California Small Business (1–50) Plan Benefit Changes

For groups renewing January 1, 2015 and after

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Plan Benefit Changes

Plans Impacted	Product/Benefit Change	Benefits Prior to January, 1, 2015	New Benefits Effective January 1, 2015 and After
All plans	Orally administered anti-cancer medications	No maximum	Coinsurance/copayment maximum of $200 for up to a 30-day supply of an orally administered anti-cancer medication. The limit applies to HSA plans after the deductible has been met.
All plans	Outpatient prescription drug mail service program	Option for retail or mail service	Retail, then mail service for maintenance medications. Member may request to opt out of mail service program.
All HMO plans, except: Alliance 20-40/250d (AB-GV) Alliance 30-50/600d (AB-GW) Alliance HSA 20%/1500ded (AB-GX) Alliance HSA 40%/4500ded (77-B)	Chiropractic benefit	Optional rider $10/visit, limited to 30 visits/year	Covered under medical $15/visit, limited to 20 visits/year. Not covered under the four Alliance State plan designs excluded in the “Plans Impacted” column. Optional rider no longer available.
All HMO plans	Infertility benefit	Covered under Platinum HMO plans only	Not covered under any HMO plan. Offered as an optional rider.
All HMO plans	Non-physician Health Care Practitioner Office Visits	Some Non-physician Health Care Practitioner Office visits were charged at the specialist copayment	Benefits previously charged a copayment at the specialist will now be assessed the PCP copayment. See Schedule of Benefits for benefit changes.
Select 30/20% Select 45/1500/20% Select HSA 4500/40% Alliance 30-50/600d Alliance HSA 20%/1500ded Alliance HSA 40%/4500ded	Out-of-pocket maximum	$6,350 individual /$12,700 family	$6,250 individual /$12,500 family
Select 30/20% Select 45/1500/20% Alliance 30-50/600d	Outpatient prescription drug benefit	$19 Tier 1 copay	$15 Tier 1 copay
Platinum and Gold HMO plans	Plan benefit changes	See detailed plan benefit mapping	See detailed plan benefit mapping

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Platinum Plan Mapping

Platinum Plan Benefits	Signature 10-20/300a/250ded Advantage 10-20/300a/250ded Alliance 10-20/300a/250ded	Signature* 20-40/250d Advantage* 20-40/250d Alliance* 20-40/250d
	Prior to January 1, 2015	**Effective January 1, 2015**
General Features		
Deductible	$250/$500	None
Annual Out-of-Pocket Maximum	$1,500/$3,000	$4,000/$8,000
PCP Office Visits	$10	$20
Specialist/Nonphysician Health Care Practitioner Office Visits	$20	$40
Hospital Benefits	$300 per admit after deductible	$250 per day, max 4 days per stay
Emergency Services	$100	$100
Urgently Needed Services	$50	$50
Benefits Available While Hospitalized as an Inpatient		
Hospital Benefits	$300 per admit after deductible	$250 per day, max 4 days per stay
Maternity Care	$300 per admit after deductible	$250 per day, max 4 days per stay
Mental Health Services	$300 per admit after deductible	$250 per day, max 4 days per stay
Physician Care	Paid in full	Paid in full
Rehabilitation Care – PT/ST/OT	$300 per admit after deductible	$250 per day, max 4 days per stay
Skilled Nursing Facility Care - 100 days per benefit period	$300 per admit after deductible	$250 per day
Substance Use Disorder	$300 per admit after deductible	$250 per day, max 4 days per stay
Benefits Available on an Outpatient Basis		
Acupuncture	$10	$10
Ambulance	$100	$100
Chiropractic	Not covered	$15/visit, 20 visit max
Durable Medical Equipment	$50	$50
Home Health Care Visits	$10	$20
Infertility Services	50%	Not covered
Laboratory Services (Additional copayment for office visits may apply)	Paid in full	$15
Maternity Care, Tests and Procedures:		
PCP Office Visit	Paid in full	Paid in full
Specialist/Nonphysician Health Care Practitioner Office Visit	Paid in full	Paid in full
Mental Health Services	$20	$40
Outpatient Medical Habilitation and Rehabilitation Therapy PT/ST/OT:		
PCP Office Visit	$10	$20
Specialist/Nonphysician Health Care Practitioner Office Visit	$20	$40
Outpatient Prescription Drug Benefit:		
Deductible	None	None
Tier 1	$15	$15
Tier 2	$35	$35
Tier 3	$50	$50
Tier 4	25%	25%
Outpatient Surgery	$150 per admit after deductible	$150 per admit
Outpatient Surgery Physician Care	Paid in full	Paid in full
Preventive Care Services	Paid in full	Paid in full
Radiology Services - Standard	Paid in full	$15
Radiology Services - Specialized Scanning and Imaging Procedures	$50	$50
Substance Use Disorder	$20	$40
Vision Refractions:		
PCP Office Visit	$10	$20
Specialist/Nonphysician Health Care Practitioner Office Visit	$20	$40

* Formal HMO product names:
Signature = UnitedHealthcare SignatureValue®
Advantage = UnitedHealthcare SignatureValue Advantage
Alliance = UnitedHealthcare SignatureValue Alliance

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Gold Plan Mapping

Gold Plan Benefits	Signature 20-40/1000d/500ded Advantage 20-40/1000d/500ded Alliance 20-40/1000d/500ded	Signature 30-50/1000d Advantage 30-50/1000d Alliance 30-50/1000d
	Prior to January 1, 2015	**Effective January 1, 2015**
General Features		
Deductible	$500/$1,000	None
Annual Out-of-Pocket Maximum	$4,000/$8,000	$6,350/$12,700
PCP Office Visits	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visits	$40	$50
Hospital Benefits	$1,000 per day, max 4 days per stay after deductible	$1,000 per day, max 4 days per stay
Emergency Services	$200	$300
Urgently Needed Services	$75	$75
Benefits Available While Hospitalized as an Inpatient		
Hospital Benefits	$1,000 per day, max 4 days per stay after deductible	$1,000 per day, max 4 days per stay
Maternity Care	$1,000 per day, max 4 days per stay after deductible	$1,000 per day, max 4 days per stay
Mental Health Services	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay
Physician Care	Paid in full	Paid in full
Rehabilitation Care – PT/ST/OT	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay
Skilled Nursing Facility Care - 100 days per benefit period	$300 per day after deductible	$300 per day
Substance Use Disorder	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay
Benefits Available on an Outpatient Basis		
Acupuncture	$10	$10
Ambulance	$100	$100
Chiropractic	Not covered	$15/visit, 20 visit max
Durable Medical Equipment	$50	$50
Home Health Care Visits	$20	$30
Infertility Services	Not covered	Not covered
Laboratory Services (Additional copayment for office visits may apply)	$20	$25
Maternity Care, Tests and Procedures:		
PCP Office Visit	Paid in full	Paid in full
Specialist/Nonphysician Health Care Practitioner Office Visit	Paid in full	Paid in full
Mental Health Services	$40	$40
Outpatient Medical Habilitation and Rehabilitation Therapy PT/ST/OT:		
PCP Office Visit	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visit	$40	$50
Outpatient Prescription Drug Benefit:		
Deductible	None	None
Tier 1	$15	$15
Tier 2	$35	$35
Tier 3	$60	$70
Tier 4	25%	25%
Outpatient Surgery	$500 per admit after deductible	$500 per admit
Outpatient Surgery Physician Care	Paid in full	Paid in full
Preventive Care Services	Paid in full	Paid in full
Radiology Services - Standard	$20	$25
Radiology Services - Specialized Scanning and Imaging Procedures	$200	$200
Substance Use Disorder	$40	$40
Vision Refractions:		
PCP Office Visit	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visit	$40	$50

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Gold Plan Mapping

Gold Plan Benefits	Signature 20-40/1000d/1000ded Advantage 20-40/1000d/1000ded Alliance 20-40/1000d/1000ded	Signature 30-50/900d/1000ded Advantage 30-50/900d/1000ded Alliance 30-50/900d/1000ded
	Prior to January 1, 2015	**Effective January 1, 2015**
General Features		
Deductible	$1,000/$2,000	$1,000/$2,000
Annual Out-of-Pocket Maximum	$4,000/$8000	$6,350/$12,700
PCP Office Visits	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visits	$40	$50
Hospital Benefits	$1,000 per day, max 4 days per stay after deductible	$900 per day, max 4 days per stay after deductible
Emergency Services	$200	$300
Urgently Needed Services	$75	$75
Benefits Available While Hospitalized as an Inpatient		
Hospital Benefits	$1,000 per day, max 4 days per stay after deductible	$900 per day, max 4 days per stay after deductible
Maternity Care	$1,000 per day, max 4 days per stay after deductible	$900 per day, max 4 days per stay after deductible
Mental Health Services	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay after deductible
Physician Care	Paid in full	Paid in full
Rehabilitation Care – PT/ST/OT	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay after deductible
Skilled Nursing Facility Care - 100 days per benefit period	$300 per day after deductible	$300 per day after deductible
Substance Use Disorder	$500 per day, max 4 days per stay after deductible	$500 per day, max 4 days per stay after deductible
Benefits Available on an Outpatient Basis		
Acupuncture	$10	$10
Ambulance	$100	$100
Chiropractic	Not covered	$15/visit, 20 visit max
Durable Medical Equipment	$50	$50
Home Health Care Visits	$20	$30
Infertility Services	Not covered	Not covered
Laboratory Services (Additional copayment for office visits may apply)	$20	$25
Maternity Care, Tests and Procedures:		
PCP Office Visit	Paid in full	Paid in full
Specialist/Nonphysician Health Care Practitioner Office Visit	Paid in full	Paid in full
Mental Health Services	$40	$40
Outpatient Medical Habilitation and Rehabilitation Therapy PT/ST/OT:		
PCP Office Visit	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visit	$40	$50
Outpatient Prescription Drug Benefit:		
Deductible	None	None
Tier 1	$15	$15
Tier 2	$35	$35
Tier 3	$60	$70
Tier 4	25%	25%
Outpatient Surgery	$500 per admit after deductible	$500 per admit after deductible
Outpatient Surgery Physician Care	Paid in full	Paid in full
Preventive Care Services	Paid in full	Paid in full
Radiology Services - Standard	$20	$25
Radiology Services - Specialized Scanning and Imaging Procedures	$200	$200
Substance Use Disorder	$40	$40
Vision Refractions:		
PCP Office Visit	$20	$30
Specialist/Nonphysician Health Care Practitioner Office Visit	$40	$50

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Please contact your UnitedHealthcare representative for more information.

These benefit grids are intended only to highlight plan benefits and should not be relied upon to fully determine coverage. Every effort has been made to ensure accuracy in information printed in this book; however, UnitedHealthcare and its affiliates cannot guarantee that there are no errors. In the event of a conflict between this document and the terms of an individual member's Certificate of Coverage, the Certificate of Coverage prevails.

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