WellFirst Health™

2020 Marketplace Individual Plan Options

Available at **wellfirstbenefits.com**

Copay Plus & Classic Plan Options

Plan Name	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Gold Copay Plus 1500X	$1,500 / $3,000	20%	$4,000 / $8,000	$30 copay	$60 copay	$15 copay	No Charge	$60 copay	$325 copay before policy deductible & coinsurance	20% after deductible	20% after deductible
Silver Copay Plus 4400X	$4,400 / $8,800	30%	$8,150 / $16,300							30% after deductible	30% after deductible
Bronze Copay Plus 8100X	$8,100 / $16,200	0%	$8,100 / $16,200						$500 copay before policy deductible & coinsurance	No charge after deductible	No charge after deductible
Silver Classic 5000X	$5,000 / $10,000	20%	$8,150 / $16,300	20% after deductible	20% after deductible	20% after deductible		20% after deductible	$325 copay before policy deductible & coinsurance	20% after deductible	20% after deductible

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

Value Copay Plan Options

Plan Name	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Gold Value Copay 3700X	$3,700 / $7,400	0%	$3,700 / $7,400	$25 copay for 3 visits then no charge after deductible	No charge after deductible	$25 copay	No Charge	No charge after deductible	$325 copay before policy deductible & coinsurance	No charge after deductible	No charge after deductible
Silver Value Copay 5000X	$5,000 / $10,000	30%	$8,150 / $16,300	$25 copay for 3 visits then 30% coinsurance after deductible	30% after deductible			30% after deductible		30% after deductible	30% after deductible
Bronze Value Copay 8100X	$8,100 / $16,200	0%	$8,100 / $16,200	$25 copay for 3 visits then no charge after deductible	No charge after deductible			No charge after deductible		No charge after deductible	No charge after deductible

Value Copay Prescription Drug Benefits – Gold & Silver offer $15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty; Bronze - All tiers offer no charge after deductible

HSA Eligible & Catastrophic Plan Options

Plan Name	Deductible** (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Silver HSA-E 4000X	$4,000 / $8,000	20%	$6,750 / $13,500	20% after deductible	20% after deductible	$25 copay	No Charge	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Bronze HSA-E 6700X	$6,700 / $13,400	0%	$6,700 / $13,400	No charge after deductible	No charge after deductible			No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Catastrophic Safety Net	$8,150 / $16,300		$8,150 / $16,300	$0 copay for 3 visits then no charge after deductible							

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.*

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

You may be eligible for cost savings programs like discounted premiums or reduced costs on medical services. Visit **wellfirstbenefits.com/calculator** to determine if you are eligible for and how much you can receive under these programs.

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.

The following table shows the Federal Poverty Level guidelines, but an agent or WellFirst Health Plan representative can help you if you're not sure.

2019 Federal Poverty Level Guidelines

Size of Household	Percentage of Federal Poverty Level 100%	250%	400%
1	$12,490	$31,225	$49,960
2	$16,910	$42,275	$67,640
3	$21,330	$53,325	$85,320
4	$25,750	$64,375	$103,000
Coverage Information	**May qualify for cost-sharing reductions and advanced premium tax credits**	**May qualify for cost-sharing reductions and advanced premium tax credits**	**May qualify for advanced premium tax credits**

Silver Cost Sharing Reduction Plans

Copay Plus 4400X

Subsidy Level	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Standard	$4,400 / $8,800	30%	$8,150 / $16,300	$30 copay	$60 copay	$15 copay	No Charge	$60 copay	$325 copay before policy deductible & coinsurance	30% after deductible	30% after deductible
200-250% FPL	$4,100 / $8,200		$6,500 / $13,000								
150-200% FPL	$400 / $800	10%	$2,700 / $5,400							10% after deductible	10% after deductible
100-150% FPL	$100 / $200	5%	$750 / $1,500							5% after deductible	5% after deductible

Copay Plus 4400X Prescription Drug Benefits – $15 Generics, $50 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty

Classic 5000X

Subsidy Level	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Standard	$5,000 / $10,000	20%	$8,150 / $16,300	20% after deductible	20% after deductible	20% after deductible	No Charge	20% after deductible	$325 copay before policy deductible & coinsurance	20% after deductible	20% after deductible
200-250% FPL	$3,750 / $7,500	10%	$6,500 / $13,000	10% after deductible	10% after deductible	10% after deductible		10% after deductible		10% after deductible	10% after deductible
150-200% FPL	$750 / $1,500	5%	$2,700 / $5,400	5% after deductible	5% after deductible	5% after deductible		5% after deductible		5% after deductible	5% after deductible
100-150% FPL	$200 / $400		$900 / $1,800								

Classic 5000X Prescription Drug Benefits – $15 Generics, $50 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty

Value Copay 5000X

Subsidy Level	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Standard	$5,000 / $10,000	30%	$8,150 / $16,300	$25 copay for 3 visits then 30% coinsurance after deductible	30% after deductible	$25 copay	No Charge	30% after deductible	$325 copay before policy deductible & coinsurance	30% after deductible	30% after deductible
200-250% FPL	$3,750 / $7,500	20%	$6,500 / $13,000	$25 copay for 3 visits then 20% coinsurance after deductible	20% after deductible			20% after deductible		20% after deductible	20% after deductible
150-200% FPL	$800 / $1,600	5%	$2,700/$5,400	$25 copay for 3 visits then 5% coinsurance after deductible	5% after deductible			5% after deductible		5% after deductible	5% after deductible
100-150% FPL	$100 / $200		$950 / $1,900								

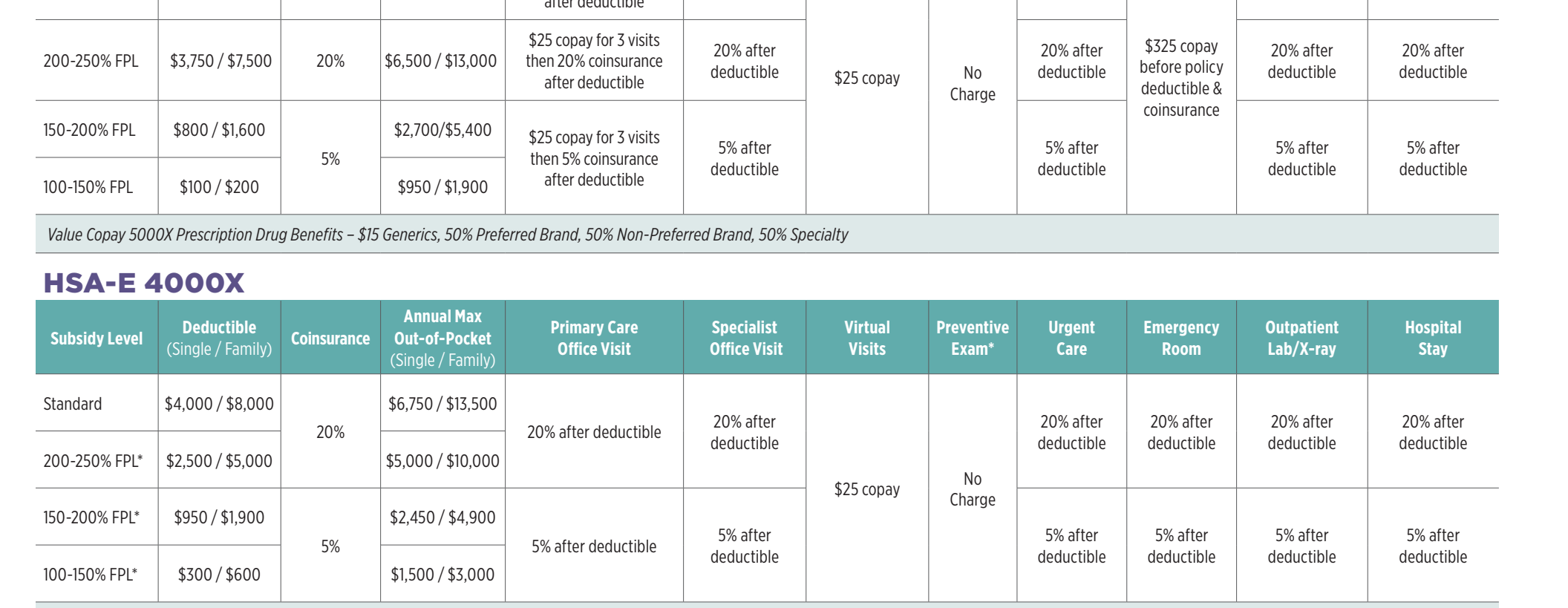
Value Copay 5000X Prescription Drug Benefits – $15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty

HSA-E 4000X

Subsidy Level	Deductible (Single / Family)	Coinsurance	Annual Max Out-of-Pocket (Single / Family)	Primary Care Office Visit	Specialist Office Visit	Virtual Visits	Preventive Exam*	Urgent Care	Emergency Room	Outpatient Lab/X-ray	Hospital Stay
Standard	$4,000 / $8,000	20%	$6,750 / $13,500	20% after deductible	20% after deductible	$25 copay	No Charge	20% after deductible	20% after deductible	20% after deductible	20% after deductible
200-250% FPL*	$2,500 / $5,000		$5,000 / $10,000								
150-200% FPL*	$950 / $1,900	5%	$2,450 / $4,900	5% after deductible	5% after deductible			5% after deductible	5% after deductible	5% after deductible	5% after deductible
100-150% FPL*	$300 / $600		$1,500 / $3,000								

HSA-E 4000X Prescription Drug Benefits: Policy coinsurance after deductible (separate HDHP HSA formulary)

**Special Note: Cost sharing reduction plan options 100-250% FPL do not meet the IRS qualifications for Health Savings Account (HSA) eligibility.*



You may be eligible for cost savings programs like discounted premiums or reduced costs on medical services. Visit **wellfirstbenefits.com/calculator** to determine if you are eligible for and how much you can receive under these programs.