2027 以患者为本的福利设计与医疗费用分摊

米色标记的福利：不适用自付额。橘色标记的福利：前三次就诊后适用自付额。

	最低保障 在达到自付上限前保障为0%	铜 BRONZE 承保60%的平均年度费用	银 SILVER 承保70%的平均年度费用[1]	银73 SILVER73 承保73%的平均年度费用[1]	银 87 SILVER87 承保87%的平均年度费用[1]	银 94 SILVER94 承保94%的平均年度费用[1]	金 GOLD 承保80%的平均年度费用	白金 PLATINUM 承保90%的平均年度费用
费用分摊减免（单一收入范围）	不适用	不适用	不适用	**$31,921-$39,900** (>200% 到 <250% FPL)	**$23,941–$31,920** (>150% 到 <200% FPL)	**最高 $23,940** (>100% 到 <150% FPL)	不适用	不适用
预防性保健就诊	$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
初级保健就诊	前三次非预防性就诊后，直到达到自付上限前需支付全额	**$60**	**$50**	**$50**	**$15**	**$5**	**$40**	**$20**
紧急照护就诊		**$60**	**$50**	**$50**	**$15**	**$5**	**$40**	**$20**
专科医师	直到达到自付上限前需支付全额	**$100[1]** (前三次就诊不适用自付额)	**$100**	**$100**	**$30**	**$8**	**$80**	**$45**
急诊室		达自付额后40%	**$400**	**$400**	**$200**	**$50**	**$350**	**$225**
实验室检验		**$50**	**$50**	**$50**	**$35**	**$10**	**$40**	**$25**
X光與诊断		达自付额后40%	**$95**	**$95**	**$50**	**$10**	**$85**	**$35**
影像检查			**$325**	**$325**	**$100**	**$50**	**$125 共付或 25%共保[3]**	**$90 共付或 15%共保[3]**
第一级（仿制药）	直到達到自付上限前需支付全額	**$20**	**$20**	**$20**	**$10**	**$3**	**$19**	**$10**
第二级 （首选药物）		达药品自付额后，每张处方按药价40%收费，每张最高不超过$500	$65[2]	**$55[2]**	**$30[2]**	**$10**	**$60**	**$25**
第三级 （非首选药物）			$95[2]	**$95[2]**	**$50[2]**	**$15**	**$90**	**$45**
第四级 （专科用药）			每张处方按药价20%收费，每张最高不超过$250[2]	**每张处方按药价20%收费，每张最高不超过$250[2]**	**每张处方按药价15%收费，每张最高不超过$150[2]**	**每张处方按药价10%收费，每张最高不超过$150**	**每张处方按药价20%收费，每张最高不超过$250**	**每张处方按药价10%收费，每张最高不超过$250**
医疗自付额	不适用	个人：$5,800 家庭：$11,600	个人：$4,700 家庭：$9,400	个人：$4,700 家庭：$9,400	个人：$1,100 家庭：$2,200	个人：$200 家庭：$400	不适用	不适用
药品自付额	不适用	个人：$450 家庭：$900	个人：$50 家庭：$100	个人：$50 家庭：$100	个人：$50 家庭：$100	不适用	不适用	不适用
年度自付上限	个人：$12,000 家庭：$24,200	个人：$11,650 家庭：$23,300	个人：$11,650 家庭：$23,300	个人：$9,600 家庭：$19,200	个人：$4,000 家庭：$8,000	个人：$3,000 家庭：$6,000	个人：$9,600 家庭：$19,200	个人：$5,500 家庭：$11,000

药品价格为30天用量

自付额：指在保险开始给付前，您需先自行支付的金额

1. 共付额 (Copay) 适用于前三次专科服务；之后须全额支付，直到达到医疗自付额

2. 价格为达到药品自付额之费用

3. 影像检查费用请参阅保险计划【保障说明文件】

Covered California在必要时，为执行California Mental Health Parity Act或federal Mental Health Parity and Addiction Equity Act (MHPAEA)，可逐案核准，对福利设计进行调整。

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2027 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in beige are **NOT** subject to a deductible. Benefits in orange are subject to a deductible after the first three visits.

	MINIMUM COVERAGE Covers 0% until out-of-pocket max is met	BRONZE Covers 60% of average annual cost	SILVER Covers 70% of average annual cost[1]	SILVER 73 Covers 73% of average annual cost[1]	SILVER 87 Covers 87% of average annual cost[1]	SILVER 94 Covers 94% of average annual cost[1]	GOLD Covers 80% of average annual cost	PLATINUM Covers 90% of average annual cost
Cost-Sharing Reduction Single-Income Range	N/A	N/A	N/A	**$31,921–$39,900** (>200% to <250% FPL)	**$23,941–$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	Full cost per instance until out-of-pocket maximum is met (after first three non-preventive visits)	**$60**	**$50**	**$50**	**$15**	**$5**	**$40**	**$20**
Urgent Care Visit		**$60**	**$50**	**$50**	**$15**	**$5**	**$40**	**$20**
Specialist Visit	Full cost per service until out-of-pocket maximum is met	**$100[1]**	**$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[3]**	**$90 copay or 15% coinsurance[3]**
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[2]	**$55[2]**	**$30[2]**	**$10**	**$60**	**$25**
Tier 3 (Non-Preferred Drugs)			$95[2]	**$95[2]**	**$50[2]**	**$15**	**$90**	**$45**
Tier 4 (Specialty Drugs)			20% up to $250[2] per script	**20% up to $250[2] per script**	**15% up to $150[2] 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: $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	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 Max	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.

Deductible = The amount you pay before the plan pays.

1. 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.

2. Price is after pharmacy deductible amount is met.

3. 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).

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