COVERED CALIFORNIA™

2020 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	Enhanced Silver 73	Enhanced Silver 87	Enhanced 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	**$24,981 to $31,225 (>200% to ≤250% FPL)**	**$18,736 to $24,980 (>150% to ≤200% FPL)**	**up to $18,735 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$40	$35	$15	$5	$30	$15
Urgent Care		$65*	$40	$35	$15	$5	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$80	$75	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$16**	$5 or less	$3 or less	$15 or less	$5 or less
Tier 2 (Preferred Drugs)		40% up to $500 after drug deductible is met	$60**	$55**	$25**	$10 or less	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15 or less	$80 or less	$25 or less
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	N/A	Individual: $6,300 Family: $12,600	Individual: $4,000 Family: $8,000	Individual: $3,700 Family: $7,400	Individual: $1,400 Family: $2,800	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $300 Family: $600	Individual: $275 Family: $550	Individual: $100 Family: $200	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,150 individual only	$7,800 individual $15,600 family	$7,800 individual $15,600 family	$6,500 individual $13,000 family	$2,700 individual $5,400 family	$1,000 individual $2,000 family	$7,800 individual $15,600 family	$4,500 individual $9,000 family

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.

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