2023 Marketplace
Individual and Family Plan Options

Premium subsidies available if you qualify

Questions about your health care options?

Visit **prevea360.com/enroll2023** for help deciding which option is best for you.

Copay Plus Plans

Plan Name	Gold Copay Plus 1500X	Silver Copay Plus 4800X	Bronze Copay Plus 9050X
Deductible (Single / Family)	$1,500 / $3,000	$4,800 / $9,600	$9,050 / $18,100
Coinsurance	20%	30%	0%
Annual Max Out-of-Pocket (Single / Family)	$5,700 / $11,400	$9,100 / $18,200	$9,050 / $18,100
Primary Care Office Visit	$30 copay	$40 copay	
Specialist Office Visit	$60 copay	$80 copay	
Virtual Care	No charge		
Preventive Exam*			
Urgent Care	$30 copay	$40 copay	
Emergency Room	$500 copay before policy deductible and coinsurance		
Outpatient Lab/X-ray	20% after deductible	30% after deductible	No charge after deductible
Hospital Stay			

Copay Plus Prescription Drug Benefits - Gold and Silver offer $15 Generics, $60 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty; Bronze offers $20 Generics and no charge after deductible on all other tiers

Copay PCP Plans

Plan Name	Gold Copay PCP 2000X	Silver Copay PCP 4500X	Bronze Copay PCP 8000X
Deductible (Single / Family)	$2,000 / $4,000	$4,500 / $9,000	$8,000 / $16,000
Coinsurance	20%		
Annual Max Out-of-Pocket (Single / Family)	$6,900 / $13,800	$9,100 / $18,200	$9,100 / $18,200
Primary Care Office Visit	$30 copay		
Specialist Office Visit	20% after deductible		
Virtual Care	No charge		
Preventive Exam*			
Urgent Care	20% after deductible		
Emergency Room			
Outpatient Lab/X-ray			
Hospital Stay			

Copay PCP Prescription Drug Benefits - $15 Generics and policy coinsurance after deductible on all other tiers

Value Copay Plans

Plan Name	Gold Value Copay 4000X	Silver Value Copay 4100X	Bronze Value Copay 9050X
Deductible (Single / Family)	$4,000 / $8,000	$4,100 / $8,200	$9,050 / $18,100
Coinsurance	0%	30%	0%
Annual Max Out-of-Pocket (Single / Family)	$4,000 / $8,000	$8,700 / $17,400	$9,050 / $18,100
Primary Care Office Visit	$25 copay for 3 visits then no charge after deductible	$25 copay for 3 visits then 30% coinsurance after deductible	$100 copay for 3 visits then no charge after deductible
Specialist Office Visit	No charge after deductible	30% after deductible	No charge after deductible
Virtual Care	No charge		
Preventive Exam*			
Urgent Care	No charge after deductible	30% after deductible	No charge after deductible
Emergency Room	$500 copay before policy deductible and coinsurance		
Outpatient Lab/X-ray	No charge after deductible	30% after deductible	No charge after deductible
Hospital Stay			

Value Copay Prescription Drug Benefits - Gold and Silver offer $15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty; Bronze offers no charge after deductible on all tiers

Additional cost sharing reductions are available to individuals who have a household income of at least 100 percent but not more than 250 percent of the federal poverty level and are enrolled in a silver tier plan. If you qualify for cost sharing reductions, see pages two and three for more plan options.

The following table shows the Federal Poverty Level guidelines, but an agent or Prevea360 Health Plan representative can help you determine if you qualify.

2022 Federal Poverty Level Guidelines

Size of Household	Percentage of Federal Poverty Level 100%	250%	400%
1	$13,590	$33,975	$54,360
2	$18,310	$45,775	$73,240
3	$23,030	$57,575	$92,120
4	$27,750	$69,375	$111,000
Coverage Information	May qualify for cost-sharing reductions and advance premium tax credits	May qualify for cost-sharing reductions and advance premium tax credits	May qualify for advance premium tax credits

Metal Tiers

You can use metal tiers to help determine which type of plan is right for you. Visit **prevea360.com/metaltiers** to view your options.

We are here to help

Visit **prevea360.com** for more plan information.

See the reverse side and page 3 for additional Marketplace plan options.

** Preventive exams are covered in accordance with the recommended preventive services as required by the Patient Protection and Affordable Care Act (PPACA).*

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Health Savings Account (HSA) Eligible and Catastrophic Plans

Plan Name	Gold HSA HDHP 2000X	Silver HSA-E HDHP 3550X	Bronze HSA-E HDHP 7000X	Catastrophic Safety Net
Deductible** (Single / Family)	$2,000 / $4,000	$3,550 / $7,100	$7,000 / $14,000	$9,100 / $18,200
Coinsurance	20%		0%	
Annual Max Out-of-Pocket (Single / Family)	$4,500 / $9,000	$7,050 / $14,100	$7,000 / $14,000	$9,100 / $18,200
Primary Care Office Visit	20% after deductible		No charge after deductible	$0 copay for 3 visits then no charge after deductible
Specialist Office Visit	20% after deductible		No charge after deductible	
Virtual Care				
Preventive Exam*	No charge			
Urgent Care	20% after deductible		No charge after deductible	
Emergency Room				
Outpatient Lab/X-ray				
Hospital Stay				

HSA Eligible Prescription Drug Benefits - Policy coinsurance after deductible on all tiers
Our HSA eligible plans are designed to offer maximum consumer value through a separate HDHP HSA formulary, increasing access to lower cost generic drugs.
*** If purchasing an HSA eligible family plan, the Silver and Bronze options offer benefits to each individual after the single deductible has been met.*

Standard Plans

Plan Name	Gold Standard 2000X	Silver Standard 5800X	Bronze Standard 7500X	Bronze Standard 9100X
Deductible (Single / Family)	$2,000 / $4,000	$5,800 / $11,600	$7,500 / $15,000	$9,100 / $18,200
Coinsurance	25%	40%	50%	0%
Annual Max Out-of-Pocket (Single / Family)	$8,700 / $17,400	$8,900 / $17,800	$9,000 / $18,000	$9,100 / $18,200
Primary Care Office Visit	$30 copay	$40 copay	$50 copay	No charge after deductible
Specialist Office Visit	$60 copay	$80 copay	$100 copay	No charge after deductible
Virtual Care	No charge			
Preventive Exam*				
Urgent Care	$45 copay	$60 copay	$75 copay	No charge after deductible
Emergency Room	25% after deductible	40% after deductible	50% after deductible	No charge after deductible
Outpatient Lab/X-ray				
Hospital Stay				

Standard Plan Prescription Drug Benefits (Generic/Preferred Brand/Non-Preferred Brand/Specialty) - Gold 2000X offers $15/$30/$60/$250; Silver 5800X offers $20/$40/$80‡/$350‡; Bronze 7500X offers $25/$50‡/$100‡/$500‡; and Bronze 9100X offers no charge after deductible on all tiers
‡ Subject to plan deductible.

Silver Cost Sharing Reduction Plan Options

Copay Plus 4800X Plans

Subsidy Level	4800X (Standard)	4500X (200-250% FPL)	1000X (150-200% FPL)	100X (100-150% FPL)
Deductible (Single / Family)	$4,800 / $9,600	$4,500 / $9,000	$1,000 / $2,000	$100 / $200
Coinsurance	30%		10%	5%
Annual Max Out-of-Pocket (Single / Family)	$9,100 / $18,200	$7,250 / $14,500	$3,000 / $6,000	$750 / $1,500
Primary Care Office Visit	$40 copay		$5 copay	
Specialist Office Visit	$80 copay			
Virtual Care	No charge			
Preventive Exam*				
Urgent Care	$40 copay		$5 copay	
Emergency Room	$500 copay before policy deductible and coinsurance			
Outpatient Lab/X-ray	30% after deductible		10% after deductible	5% after deductible
Hospital Stay				

Copay Plus Prescription Drug Benefits: 4800X and 4500X offer $15 Generics, $60 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty; 1000X and 100X offer $5 Generics, $60 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty

Copay PCP 4500X Plans

Subsidy Level	4500X (Standard)	4500X (200-250% FPL)	900X (150-200% FPL)	200X (100-150% FPL)
Deductible (Single / Family)	$4,500 / $9,000	$4,500 / $9,000	$900 / $1,800	$200 / $400
Coinsurance	20%			
Annual Max Out-of-Pocket (Single / Family)	$9,100 / $18,200	$5,600 / $11,200	$3,000 / $6,000	$900 / $1,800
Primary Care Office Visit	$30 copay		$5 copay	
Specialist Office Visit	20% after deductible			
Virtual Care	No charge			
Preventive Exam*				
Urgent Care	20% after deductible			
Emergency Room				
Outpatient Lab/X-ray				
Hospital Stay				

Copay PCP Prescription Drug Benefits - 4500X offers $15 Generics and policy coinsurance after deductible on all other tiers; 900X and 200X offer $5 Generics and policy coinsurance after deductible on all other tiers

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Value Copay 4100X Plans

Subsidy Level	4100X (Standard)	3750X (200-250% FPL)	900X (150-200% FPL)	100X (100-150% FPL)
Deductible (Single / Family)	$4,100 / $8,200	$3,750 / $7,500	$900 / $1,800	$100 / $200
Coinsurance	30%	20%	10%	5%
Annual Max Out-of-Pocket (Single / Family)	$8,700 / $17,400	$7,000 / $14,000	$3,000 / $6,000	$1,400 / $2,800
Primary Care Office Visit	$25 copay for 3 visits then 30% coinsurance after deductible	$25 copay for 3 visits then 20% coinsurance after deductible	$5 copay for 3 visits then 10% coinsurance after deductible	$5 copay for 3 visits then 5% coinsurance after deductible
Specialist Office Visit	30% after deductible	20% after deductible	10% after deductible	5% after deductible
Virtual Care	No charge			
Preventive Exam*				
Urgent Care	30% after deductible	20% after deductible	10% after deductible	5% after deductible
Emergency Room	$500 copay before policy deductible and coinsurance			
Outpatient Lab/X-ray	30% after deductible	20% after deductible	10% after deductible	5% after deductible
Hospital Stay				

Value Copay Prescription Drug Benefits - 4100X and 3750X offer $15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty; 900X and 100X offer $5 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty

HSA-E HDHP 3550X Plans

Subsidy Level	3550X (Standard)	3000X (200-250% FPL)	1150X (150-200% FPL)†	250X (100-150% FPL)†
Deductible (Single / Family)	$3,550 / $7,100	$3,000 / $6,000	$1,150 / $2,300	$250 / $500
Coinsurance	20%		5%	
Annual Max Out-of-Pocket (Single / Family)	$7,050 / $14,100	$5,500 / $11,000	$3,000 / $6,000	$1,500 / $3,000
Primary Care Office Visit	20% after deductible		5% after deductible	
Specialist Office Visit				
Virtual Care				
Preventive Exam*	No charge			
Urgent Care	20% after deductible		5% after deductible	
Emergency Room				
Outpatient Lab/X-ray				
Hospital Stay				

HSA Eligible Prescription Drug Benefits - Policy coinsurance after deductible (separate HDHP HSA formulary)
† Special Note: Cost sharing reduction plan options 100-200% FPL do not meet the IRS qualifications for Health Savings Account (HSA) eligibility.

Standard 5800X Plans

Subsidy Level	5800X (Standard)	5700X (200-250% FPL)	800X (150-200% FPL)	0X (100-150% FPL)
Deductible (Single / Family)	$5,800 / $11,600	$5,700 / $11,400	$800 / $1,600	$0 / $0
Coinsurance	40%		30%	25%
Annual Max Out-of-Pocket (Single / Family)	$8,900 / $17,800	$7,200 / $14,400	$3,000 / $6,000	$1,700 / $3,400
Primary Care Office Visit	$40 copay	$30 copay	$20 copay	$0 copay
Specialist Office Visit	$80 copay	$60 copay	$40 copay	$10 copay
Virtual Care	No charge			
Preventive Exam*				
Urgent Care	$60 copay	$45 copay	$30 copay	$5 copay
Emergency Room	40% after deductible		30% after deductible	25%
Outpatient Lab/X-ray				
Hospital Stay				

Standard Plan Prescription Drug Benefits (Generic/Preferred Brand/Non-Preferred Brand/Specialty) - 5800X and 5700X offer $20/$40/$80‡/$350‡/800X offers $10/$20/$60‡/$250‡; 0X offers $0/$15/$50/$150
‡ Subject to plan deductible

You may be eligible for cost savings programs like discounted premiums or reduced costs on medical services.

Visit **prevea360.com/calculator** to determine if you are eligible for and how much you can receive under these programs.

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