COVERED CALIFORNIA™

2026 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	**$31,301 to $39,125** (>200% to ≤250% FPL)	**$23,476 to $31,300** (>150% to ≤200% FPL)	**up to $23,475** (>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	$15
Urgent Care		$60*	$50	$50	$15	$5	$40	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$90	$90	$25	$8	$70	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$200	$50	$350	$175
Laboratory Tests		$50	$50	$50	$30	$10	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$95	$95	$50	$10	$75	$30
Imaging			$325	$325	$100	$50	$75 copay or 25% coinsurance***	$30 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$20	$19	$19	$8	$3	$18	$9
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$60**	$55**	$25**	$10	$60	$16
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15	$85	$25
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: $5,200 Family: $10,400	Individual: $5,200 Family: $10,400	Individual: $1,400 Family: $2,800	N/A	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	$10,600 individual $21,200 family	$9,800 individual $19,600 family	$9,800 individual $19,600 family	$8,100 individual $16,200 family	$3,350 individual $6,700 family	$1,400 individual $2,800 family	$9,200 individual $18,400 family	$5,000 individual $10,000 family

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).