacy Services	Preventive Drugs	No Charge	Not Covered
	Generic Drugs Tier 1	\$0 No Deductible	Not Covered
	Generic Drugs Tier 2	\$20 No Deductible	Not Covered
	Preferred Brand Drugs	\$50 No Deductible	Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance After Deductible	Not Covered
	Specialty Drugs	50% Coinsurance After Deductible	Not Covered



How to Enroll

Enrolling is easy! We're here to help you every step of the way. Here's how to get in touch:

Call 1-866-599-0688
(TTY 711)

 to speak with our friendly, experienced team of licensed representatives

We're available:

Nov 1 – Jan 31
8 a.m. to 8 p.m.
7 days/week

Feb 1 – Oct 31
8 a.m. to 6 p.m.
Monday – Friday



Or contact your local broker.

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