HEALTH COVERAGE
ENROLLMENT & UTILIZATION

Presented by Health Access Program

Sponsored by Cedars Sinai

LAST UPDATED: 11/01/2023
WHY ARE CALIFORNIANS REQUIRED TO HAVE HEALTH INSURANCE?

In 2020, California started implementing its own individual mandate.

Californians must either have qualifying health insurance or pay a penalty.

California offers low-income and middle-income families financial help with health insurance.
TYPES OF HEALTH INSURANCE

MEDICARE
Free or low cost health insurance for people 65 and older, or people with disabilities

MEDI-CAL
California's Medicaid Program provides free or low-cost medical services for low-income individuals

COVERED CALIFORNIA
California's Obamacare is a health insurance marketplace through which California residents can purchase private health insurance with financial help from the government
PUBLIC CHARGE

Applying and receiving financial assistance for health insurance coverage through Covered California or Medi-Cal will **NOT** count as a “public charge”

- Will **NOT** affect the consumer’s immigration status or their chances of becoming a lawful permanent resident or naturalized citizen
- EXCEPTION: Receiving long-term care, such as nursing home, under Medi-Cal paid for by the government

HEALTH4ALL EXPANSION FOR MEDI-CAL

Quality, affordable health care for **ALL** Californians

- Starting **January 1, 2024**, all income-eligible Californians will be able to enroll for comprehensive/full-scope Medi-Cal coverage regardless of immigration status
ASSET TEST FOR MEDI-CAL

- Starting **July 1, 2022**, the asset limit increased to $130,000 for one person and $65,000 for each additional person up to ten in a household.
- Beginning **January 1, 2024**, the asset test will be eliminated for all Medi-Cal enrollees and the financial criteria for Medi-Cal benefits will be based solely on income.

ESTATE RECOVERY FOR MEDI-CAL

- Repayment only applies to benefits received by Medi-Cal beneficiaries on or after their 55th birthday and who own assets at the time of death.
- If a deceased beneficiary owns nothing, nothing will be owed.
- Only applies to long term care services, such as receiving care in a nursing home paid for by Medi-Cal.
NETWORK AND REFERRAL
HMO V. PPO V. EPO?

REQUIRED TO HAVE A PCP/FAMILY DOCTOR?
- HMO: Yes
- PPO: No
- EPO: Yes

OUT-OF-NETWORK COVERAGE?
- HMO: Yes
- PPO: Yes
- EPO: No

REFERRAL NEEDED FROM PCP?
- HMO: Yes
- PPO: No
- EPO: No

MONTHLY PREMIUM COST?
- HMO: $${}$
- PPO: $$$$${}$
- EPO: $$${}$
EXAMPLE SCENARIO

STEVEN

1. Wants to see an in-network specialist without a PCP's referral
2. Wants a low monthly premium

WHICH PLAN TYPE WOULD BE THE BEST FIT FOR STEVEN?
HMO V. PPO V. EPO?

REQUIRED TO HAVE A PCP/FAMILY DOCTOR?
- HMO: Yes
- PPO: No
- EPO: Yes/No

OUT-OF-NETWORK COVERAGE?
- HMO: Yes
- PPO: Yes
- EPO: Yes

REFERRAL NEEDED FROM PCP?
- HMO: Yes
- PPO: No
- EPO: No

MONTHLY PREMIUM COST?
- HMO: $1
- PPO: $$$
- EPO: $$
EXAMPLE SCENARIO

AMY

1. Has an HMO
2. Wants to see a specialist for knee pain

DOES AMY NEED A REFERRAL?
HMO

- REQUIRED TO HAVE A PCP/FAMILY DOCTOR? ✔
- OUT-OF-NETWORK COVERAGE? ✔
- REFERRAL NEEDED FROM PCP? ✔
- MONTHLY PREMIUM COST? 

V. PPO

- REQUIRED TO HAVE A PCP/FAMILY DOCTOR? ✗
- OUT-OF-NETWORK COVERAGE? ✔
- REFERRAL NEEDED FROM PCP? ✗
- MONTHLY PREMIUM COST? $$$

V. EPO

- REQUIRED TO HAVE A PCP/FAMILY DOCTOR? ✗
- OUT-OF-NETWORK COVERAGE? ✗
- REFERRAL NEEDED FROM PCP? ✗
- MONTHLY PREMIUM COST? $
WHAT'S COVERED?

All plans must include **essential health benefits:**

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity & newborn care
5. Mental health & substance use disorder services
6. Prescription drugs
7. Rehabilitative & habilitative services & devices
8. Laboratory services
9. Preventive & wellness services & chronic disease management
10. Services for children, including dental & vision care

*Coverage level varies by insurance plans, check Summary of Benefits and Coverage*
KEY TERMS

**Premium:** the monthly cost of your health insurance

**Copayment (copay):** a predetermined rate you pay for a health care service such as a doctor's visit or prescription

**Coinsurance:** percentage of cost that you need to pay for covered medical expenses after you’ve met your deductible

**Deductible:** the amount you pay out-of-pocket for health services before your plan starts contributing (premiums, copayments, and coinsurance do not typically count)

**Out-of-pocket maximum:** the amount you must spend on health expenses through copays, coinsurance, or deductibles before the plan starts covering all covered expenses
GENERAL ELIGIBILITY

MEDI-CAL

California Resident
Low-income
Beginning January 2024, ALL income-eligible Californians will qualify for full-scope Medi-Cal, regardless of immigration status

COVERED CALIFORNIA

California Resident
Low-to-moderate income
Lawfully present
MEDI-CAL ELIGIBILITY

**California Resident**
Live (and intend to reside) or work (or be seeking employment) in California

**Low-Income**
At or below the 138% Federal Poverty Level (FPL) for adults & 266% FPL for children, dependent on household size. Those who are 65/+; blind, or disabled are subject to the asset test ($130,000 for a single individual and $65,000 for each additional household member).

Starting January 2024, there will no longer be an asset test

**Immigration Status**
As of August 2023, undocumented individuals aged 26-49 can only get emergency scope Medi-Cal. Those under 26 and over 49 can get full-scope Medi-Cal, regardless of their immigration status.

Beginning January 2024, ALL income-eligible Californians will qualify for full-scope Medi-Cal, regardless of immigration status.
COVERED CALIFORNIA ELIGIBILITY

California Resident
Live in California

Low-to-Moderate Income
Earn above 138% Federal Poverty Level (FPL), determined by household size and income

Lawfully Present
Eligible immigrants include:
• Lawful permanent residents (green card holders)
• Lawful temporary residents
• Persons fleeing persecution including refugees and asylees
• Other humanitarian immigrants such as those granted temporary protected status
• Non-immigrant status holders including worker visas and student visas

As of August 2023:
• There are proposed rules from Biden Administration to allow DACA recipients to enroll in Covered California
• Undocumented immigrants are ineligible for Covered California
Program Eligibility by Federal Poverty Level for 2024

Your financial help and whether you qualify for various Covered California or Medi-Cal programs depends on your income, based on the Federal Poverty Level (FPL).

<table>
<thead>
<tr>
<th>% FPL</th>
<th>0%</th>
<th>100%</th>
<th>138%</th>
<th>150%</th>
<th>200%</th>
<th>213%</th>
<th>250%</th>
<th>266%</th>
<th>300%</th>
<th>322%</th>
<th>400%*</th>
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<tr>
<td>1</td>
<td>$0</td>
<td>$14,580</td>
<td>$20,121</td>
<td>$21,870</td>
<td>$29,160</td>
<td>$31,056</td>
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<td>$52,952</td>
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<td>$60,420</td>
<td>$80,560</td>
<td>$85,797</td>
<td>$100,700</td>
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<td>$120,840</td>
<td>$129,702</td>
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<td>$45,420</td>
<td>$62,680</td>
<td>$68,130</td>
<td>$90,840</td>
<td>$96,745</td>
<td>$113,550</td>
<td>$120,818</td>
<td>$136,260</td>
<td>$146,253</td>
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<td>$5,140</td>
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<td>$7,710</td>
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<td>$13,673</td>
<td>$15,420</td>
<td>$16,551</td>
<td>$20,560</td>
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</tbody>
</table>

### Medi-Cal for Adults

<table>
<thead>
<tr>
<th>Medi-Cal for Pregnant</th>
<th>Medi-Cal Access Program (for Pregnant Women)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>CCHIP (San Francisco, San Mateo, and Santa Clara county residents)</td>
</tr>
</tbody>
</table>

### Medi-Cal for Kids (0-18 Yrs.)

**Note:** Most consumers up to 138% FPL will be eligible for Medi-Cal. If ineligible for Medi-Cal, consumers may qualify for a Covered California health plan with financial help including: federal premium tax credit, Silver (94, 87, 73) plans and Zero Cost Sharing and Limited Cost Sharing AIAN plans.

**Silver 94, 87 and 73 plans** have no deductibles, and lower co-pays and out-of-pocket maximum costs.

* Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5 percent of their income based on the second-lowest-cost Silver plan in their area. See the chart on page 2 for more information.

9/2023
WHEN CAN I APPLY?

Year Round

Nov 1 to Jan 31

Medi-Cal

Special Enrollment

Covered California

Open Enrollment
Special Enrollment

Within 60 days of a Qualifying Life Event, such as:

- losing health insurance
- having a baby
- gaining citizenship or lawful presence
- moving to or within California
- getting married
HOW DO I APPLY FOR MEDI-CAL?
HOW CAN I APPLY?

Online

https://benefitscal.com/

In-Person

Local County Social Services Office

Over the Phone

Local County Social Services Office

You can also apply for Medi-Cal through Covered California
DOCUMENTS TO PREPARE

Proof of Identity
- Driver's License
- ID Card
- Photo ID
- Passport

Proof of Citizenship or Immigration Status*
- U.S. Passport
- Certificate of Citizenship/Naturalization
- Immigration Documents
  *only needed if aged 26-49 before Jan. 2024. No longer required for determining eligibility beginning Jan. 2024

Proof of Income
- Pay Stub
- Income Tax Return

Proof of Residency
- Utility Bill
- Rental Agreement
- Bank Statement
- Driver's License
- ID Card
I APPLIED, NOW WHAT?

Keep an eye out for mail

You will receive a final Notice of Action

If you are approved, you will receive your Benefits Identification Card (BIC)

The process for verifying eligibility, from completing your application to receiving your BIC, normally takes 45 days
I RECEIVED MY BIC, NOW WHAT?

You are covered under Fee-for-Service Medi-Cal

You will receive a health plan selection packet within 45 days of receiving your BIC

30
You must choose a health plan within 30 days of receiving the packet
NOTES ABOUT MANAGED CARE PLANS

Medi-Cal managed care plans function similar to an HMO

The available plans vary by county

You can choose a plan on the Health Care Options (HCO) website, by mailing back your Medi-Cal Choice Form, or by calling HCO (1-800-430-4263)

If you are not happy with your medical plan, you can choose another plan
COST

For many individuals who enroll in Medi-Cal, there is no premium, no copayment, and no out of pocket cost.
SOME QUESTIONS TO CONSIDER WHEN SELECTING A HEALTH PLAN

1. If I already have a doctor that I am happy with, does my doctor belong to a medical plan? If so, which plan?

2. If I do not have a doctor, is there a trusted provider recommended by my family or friends? If so, which plan does that provider belong to?

3. Are there providers in the health plan who are located nearby and accessible?

4. Are there providers in the health plan who speak my language or provide interpreters who do?
HOW DO I SELECT MY PRIMARY CARE PROVIDER (PCP)?

When choosing a health plan, you can also select a PCP.

If you do not select a PCP, the health plan that you select will automatically assign one to you.

If you are not happy with your PCP, you can contact your Medi-Cal plan's member services department to choose a different PCP.
WHAT HAPPENS AFTER I SELECT MY HEALTH PLAN?

Within 7-10 days you should receive a confirmation letter letting you know when your coverage within that health plan will become active.

Once you become active (typically 30-45 days after selecting a plan) you should receive your health plan welcome packet and insurance card.

Before becoming active in a health plan, your coverage will be fee-for-service Medi-Cal
REQUESTING INTERPRETATION

All health plans are required to provide qualified interpreters, so do not be afraid to ask for one if needed.

Most health plans must provide written materials in the main languages spoken by their members.
REQUESTING TRANSPORTATION

Medi-Cal offers transportation to and from appointments for covered services

Nonemergency Medical Transportation (NEMT) ambulance, wheelchair van, or litter van for those who cannot use public or private transportation

- Contact your provider or your health plan’s member services department
- Prescription from a licensed provider needed

Nonmedical Transportation (NMT) private or public vehicle for people who do not have another way to get to their appointment

- Contact the plan’s member services department
- All other resources must be reasonably exhausted
- Does not require prior authorization
WHAT ABOUT DENTAL AND VISION COVERAGE?

Comprehensive preventative and restorative dental benefits are offered to children and adults through Medi-Cal Dental enrolled providers.

Vision benefits are covered through your managed care plan, or through Medi-Cal Vision providers for those with Fee-For-Service Medi-Cal.
SUBMIT CHANGES

Medi-Cal enrollees must report changes to their local county office within 10 days of the change, such as changes in address, family size, and income.
RENEWALS

Medi-Cal members must renew their coverage each year.

Sometimes the county will send you a renewal form that you must review and return.
HOW DO I APPLY FOR COVERED CALIFORNIA?
HOW CAN I APPLY?

ONLINE
www.coveredca.com/apply/

IN-PERSON
Find an Enrollment Center
https://storefronts.coveredca.com/

OVER THE PHONE
Service Center:
(800) 300-1506
DOCUMENTS TO PREPARE

Proof of Identity
- Driver's license
- ID card
- Photo ID
- Passport

Proof of Citizenship or Immigration Status
- U.S Passport
- Certificate of Citizenship/Naturalization
- Permanent resident card
- Non-immigrant visa documents

Proof of Social Security Number
- Social security card
- Tax form(s)

Proof of Income
- Pay stub
- Income tax return
- Wage/income tax statement
HOW DO I SELECT A HEALTH PLAN?

1. Enter your health plan preferences
2. Search for providers
3. Select and compare different health plans
Levels of Coverage

- **Metal tiers**: Minimum, Bronze, Silver, Silver 73, Silver 87, Silver 94, Gold, Platinum
- Typically, the higher the metal tier, the higher the monthly premium will be while the copays/deductibles will be lower (more medical expenses are covered)
- The amount of government financial assistance depends on household annual income level and household size
## 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.

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Minimum Coverage</th>
<th>Bronze</th>
<th>Silver</th>
<th>Silver 73 CA Enhanced CSR</th>
<th>Silver 87 CA Enhanced CSR</th>
<th>Silver 94 CA Enhanced CSR</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of cost coverage</td>
<td>Covers 0% until out-of-pocket maximum is met</td>
<td>Covers 60% average annual cost</td>
<td>Covers 70% average annual cost</td>
<td>Covers 73% average annual cost</td>
<td>Covers 87% average annual cost</td>
<td>Covers 94% average annual cost</td>
<td>Covers 80% average annual cost</td>
<td>Covers 90% average annual cost</td>
</tr>
<tr>
<td>Cost-sharing Reduction Single Income Range</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$29,161 to $36,450 (≥200% to ≤250% FPL)</td>
<td>$23,873 to $29,160 (≥150% to ≤200% FPL)</td>
<td>up to $21,870 (100% to ≤150% FPL)</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met</td>
<td>$60*</td>
<td>$50</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$35</td>
<td>$15</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td>$60*</td>
<td>$50</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$35</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>Full cost per service until out-of-pocket maximum is met</td>
<td>$95*</td>
<td>$90</td>
<td>$85</td>
<td>$25</td>
<td>$8</td>
<td>$65</td>
<td>$30</td>
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<tr>
<td>Emergency Room Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>40% after deductible is met</td>
<td>$450</td>
<td>$350</td>
<td>$150</td>
<td>$50</td>
<td>$350</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>X-Rays and Diagnostics</td>
<td>40% after deductible is met</td>
<td>$95</td>
<td>$95</td>
<td>$40</td>
<td>$8</td>
<td>$75</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td></td>
<td>$325</td>
<td>$325</td>
<td>$100</td>
<td>$50</td>
<td>$75 copy or 25% coinsurance***</td>
<td>$75 copy or 10% coinsurance***</td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generic Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>$17**</td>
<td>$19</td>
<td>$15</td>
<td>$5</td>
<td>$3</td>
<td>$15</td>
<td>$7</td>
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<tr>
<td>Tier 2 (Preferred Drugs)</td>
<td>40% up to $500 per script after drug deductible is met</td>
<td>$60**</td>
<td>$55</td>
<td>$25</td>
<td>$10</td>
<td>$60</td>
<td>$16</td>
<td></td>
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<tr>
<td>Tier 3 (Non-preferred Drugs)</td>
<td>20% up to $250** per script</td>
<td>$90**</td>
<td>$85</td>
<td>$45</td>
<td>$15</td>
<td>$85</td>
<td>$25</td>
<td></td>
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<td>Tier 4 (Specialty Drugs)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical Deductible</td>
<td>Individual: $6,300 Family: $12,600</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Pharmacy Deductible</td>
<td>Individual: $500 Family: $1,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$9,450 individual $18,900 family</td>
<td>$9,100 individual $18,200 family</td>
<td>$9,100 individual $18,200 family</td>
<td>$6,100 individual $12,200 family</td>
<td>$3,000 individual $6,000 family</td>
<td>$1,150 individual $2,300 family</td>
<td>$8,700 individual $17,400 family</td>
<td>$4,500 individual $9,000 family</td>
</tr>
</tbody>
</table>

Drug prices are for a 30 day supply.

* Copy is for any combination of services (primary care, specialist, urgent care) for the first three visits.

** 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).
# 2024 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.

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<td>Cost-sharing Reduction</td>
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<td>N/A</td>
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<tr>
<td>Single Income Range</td>
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<td></td>
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<td>Medical Deductible</td>
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<td>Pharmacy Deductible</td>
<td>N/A</td>
<td>Individual: $500 Family: $1,000</td>
<td>Individual: $150 Family: $300</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Out-of-Pocket</td>
<td>$9,450 individual $18,900 family</td>
<td>$9,100 individual $18,200 family</td>
<td>$9,100 individual $18,200 family</td>
<td>$6,100 individual $12,200 family</td>
<td>$3,000 individual $6,000 family</td>
<td>$1,150 individual $2,300 family</td>
<td>$8,700 individual $17,400 family</td>
<td>$4,500 individual $9,000 family</td>
</tr>
</tbody>
</table>
## 2024 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.

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Minimum Coverage</th>
<th>Bronze</th>
<th>Silver</th>
<th>Silver 73 CA Enhanced CSR</th>
<th>Silver 87 CA Enhanced CSR</th>
<th>Silver 94 CA Enhanced CSR</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met</td>
<td>$60*</td>
<td>$50</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$35</td>
<td>$15</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$60*</td>
<td>$50</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$35</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$95*</td>
<td>$90</td>
<td>$85</td>
<td>$25</td>
<td>$8</td>
<td>$65</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td>Emergency Room Facility</td>
<td>Full cost per service until out-of-pocket maximum is met</td>
<td>$450</td>
<td>$350</td>
<td>$150</td>
<td>$50</td>
<td>$350</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$40</td>
<td>$50</td>
<td>$50</td>
<td>$20</td>
<td>$8</td>
<td>$40</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>X-Rays and Diagnostics</td>
<td>$95</td>
<td>$95</td>
<td>$40</td>
<td>$8</td>
<td>$75</td>
<td>$30</td>
<td>$75</td>
<td>$30</td>
</tr>
<tr>
<td>Imaging</td>
<td>$325</td>
<td>$325</td>
<td>$100</td>
<td>$50</td>
<td>$75 copay or 25% coinsurance***</td>
<td>$75 copay or 10% coinsurance***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generic Drugs)</td>
<td>$17**</td>
<td>$19</td>
<td>$15</td>
<td>$5</td>
<td>$3</td>
<td>$15</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Tier 2 (Preferred Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>$60**</td>
<td>$55</td>
<td>$25</td>
<td>$10</td>
<td>$60</td>
<td>$16</td>
<td>$16</td>
</tr>
<tr>
<td>Tier 3 (Non-preferred Drugs)</td>
<td>$90**</td>
<td>$85</td>
<td>$45</td>
<td>$15</td>
<td>$85</td>
<td>$25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Specialty Drugs)</td>
<td>20% up to $250** per script</td>
<td>20% up to $250 per script</td>
<td>15% up to $150 per script</td>
<td>10% up to $150 per script</td>
<td>20% up to $250 per script</td>
<td>10% up to $250 per script</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
THINGS TO KEEP IN MIND WHEN CHOOSING A HEALTH PLAN

1. Coverage Level
2. Type of Plan (HMO, EPO, PPO)
3. Provider Network
4. Essential Health Benefits
5. Total Cost
WHAT HAPPENS AFTER I SELECT A PLAN?

- After picking a plan, click the Pay Now button to make your first payment.

- If you do not pay online, you will get a bill from your health insurance company ~2 weeks after it receives your application.

- All future bills will need to be paid directly to the health insurance company, not Covered California.
WHAT HAPPENS AFTER I COMPLETE MY FIRST PAYMENT?

You will receive a welcome letter from Covered California.

You will also get an enrollment package & membership ID card from your health insurance company.

Your coverage will typically begin the first day of the following month.
HOW DO I SELECT A PRIMARY CARE PROVIDER?

Your health insurance company will typically match you with a primary care provider who is in its network.

You can change your primary care provider by contacting your health insurance company.
REQUESTING TRANSPORTATION OR INTERPRETATION

Contact your health plan for interpretation or transportation services

Health plans are required to provide interpretation services
WHAT ABOUT DENTAL AND VISION COVERAGE?

All health plans include dental care for children at no extra cost

For adults, a dental plan can be added to the health plan purchase

All health plans include vision care for children at no extra cost

Adult vision care is NOT included in the health plans, but the consumer can choose to enroll directly with EyeMed, VSP, & Superior Vision selected by Covered California
SUBMIT CHANGES

For Covered California members, you must **report changes**, such as changes in address, income, and family size **within 30 days**.
RENEWALS

Covered California renewals begin annually in October.

During renewal, members can update contact and application information, compare different plans, and find out if costs have changed.

15 days after the date on the renewal notice, if you do not actively renew, Covered California will automatically enroll you into the same plan from the previous year, using the most recent household size and income information provided to determine the amount of financial assistance.