Covered California's 2014 Sliding Scale Plans – Single Person

*Eligible for Federal Subsidy

Annual Income	$11,490 - $17,235	$17,235 - $22,980	$22,980 - $28,725	$28,725 - $45,960
Consumer Portion of Monthly Premium For Silver Plans (Balance paid by Federal subsidy)	$19 - $57	$57 - $121	$121 - $193	$193 - $364
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE, OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	$1500 Medical Deductible	$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	$4	$20	$45	$45
Specialty Care Visit Copay	$6	$25	$55	$65
Urgent Care Visit Copay	$8	$40	$90	$90
Lab Testing Copay	$6	$20	$45	$45
X-Ray Copay	$10	$25	$65	$65
Generic Medication	$4	$8	$20	$25
Emergency Room Copay	$25	$75	$250	$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	**HMO** Outpatient Surgery — $250; Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600; Hospital — $600 per day up to 5 days **PPO** 20%	20% of Your Plan's Negotiated Rate	20% of Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	$50 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	$7	$18	$30	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$2,250	$2,250	$5,200	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$4,500	$4,500	$10,400	$12,800

Covered California's 2014 Sliding Scale Plans – Couple

*Eligible for Federal Subsidy

Annual Income	$15,510 - $23,265	$23,265 - $31,020	$31,020 - $38,775	$38,775 - $62,040
Consumer Portion of Monthly Premium For Silver Plans (Balance paid by Federal subsidy)	$26 - $78	$78 - $163	$163 - $260	$260 - $491
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE, OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	$1500 Medical Deductible	$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	$4	$20	$45	$45
Specialty Care Visit Copay	$6	$25	$55	$65
Urgent Care Visit Copay	$8	$40	$90	$90
Lab Testing Copay	$6	$20	$45	$45
X-Ray Copay	$10	$25	$65	$65
Generic Medication	$4	$8	$20	$25
Emergency Room Copay	$25	$75	$250	$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	**HMO** Outpatient Surgery — $250; Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600; Hospital — $600 per day up to 5 days **PPO** 20%	20% of Your Plan's Negotiated Rate	20% of Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	$50 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	$7	$18	$30	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$2,250	$2,250	$5,200	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$4,500	$4,500	$10,400	$12,800

Covered California's 2014 Sliding Scale Plans – Family of 4

*Eligible for Federal Subsidy

Annual Income	$23,550 - $35,325	$35,325 - $47,100	$47,100 - $58,875	$58,875 - $94,200
Consumer Portion of Monthly Premium For Silver Plans (Balance paid by Federal subsidy)	$39 - $118	$118 - $247	$247 - $395	$395 - $746
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE, OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	$1500 Medical Deductible	$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	$4	$20	$45	$45
Specialty Care Visit Copay	$6	$25	$55	$65
Urgent Care Visit Copay	$8	$40	$90	$90
Lab Testing Copay	$6	$20	$45	$45
X-Ray Copay	$10	$25	$65	$65
Generic Medication	$4	$8	$20	$25
Emergency Room Copay	$25	$75	$250	$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	**HMO** Outpatient Surgery — $250; Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600; Hospital — $600 per day up to 5 days **PPO** 20%	20% of Your Plan's Negotiated Rate	20% of Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	$50 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	$7	$18	$30	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$2,250	$2,250	$5,200	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$4,500	$4,500	$10,400	$12,800

Covered California's 2014 Sliding Scale Plans – Family of 6

*Eligible for Federal Subsidy

Annual Income	$31,590 - $47,385	$47,385 - $63,180	$63,180 - $78,975	$78,975 - $126,360
Consumer Portion of Monthly Premium For Silver Plans (Balance paid by Federal subsidy)	$53 - $158	$158 - $332	$332 - $530	$530 - $1000
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE, OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	$1500 Medical Deductible	$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	$4	$20	$45	$45
Specialty Care Visit Copay	$6	$25	$55	$65
Urgent Care Visit Copay	$8	$40	$90	$90
Lab Testing Copay	$6	$20	$45	$45
X-Ray Copay	$10	$25	$65	$65
Generic Medication	$4	$8	$20	$25
Emergency Room Copay	$25	$75	$250	$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	**HMO** Outpatient Surgery — $250; Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600; Hospital — $600 per day up to 5 days **PPO** 20%	20% of Your Plan's Negotiated Rate	20% of Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	$50 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	$7	$18	$30	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$2,250	$2,250	$5,200	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$4,500	$4,500	$10,400	$12,800

Covered California's 2014 Sliding Scale Plans – Family of 8

*Eligible for Federal Subsidy

Annual Income	$39,630 - $59,445	$59,445 - $79,260	$79,260 - $99,075	$99,075 - $158,520
Consumer Portion of Monthly Premium For Silver Plans (Balance paid by Federal subsidy)	$66 - $198	$198 - $416	$416 - $665	$665 - $1255
COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM			BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE, OR BOTH	
Deductible (if Any)	No Deductible	No Deductible	$1500 Medical Deductible	$2000 Medical Deductible
Preventive Care Copay	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit	No Cost – 1 Annual Visit
Primary Care Visit Copay	$4	$20	$45	$45
Specialty Care Visit Copay	$6	$25	$55	$65
Urgent Care Visit Copay	$8	$40	$90	$90
Lab Testing Copay	$6	$20	$45	$45
X-Ray Copay	$10	$25	$65	$65
Generic Medication	$4	$8	$20	$25
Emergency Room Copay	$25	$75	$250	$250
High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans)	**HMO** Outpatient Surgery — $250; Hospital — $250 per day up to 5 days **PPO** 10%	**HMO** Outpatient Surgery — $600; Hospital — $600 per day up to 5 days **PPO** 20%	20% of Your Plan's Negotiated Rate	20% of Your Plan's Negotiated Rate
Brand Medications May be subject to Annual Drug Deductible before the Copay	No Deductible on Brand Drugs	$50 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount	$500 Brand Drug Deductible then you pay the Copay Amount
Preferred Brand Copay After Drug Deductible	$7	$18	$30	$50
MAXIMUM OUT-OF-POCKET FOR ONE	$2,250	$2,250	$5,200	$6,400
MAXIMUM OUT-OF-POCKET FOR FAMILY	$4,500	$4,500	$10,400	$12,800