



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).