



2027 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in beige are **NOT** subject to a deductible.

Benefits in orange are subject to a deductible after the first three visits.

For the love of Californians

Drug prices are for a 30-day supply.

Deductible = The amount you pay before the plan pays.

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

2. Price is after pharmacy deductible amount is met.

3. See plan Evidence of Coverage for imaging cost share.

Covered California may approve deviations from the benefit plan designs for certain services on a case-by-case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

	MINIMUM COVERAGE Covers 0% until out-of-pocket max is met	BRONZE Covers 60% of average annual cost	SILVER Covers 70% of average annual cost ¹	SILVER 73 Covers 73% of average annual cost ¹	SILVER 87 Covers 87% of average annual cost ¹	SILVER 94 Covers 94% of average annual cost ¹	GOLD Covers 80% of average annual cost	PLATINUM Covers 90% of average annual cost
Cost-Sharing Reduction Single-Income Range	N/A	N/A	N/A	\$31,921–\$39,900 (>200% to <250% FPL)	\$23,941–\$31,920 (>150% to <200% FPL)	up to \$23,940 (>100% to <150% FPL)	N/A	N/A
Free Preventive Care Visit	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	Full cost per instance until out-of-pocket maximum is met (after first three non-preventive visits)	\$60	\$50	\$50	\$15	\$5	\$40	\$20
Urgent Care Visit		\$60	\$50	\$50	\$15	\$5	\$40	\$20
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$100 ¹	\$100	\$100	\$30	\$8	\$80	\$45
Emergency Room Facility		40% after deductible is met	\$400	\$400	\$200	\$50	\$350	\$225
Laboratory Tests		\$50	\$50	\$50	\$35	\$10	\$40	\$25
X-Rays and Diagnostics		40% after deductible is met	\$95	\$95	\$50	\$10	\$85	\$35
Imaging			\$325	\$325	\$100	\$50	\$125 copay or 25% coinsurance ³	\$90 copay or 15% coinsurance ³
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	\$20	\$20	\$20	\$10	\$3	\$19	\$10
Tier 2 (Preferred Drugs)		40% up to \$500 per script after drug deductible is met	\$65 ²	\$55 ²	\$30 ²	\$10	\$60	\$25
Tier 3 (Non-Preferred Drugs)			\$95 ²	\$95 ²	\$50 ²	\$15	\$90	\$45
Tier 4 (Specialty Drugs)			20% up to \$250 ² per script	20% up to \$250 ² per script	15% up to \$150 ² per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$5,800 Family: \$11,600	Individual: \$4,700 Family: \$9,400	Individual: \$4,700 Family: \$9,400	Individual: \$1,100 Family: \$2,200	Individual: \$200 Family: \$400	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$450 Family: \$900	Individual: \$50 Family: \$100	Individual: \$50 Family: \$100	Individual: \$50 Family: \$100	N/A	N/A	N/A
Annual Out-of-Pocket Max	Individual: \$12,000 Family: \$24,000	Individual: \$11,650 Family: \$23,300	Individual: \$11,650 Family: \$23,300	Individual: \$9,600 Family: \$19,200	Individual: \$4,000 Family: \$8,000	Individual: \$3,000 Family: \$6,000	Individual: \$9,600 Family: \$19,200	Individual: \$5,500 Family: \$11,000