



COVERED CALIFORNIA 2027 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Silver 73	Silver 87	Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	> \$31,921 to \$39,900 (>200% to ≤250% FPL)	\$23,941 to \$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	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	\$60	\$50	\$50	\$15	\$5	\$40	\$20
Urgent Care		\$60	\$50	\$50	\$15	\$5	\$40	\$20
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$100*	\$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***	\$90 copay or 15% coinsurance***
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**	\$55**	\$30**	\$10	\$60	\$25
Tier 3 (Non-preferred Drugs)			\$95**	\$95**	\$50**	\$15	\$90	\$45
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible - The amount you pay before the plan pays	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 - The amount you pay before the plan	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 Maximum	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

Drug prices are for a 30 day supply.

* 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.

** Price is after pharmacy deductible amount is met.

*** 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).