



**2017 Plan Change Summary
Covered California for Small Business
Platinum (90 %)**

Service Type	Platinum 90 Coinsurance Plans:		Platinum 90 Coinsurance (Out of Network):		Platinum 90 Copay Plans:		Platinum 90 Copay Plans:	
	Platinum 90 Coinsurance 0/15: • Health Net • Blue Shield (2017 New Plan) • Sharp Network 2		Platinum 90 Coinsurance 0/15 (Out of Network): • Health Net • Blue Shield (2017 New Plan)		Platinum 90 Copay 0/15: • Kaiser • Western Health Advantage • CCHP • Blue Shield • Sharp Network 1		• Kaiser Platinum 90 HMO 0/10 Alternate	
Service Type	2016	2017	2016	2017	2016	2017	2016	2017
Individual Deductible (if any)	\$0	\$0	\$0	\$2,000 Blue Shield: \$0	\$0	\$0	\$0 Medical/ \$0 Pharmacy	\$0 Medical/ \$0 Pharmacy
Family Deductible (if any)	\$0	\$0	\$0	\$4,000 Blue Shield: \$0	\$0	\$0	\$0 Medical/ \$0 Pharmacy	\$0 Medical/ \$0 Pharmacy
Preventive Care/Screening/Immunization	No Charge	No Charge	100%	100%	No Charge	No Charge	No Charge	No Charge
Primary care visit to treat an injury, illness, or condition	\$20	\$15	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$20	\$15	\$15	\$10
Specialist Visit	\$40	\$40	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$40	\$40	\$15	\$20
Prenatal Care and Preconception Visit	No Charge	No Charge	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	No Charge	No Charge	No Charge	No Charge
Urgent Care	\$40	\$15	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$40 Kaiser: \$20	\$15	\$15	\$10
Laboratory Tests	\$20	\$20	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$20	\$20	\$20	\$20
X-rays and Diagnostic Imaging	\$40	\$40	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$40 Kaiser: \$20	\$40	\$40	\$40
Emergency Room Facility Fee (waived if admitted)	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$200
Emergency Room Physician Fee (waived if admitted)	10%	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency medical transportation	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Outpatient Surgery Facility Fee (e.g., ASC)	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$250 per day (up to 5 days) Kaiser: \$290	\$250	\$250	\$250
Inpatient Physician/Surgeon Fee	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$40 Kaiser: \$40 per day (up to 5 days)	\$40	No Charge	No Charge
Inpatient Facility fee (e.g. hospital room)	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$250 per day (up to 5 days)	\$250 Copay per day (up to 5 days)	\$250 Copay per day (up to 5 days)	\$500 Copay per day (up to 5 days)
Durable Medical Equipment	10%	10%	100%	Health Net: 100% Blue Shield: 50%	10%	10%	10%	10%
Imaging (CT/PET scans, MRIs)	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$150	\$150	\$100	\$150
Tier 1 (Generic Drugs)	\$5	\$5	100%	100%	\$5	\$5	\$5	\$5
Tier 2 (Preferred Brand Drugs)	\$15	\$15	100%	100%	\$15	\$15	\$15	\$15
Tier 3 (Nonpreferred Brand Drugs)	\$25	\$25	100%	100%	\$25 Kaiser: \$15	\$25 Kaiser: \$15	\$15	\$15
Tier 4 (Specialty Drugs)	10% (up to \$250 per script)	10% (up to \$250 per script)	100%	100%	10% (up to \$250 per script)	10% (up to \$250 per script)	10% (up to \$250 per script)	10% (up to \$250 per script)
Mental/Behavioral health outpatient office visits	\$20	\$15	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$20	\$15	\$15	\$10
Mental/Behavioral health inpatient physician fee	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$250 per day (up to 5 days) Kaiser: \$290 per day (up to 5 days)	\$250 per day (up to 5 days)	\$250 per day (up to 5 days)	\$500 Copay per day (up to 5 days)
Substance Use disorder outpatient office visits	\$20	\$15	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$20	\$15	\$15	\$10
Substance Use inpatient facility fee (e.g. hospital room)	10%	10%	50%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	\$250 per day (up to 5 days)	\$250 per day (up to 5 days)	\$250 per day (up to 5 days)	\$500 per day (up to 5 days)
Embedded Pediatric Dental	Sharp: Pediatric Dental Embedded	Pediatric Dental Embedded	Health Net: Not Embedded	Pediatric Dental Embedded	CCHP, Sharp, Western Health Advantage: Pediatric Dental Embedded	CCHP, Sharp, Western Health Advantage, Blue Shield: Pediatric Dental Embedded	Not Embedded	Not Embedded
	Health Net: Not Embedded				Kaiser, Blue Shield: Not Embedded			
Acupuncture	Health Net, Sharp: \$20	\$15	100%	100% Blue Shield: 50%	Blue Shield, CCHP, Sharp, Kaiser: \$20 Western Health Advantage: \$15	\$15	\$15	\$10
Chiropractic Care	Not Covered	Not Covered	Not Covered	Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered	\$15	Not Covered
					Western Health Advantage: \$15			
Individual Out-of-Pocket Maximum	\$4,000	\$4,000	\$8,000	\$12,000 Blue Shield: \$8,000	\$4,000	\$4,000	\$2,500	\$4,000
Family Out-of-Pocket Maximum	\$8,000	\$8,000	\$16,000	\$24,000 Blue Shield: \$16,000	\$8,000	\$8,000	\$5,000	\$8,000

Please note: this document is a high level benefit overview and is not intended as a substitution for the Summary of Benefits and Coverage (SBC) which can be viewed online at <http://www.coveredca.com/for-small-business/plans> or requested from the Covered California for Small Business Service Center at 877-453-9198.

* Deductible applies after 1st three non-preventive visits
**Up to \$500 per script after pharmacy deductible

Benefit changes



**2017 Plan Change Summary
Covered California for Small Business
Gold (80%)**

Service Type	Gold (80%)									
	Gold 80 Coinsurance Plans:		Gold 80 Coinsurance (Out of Network):		Gold 80 Copay 0/30:		Gold 80 Copay Plans:		Gold 80 EPO Plans:	
	Gold 80 Coinsurance 0/30: • Health Net • Blue Shield (2017 New Plan) • Sharp Network 2		Gold 80 Coinsurance 0/30 (Out of Network): • Health Net • Blue Shield (2017 New Plan)		Gold 80 Copay 0/30: • Kaiser • Western Health Advantage • CCHP • Blue Shield • Sharp Network 1		• Kaiser Gold 80 HMO 500/35 Alternate		• Health Net Gold 80 EPO 1300/20 Alternate	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Individual Deductible (if any)	\$0	\$0	\$0	\$3,000 Blue Shield: \$0	\$0	\$0	\$500	\$500	\$1,000	\$1,300 Medical/ \$250 Pharmacy
Family Deductible (if any)	\$0	\$0	\$0	\$6,000 Blue Shield: \$0	\$0	\$0	\$1,000	\$1,000	\$2,000	\$2,600 Medical/ \$500 Pharmacy
Preventive Care/Screening/Immunization	No Charge	No Charge	100%	100%	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Primary care visit to treat an injury, illness, or condition	\$35	\$30	50%	50% Coinsurance after deductible Blue Shield: 50%	\$35	\$30	\$30	\$35	\$20	\$20
Specialist Visit	\$55	\$55	50%	50% Coinsurance after deductible Blue Shield: 50%	\$55	\$55	\$30	\$35	\$30	\$45
Prenatal Care and Preconception Visit	No Charge	No Charge	50%	50% Coinsurance after deductible Blue Shield: 50%	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Urgent Care	\$60	\$30	50%	50% Coinsurance after deductible Blue Shield: 50%	\$60 Kaiser: \$35	\$30	\$30	\$35	\$60	\$45
Laboratory Tests	\$35	\$35	50%	50% Coinsurance after deductible Blue Shield: 50%	\$35	\$35	\$20	\$20	\$20 Copay after deductible	\$20 Copay after deductible
X-rays and Diagnostic Imaging	\$50	\$55	50%	50% Coinsurance after deductible Blue Shield: 50%	\$50	\$55	\$20	\$40	\$30 Copay after deductible	\$30 Copay after deductible
Emergency Room Facility Fee (waived if admitted)	\$250	\$325	\$250	\$325	\$250	\$325	\$250 Copay after deductible	\$250 Copay after deductible	\$175	\$200
Emergency Room Physician Fee (waived if admitted)	20%	No Charge	20%	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency medical transportation	\$250	\$250	\$250	\$250	\$250	\$250	\$250 Copay after deductible	\$250 Copay after deductible	\$200	\$200
Outpatient Surgery Facility Fee (e.g., ASC)	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$600 Kaiser: \$655	\$600	\$600 Copay after deductible	\$600 Copay after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$55	\$55	No Charge	No Charge	20% Coinsurance after deductible	20% Coinsurance after deductible
Inpatient Facility fee (e.g. hospital room)	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$600 per day (up to 5 days)	\$600 per day (up to 5 days)	\$600 per day (up to 5 days) after deductible	\$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Durable Medical Equipment	20%	20%	100%	100% Blue Shield: 50%	20%	20%	20%	20%	20% Coinsurance after deductible	20% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$250	\$275	\$250	\$250	20% Coinsurance after deductible	20% Coinsurance after deductible
Tier 1 (Generic Drugs)	\$15	\$15	100%	100%	\$15	\$15	\$15	\$15	\$5	\$5
Tier 2 (Preferred Brand Drugs)	\$50	\$55	100%	100%	\$50	\$55	\$50	\$50	\$15	\$15 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	\$70	\$75	100%	100%	\$70 Kaiser: \$50	\$75 Kaiser: \$55	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible
Tier 4 (Specialty Drugs)	20% (up to \$250 per script)	20% (up to \$250 per script)	100%	100%	20% (up to \$250 per script)	20% (up to \$250 per script)	20% (up to \$250 per script)	20% (up to \$250 per script)	20% Coinsurance after deductible	20% Coinsurance after deductible
Mental/Behavioral health outpatient office visits	\$35	\$30	50%	50% Coinsurance after deductible Blue Shield: 50%	\$35	\$30	\$30	\$35	\$20	\$20
Mental/Behavioral health inpatient physician fee	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$600 per day (up to 5 days) Kaiser: \$655 per day (up to 5 days)	\$600 per day (up to 5 days)	\$600 per day (up to 5 days) after deductible	\$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Substance Use disorder outpatient office visits	\$35	\$30	50%	50% Coinsurance after deductible Blue Shield: 50%	\$35	\$30	\$30	\$35	\$20	\$20
Substance Use inpatient facility fee (e.g. hospital room)	20%	20%	50%	50% Coinsurance after deductible Blue Shield: 50%	\$600 per day (up to 5 days) Kaiser: \$655 per day (up to 5 days)	\$600 per day (up to 5 days)	\$600 per day (up to 5 days) after deductible	\$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Embedded Pediatric Dental	Sharp: Pediatric Dental Embedded	Health Net, Blue Shield: Pediatric Dental Embedded	Not Embedded	Pediatric Dental Embedded	CCHP, Sharp, Western Health Advantage: Pediatric Dental Embedded	Western Health Advantage, CCHP, Blue Shield: Pediatric Dental Embedded	Not Embedded	Not Embedded	Not Embedded	Pediatric Dental Embedded
	Health Net: Not Embedded				Kaiser, Blue Shield: Not Embedded	Kaiser: Not Embedded				
Acupuncture	Health Net***, Sharp: \$35	\$30	100%	100% Blue Shield: 50%	Kaiser, Blue Shield, CCHP, Sharp: \$35	\$30	\$15	\$35	\$20	\$20
Chiropractic Care	Not Covered	Not Covered	Not Covered	Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered	\$15	Not Covered	Not Covered	Not Covered
					Western Health Advantage: \$15	Western Health Advantage: \$15				
Individual Out-of-Pocket Maximum	\$6,200	\$6,750	\$12,400	\$13,500 Blue Shield: \$10,000	\$6,200	\$6,750	\$6,250	\$6,750	\$4,500	\$6,000
Family Out-of-Pocket Maximum	\$12,400	\$13,500	\$24,800	\$27,000 Blue Shield: \$20,000	\$12,400	\$13,500	\$12,500	\$13,500	\$9,000	\$12,000

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**Up to \$500 per script after pharmacy deductible



FOR SMALL BUSINESS

2017 Plan Change Summary
Covered California for Small Business
Silver (70%)

Service Type	Silver 70 Coinsurance Plans:		Silver 70 Coinsurance (Out of Network)		Silver 70 Copay Plans:				Silver 70 HDHP Plans:		Silver 70 EPO Plans:	
	Silver 70 Coinsurance 2000/45: • Health Net • Blue Shield (2017 New Plan) • Sharp Network 2		Silver 70 Coinsurance 2000/45 (Out of Network): • Health Net • Blue Shield (2017 New Plan)		Silver 70 Copay 2000/45: • Kaiser • Western Health Advantage • CCHP • Sharp Network 1 • Blue Shield		Kaiser Silver 70 HMO 1000/50 Alternate		Silver 70 HDHP 2000/20%: • Kaiser (2017 New Plan) • Western Health Advantage • Sharp Network 1		Health Net Silver 70 EPO 2000/20 Alternate	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Individual Deductible (if any)	\$1,500 Medical/ \$250 Pharmacy/ \$0 Dental	\$2,000 Medical/ \$250 Pharmacy/ \$0 Dental	\$3,000 Medical	\$4,000 Medical	\$1,500 Medical/ \$250 Pharmacy/ \$0 Dental	\$2,000 Medical/ \$250 Pharmacy/ \$0 Dental	\$1,000	\$1,000 Medical/ \$200 Pharmacy	\$2,000 Integrated	\$2,000 Integrated	\$1,800	\$2,000 Medical/ \$250 Pharmacy
Family Deductible (if any)	\$3,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$4,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$6,000 Medical	\$8,000 Medical	\$3,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$4,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$2,000	\$2,000 Medical/ \$400 Pharmacy	\$4,000 Integrated	\$4,000 Integrated	\$3,600	\$4,000 Medical/ \$500 Pharmacy
Preventive Care/Screening/Immunization	No Charge	No Charge	100%	100%	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Primary care visit to treat an injury, illness, or condition	\$45	\$45	50% Coinsurance after deductible	50% Coinsurance after deductible	\$45	\$45	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$30	\$20
Specialist Visit	\$70	\$70	50% Coinsurance after deductible	50% Coinsurance after deductible	\$70	\$75	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$50	\$60
Prenatal Care and Preconception Visit	No Charge	No Charge	50% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Urgent Care	\$90	\$45	50% Coinsurance after deductible	50% Coinsurance after deductible	\$90 Kaiser: \$45	\$45	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$100	\$60
Laboratory Tests	\$35	\$40	50% Coinsurance after deductible	50% Coinsurance after deductible	\$35	\$40	\$40	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$50 Copay after deductible	\$50 Copay after deductible
X-rays and Diagnostic Imaging	\$65	\$70	50% Coinsurance after deductible	50% Coinsurance after deductible	\$65	\$70	\$40	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$60 Copay after deductible	\$60 Copay after deductible
Emergency Room Facility Fee (waived if admitted)	\$250 Copay after deductible	\$350	\$250 Copay after deductible	\$350	\$250 Copay after deductible Kaiser: \$300 Copay after deductible	\$350	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	\$300	\$300
Emergency Room Physician Fee (waived if admitted)	\$50	No Charge	\$50 Copay after deductible	No Charge	\$50 Copay after deductible	No Charge	30% Coinsurance after deductible	No Charge	20% Coinsurance after deductible	0% Coinsurance after deductible	No Charge	No Charge
Emergency medical transportation	\$250	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	\$300	\$300
Outpatient Surgery Facility Fee (e.g., ASC)	20%	20%	50% Coinsurance after deductible	50% Coinsurance after deductible	20%	20%	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20%	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	No Charge	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility fee (e.g. hospital room)	20%	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	20%	20%	100%	100% Blue Shield: 50% Coinsurance after deductible	20%	20%	30%	30%	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	20%	20%	50% Coinsurance after deductible	50% Coinsurance after deductible	\$250	\$300	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	\$15	\$15	100%	100%	\$15	\$15	\$25	\$25	20% Coinsurance after deductible	20% (up to \$250 per script after pharmacy deductible)	\$10	\$10
Tier 2 (Preferred Brand Drugs)	\$55 Copay after pharmacy deductible	\$55 Copay after pharmacy deductible	100%	100%	\$55 after pharmacy deductible	\$55 Copay after pharmacy deductible	\$50 Copay after deductible	\$50 Copay after deductible	20% Coinsurance after deductible	20% (up to \$250 per script after pharmacy deductible)	\$55	\$55 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	\$75 Copay after pharmacy deductible	\$85 Copay after pharmacy deductible	100%	100%	\$75 after pharmacy deductible Kaiser: \$55 after pharmacy deductible	\$55 (up to \$250 per script after pharmacy deductible)	\$50 Copay after deductible	\$50 Copay after deductible	20% Coinsurance after deductible	20% (up to \$250 per script after pharmacy deductible)	50% Coinsurance after deductible	40% Coinsurance after deductible
Tier 4 (Specialty Drugs)	20% (up to \$250 per script after pharmacy deductible)	20% (up to \$250 per script after pharmacy deductible)	100%	100%	20% (up to \$250 per script) after pharmacy deductible	20% (up to \$250 per script after pharmacy deductible)	20% (up to \$250 per script after pharmacy deductible)	20% (up to \$250 per script after pharmacy deductible)	20% Coinsurance after deductible	20% (up to \$250 per script after pharmacy deductible)	50% Coinsurance after deductible	40% Coinsurance after deductible
Mental/Behavioral health outpatient office visits	\$45	\$45	50% Coinsurance after deductible	50% Coinsurance after deductible	\$45	\$45	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$30	\$20
Mental/Behavioral health inpatient physician fee	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use disorder outpatient office visits	\$45	\$45	50% Coinsurance after deductible	50% Coinsurance after deductible	\$45	\$45	\$50	\$50	20% Coinsurance after deductible	20% Coinsurance after deductible	\$30	\$20
Substance Use inpatient facility fee (e.g. hospital room)	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Health Net: Not Embedded Sharp: Pediatric Dental Embedded	Pediatric Dental Embedded	Not Embedded	Pediatric Dental Embedded	CCHP, Sharp, Western Health Advantage: Pediatric Dental Embedded Kaiser, Blue Shield: Not Embedded	Western Health Advantage, CCHP, Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded	Not Embedded	Western Health Advantage: Pediatric Dental Embedded	Western Health Advantage, Sharp: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded	Pediatric Dental Embedded
Acupuncture	Health Net, Sharp: \$45	\$45	100%	100% Blue Shield: 50% Coinsurance after deductible	Kaiser, Blue Shield, CCHP, Sharp: \$45 Western Health Advantage: \$15	\$45	\$15	\$50	Sharp: 20% Coinsurance after deductible Western Health Advantage: \$15	20% Coinsurance after deductible	\$30	\$20
Chiropractic Care	Not Covered	Not Covered	Not Covered	Not Covered	Kaiser, Blue Shield, CCHP, Sharp: Not Covered Western Health Advantage: \$15	Kaiser, CCHP, Sharp: Not Covered Western Health Advantage: \$15	\$15	\$15	Not Covered	Not Covered	Not Covered	Not Covered
Individual Out-of-Pocket Maximum	\$6,500	\$6,800	\$13,000	\$13,600 Blue Shield: \$6,800	\$6,500	\$6,800	\$6,500	\$6,750	\$6,250	\$6,550	\$6,500	\$6,800
Family Out-of-Pocket Maximum	\$13,000	\$13,600	\$26,000	\$27,200 Blue Shield: \$6,800	\$13,000	\$13,600	\$13,000	\$13,500	\$12,500	\$13,100	\$13,000	\$13,600

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 **Up to \$500 per script after pharmacy deductible

Benefit changes



**2017 Plan Change Summary
Covered California for Small Business
Bronze (60%)**

Service Type	Bronze 60 Coinsurance Plans:		Bronze 60 Coinsurance (Out of Network):		Bronze 60 Copay Plans:		Bronze 60 HDHP Plans:		• Western Health Advantage Bronze 60 HDHP HMO 6500/0 Alternate	
	Bronze 60 Coinsurance 6300/75: • Health Net • Blue Shield • Sharp Network 2		Bronze 60 Coinsurance 6300/75 (Out of Network): • Health Net • Blue Shield		Bronze 60 Copay 6300/75: • Kaiser • Western Health Advantage • CCHP		Bronze 60 HDHP 4800/40%: • Kaiser • Western Health Advantage • Sharp Network 1			
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Individual Deductible (if any)	\$6,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$6,300 Medical/ \$500 Pharmacy/ \$0 Dental	\$12,000 Medical	\$12,600 Medical Blue Shield: \$6,300 Medical	\$6,000 Medical/ \$500 Pharmacy/ \$0 Dental Kaiser: \$6,000 Medical/ \$500 Pharmacy	\$6,300 Medical/ \$500 Pharmacy/ \$0 Dental	\$4,500 Integrated	\$4,800 Integrated	\$6,000	\$6,500
Family Deductible (if any)	\$12,000 Medical/ \$1,000 Pharmacy/ \$0 Dental	\$12,600 Medical/ \$1,000 Pharmacy/ \$0 Dental	\$24,000 Medical	\$25,200 Medical Blue Shield: \$12,600 Medical	\$12,000 Medical/ \$1,000 Pharmacy/ \$0 Dental Kaiser: \$12,000 Medical/ \$1,000 Pharmacy	\$12,600 Medical/ \$1,000 Pharmacy/ \$0 Dental	\$9,000 Integrated	\$9,600 Integrated	\$12,000	\$13,000
Preventive Care/Screening/Immunization	No Charge	No Charge	100%	100%	No Charge	No Charge	No Charge	No Charge	0% Coinsurance after deductible	0% Coinsurance
Primary care visit to treat an injury, illness, or condition	\$70*	\$75*	50% Coinsurance after deductible	50% Coinsurance after deductible	\$70*	\$75*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Specialist Visit	\$90*	\$105*	50% Coinsurance after deductible	50% Coinsurance after deductible	\$90*	\$105*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	No Charge	50% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	0% Coinsurance after deductible	0% Coinsurance
Urgent Care	\$120*	\$75*	50% Coinsurance after deductible Blue Shield: 100%	50% Coinsurance after deductible	\$120* Kaiser: \$70*	\$75*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Laboratory Tests	\$40	\$40	50% Coinsurance after deductible	50% Coinsurance after deductible	\$40	\$40	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
X-rays and Diagnostic Imaging	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	100% Coinsurance after deductible	No Charge	100% Coinsurance after deductible	No Charge	100% Coinsurance after deductible	No Charge	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance
Emergency medical transportation	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Facility fee (e.g. hospital room)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Durable Medical Equipment	100% Coinsurance after deductible	100% Coinsurance after deductible	100%	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Tier 1 (Generic Drugs)	100%**	100%**	100%	100%	100% Coinsurance after deductible**	100% Coinsurance after deductible**	40% Coinsurance after deductible	40% Coinsurance (up to \$500 per script after pharmacy deductible)	0% Coinsurance after deductible	0% Coinsurance after deductible
Tier 2 (Preferred Brand Drugs)	100%**	100%**	100%	100%	100% Coinsurance after deductible**	100% Coinsurance after deductible**	40% Coinsurance after deductible	40% Coinsurance (up to \$500 per script after pharmacy deductible)	0% Coinsurance after deductible	0% Coinsurance after deductible
Tier 3 (Nonpreferred Brand Drugs)	100%**	100%**	100%	100%	100% Coinsurance after deductible**	100% Coinsurance after deductible**	40% Coinsurance after deductible	40% Coinsurance (up to \$500 per script after pharmacy deductible)	0% Coinsurance after deductible	0% Coinsurance after deductible
Tier 4 (Specialty Drugs)	100%**	100%**	100%	100%	100% Coinsurance after deductible**	100% Coinsurance after deductible**	40% Coinsurance after deductible	40% Coinsurance (up to \$500 per script after pharmacy deductible)	0% Coinsurance after deductible	0% Coinsurance after deductible
Mental/Behavioral health outpatient office visits	\$70*	\$75*	50% Coinsurance after deductible	50% Coinsurance after deductible	\$70*	\$75*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Mental/Behavioral health inpatient physician fee	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use disorder outpatient office visits	\$70*	\$75*	50% Coinsurance after deductible	50% Coinsurance after deductible	\$70*	\$75*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use inpatient facility fee (e.g. hospital room)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Embedded Pediatric Dental	Health Net: Not Embedded	Health Net: Pediatric Dental Embedded	Not Embedded	Pediatric Dental Embedded	Sharp & Western Health: Pediatric Dental Embedded	Western Health Advantage, CCHP: Pediatric Dental Embedded	Sharp & Western Health: Pediatric Dental Embedded	Western Health Advantage: Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded
	Blue Shield, CCHP, Sharp, Western Health: Pediatric Dental Embedded				Kaiser: Not Embedded	Kaiser: Not Embedded	Kaiser: Not Embedded	Kaiser: Not Embedded		
Acupuncture	Health Net, Blue Shield, Sharp, CCHP: \$70 Copay before deductible	\$75 Copay before deductible	100%	100% Blue Shield: 50% Coinsurance after deductible	Kaiser, CCHP: \$70* Western Health Advantage: \$15	Kaiser, Western Health Advantage, CCHP: \$75*	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
	Western Health Advantage: \$15									
Chiropractic Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Kaiser, CCHP: Not Covered Western Health Advantage: \$15	Not Covered	Not Covered	Not Covered	Not Covered
Individual Out-of-Pocket Maximum	\$6,500	\$6,800	\$13,000	\$13,600 Blue Shield: \$10,000	\$6,500	\$6,800	\$6,500	\$6,550	\$6,000	\$6,500
Family Out-of-Pocket Maximum	\$13,000	\$13,600	\$26,000	\$27,200 Blue Shield: \$20,000	\$13,000	\$13,600	\$13,000	\$13,100	\$12,000	\$13,000

Please note: this document is a high level benefit overview and is not intended as a substitution for the Summary of Benefits and Coverage (SBC) which can be viewed online at <http://www.coveredca.com/formsmallbusiness/plans> or requested from the Covered California for Small Business Service Center at 877-453-9198.

* Deductible applies after 1st three non-preventive visits

**Up to \$500 per script after pharmacy deductible

Benefit changes