

2020 Preliminary Individual & Family Plan Monthly Premiums



Age	Min. Coverage	Bronze	Silver	Gold	Platinum
0-14	\$127.04	\$164.66	\$241.50	\$303.87	\$348.29
15	\$138.33	\$179.29	\$262.97	\$330.88	\$379.25
16	\$142.65	\$184.89	\$271.18	\$341.21	\$391.08
17	\$146.96	\$190.48	\$279.38	\$351.54	\$402.92
18	\$151.61	\$196.51	\$288.22	\$362.66	\$415.67
19	\$156.26	\$202.54	\$297.06	\$373.78	\$428.42
20	\$161.08	\$208.78	\$306.22	\$385.30	\$441.62
21	\$166.06	\$215.24	\$315.69	\$397.22	\$455.28
22	\$166.06	\$215.24	\$315.69	\$397.22	\$455.28
23	\$166.06	\$215.24	\$315.69	\$397.22	\$455.28
24	\$166.06	\$215.24	\$315.69	\$397.22	\$455.28
25	\$166.73	\$216.10	\$316.95	\$398.81	\$457.10
26	\$170.05	\$220.40	\$323.26	\$406.75	\$466.20
27	\$174.03	\$225.57	\$330.84	\$416.29	\$477.13
28	\$180.51	\$233.96	\$343.15	\$431.78	\$494.89
29	\$185.82	\$240.85	\$353.25	\$444.49	\$509.46
30	\$188.48	\$244.29	\$358.31	\$450.84	\$516.74
31	N/A	\$249.46	\$365.88	\$460.38	\$527.67
32	N/A	\$254.62	\$373.46	\$469.91	\$538.59
33	N/A	\$257.85	\$378.19	\$475.87	\$545.42
34	N/A	\$261.30	\$383.24	\$482.22	\$552.71
35	N/A	\$263.02	\$385.77	\$485.40	\$556.35
36	N/A	\$264.74	\$388.30	\$488.58	\$559.99
37	N/A	\$266.46	\$390.82	\$491.76	\$563.63
38	N/A	\$268.18	\$393.35	\$494.94	\$567.28
39	N/A	\$271.63	\$398.40	\$501.29	\$574.56
40	N/A	\$275.07	\$403.45	\$507.65	\$581.84

Subject to Regulatory Approval					
Age	Min. Coverage	Bronze	Silver	Gold	Platinum
41	N/A	\$280.24	\$411.02	\$517.18	\$592.77
42	N/A	\$285.19	\$418.29	\$526.32	\$603.24
43	N/A	\$292.08	\$428.39	\$539.03	\$617.81
44	N/A	\$300.68	\$441.02	\$554.92	\$636.02
45	N/A	\$310.80	\$455.85	\$573.59	\$657.42
46	N/A	\$322.85	\$473.53	\$595.83	\$682.92
47	N/A	\$336.41	\$493.42	\$620.85	\$711.60
48	N/A	\$351.91	\$516.15	\$649.45	\$744.38
49	N/A	\$367.19	\$538.56	\$677.66	\$776.70
50	N/A	\$384.41	\$563.82	\$709.43	\$813.13
51	N/A	\$401.41	\$588.76	\$740.81	\$849.09
52	N/A	\$420.14	\$616.22	\$775.37	\$888.70
53	N/A	\$439.08	\$644.00	\$810.33	\$928.77
54	N/A	\$459.53	\$673.99	\$848.06	\$972.02
55	N/A	\$479.98	\$703.98	\$885.80	\$1,015.27
56	N/A	\$502.15	\$736.50	\$926.71	\$1,062.16
57	N/A	\$524.53	\$769.33	\$968.02	\$1,109.51
58	N/A	\$548.42	\$804.37	\$1,012.12	\$1,160.05
59	N/A	\$560.26	\$821.73	\$1,033.96	\$1,185.09
60	N/A	\$584.15	\$856.78	\$1,078.05	\$1,235.62
61	N/A	\$604.81	\$887.08	\$1,116.19	\$1,279.33
62	N/A	\$618.37	\$906.97	\$1,141.21	\$1,308.01
63	N/A	\$635.38	\$931.91	\$1,172.59	\$1,343.98
64+	N/A	\$645.70	\$947.05	\$1,191.65	\$1,365.82

*Premiums do not include eligible subsidies



2020 Patient-Centered Benefit Designs & Medical Cost-Shares

	Min. Coverage	Bronze 60	Silver 70	Gold 80	Platinum 90
% Cost of Coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0
Office Visits: Primary Care, Urgent Care, & Mental Health, Behavioral Health	After first 3 non-preventive visits (combined), full cost per instance until out-of-pocket max. has been met	\$65*	\$40	\$30	\$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$95*	\$80	\$65	\$30
Emergency Room (cost-share waived, if admitted)		40%	\$400	\$350	\$150
Emergency Medical Transportation		40%	\$250	\$250	\$150
Laboratory Tests		\$40	\$40	\$40	\$15
X-Rays & Diagnostics		40%	\$85	\$75	\$30
Imaging (CT/PET Scans & MRIs)		40%	\$325	\$275	\$75
Tier 1 (Generic Drugs)	100% up to \$500 per script	\$18	\$16**	\$15	\$5
Tier 2 (Preferred Drugs)		40% up to \$500 per script after pharmacy deductible is met	\$60**	\$55	\$15
Tier 3 (Non-Preferred Drugs)			\$90**	\$80	\$25
Tier 4 (Specialty Drugs)		20% up to \$250** per script	20% up to \$250 per script	10% up to \$250 per script	
Medical Deductible	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$4,000 Family: \$8,000	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$300 Family: \$600	N/A	N/A
Annual Out-of-Pocket Maximum	Individual: \$8,150 Family: \$16,300	Individual: \$7,800 Family: \$15,600	Individual: \$7,800 Family: \$15,600	Individual: \$7,800 Family: \$15,600	Individual: \$4,500 Family: \$9,000

Prices (cost-share) in **blue** are the member's per-visit cost until their deductible has been met.

Prices (cost-share) in **purple** are the member's per visit cost for their first three visits. Members are responsible for full cost of service after their first three visits, until their deductible has been met. Drug prices are for a 30-day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.