



# 2023 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	\$27,181 to \$33,975 (>200% to ≤250% FPL)	\$20,386 to \$27,180 (>150% to ≤200% FPL)	up to \$20,385 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$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	\$65*	\$45	\$45	\$15	\$5	\$35	\$15
Urgent Care		\$65*	\$45	\$45	\$15	\$5	\$35	\$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$95*	\$85	\$85	\$25	\$8	\$65	\$30
Emergency Room Facility		40% after deductible is met	\$400	\$400	\$150	\$50	\$350	\$150
Laboratory Tests		\$40	\$50	\$50	\$20	\$8	\$40	\$15
X-Rays and Diagnostics		40% after deductible is met	\$95	\$90	\$40	\$8	\$75	\$30
Imaging			\$325	\$325	\$100	\$50	\$75 copay or 25% 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**	\$3	\$15	\$5
Tier 2 (Preferred Drugs)		40% up to \$500 per script after drug deductible is met	\$60**	\$55**	\$25**	\$10	\$60	\$15
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	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$4,750 Family: \$9,500	Individual: \$4,750 Family: \$9,500	Individual: \$800 Family: \$1,600	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$85 Family: \$170	Individual: \$30 Family: \$60	Individual: \$25 Family: \$50	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$9,100 individual \$18,200 family	\$8,200 individual \$16,400 family	\$8,750 individual \$17,500 family	\$7,250 individual \$14,500 family	\$3,000 individual \$6,000 family	\$900 individual \$1,800 family	\$8,550 individual \$17,100 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.

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).