UnitedHealthcare

Medical and Pharmacy Plans

California
Small Business 1-100 Employees
Effective April 1, 2019

UnitedHealthcare offers a wide variety of plan options that allow you to tailor your benefit needs to your business needs, choosing what you value in a health plan.

CA Small Business 1-100 Insurance Plans

Metallic Level	Deductible[1]		Out-Of-Pocket Maximum[2]		Coinsurance		Network[3]						Deductible Type	Combined Med/Rx Ded	Plan Code			Pharmacy Plan Code
	Network	Out of Network	Network	Out of Network	Network	Out of Network	PCP	Spec	ER	Inpatient Hospital	IP Per-Occurrence Ded[4]	OP Per-Occurrence Ded[4]						
PPO/EPO															**Select Plus**	**Core**	**Navigate[5]**	
Platinum	N/A	$1,000	$3,200	$6,400	10%	50%	$10	$20	10%	10%	N/A	N/A	Embedded	No	BH-BN	BH-BR	BH-B5	854
Platinum	$250	$1,000	$3,200	$6,400	20%	50%	$15	30	20%	20%	N/A	N/A	Embedded	No	BH-BO	BH-BS	BH-B6	854
Gold	$250	$1,000	$6,000	$12,000	20%	50%	$25	$50	$150.00	20%	$250	$250	Embedded	No	BH-CI	BH-CN	BH-CD	852
Gold	$750	$1,500	$6,000	$12,000	20%	50%	$25	$50	$150.00	20%	$250	$250	Embedded	No	BH-CJ	BH-CO	BH-CE	852
Gold	$1,250	$2,500	$6,000	$12,000	20%	50%	$25	$50	$150.00	20%	$250	$250	Embedded	No	BH-CK	BH-CP	BH-CF	852
Silver	$1,500	$3,000	$7,900	$15,800	30%	50%	$40	$70	20%	30%	$250	$250	Embedded	No	BH-CL	BH-CQ	BH-CG	855
Silver	$2,250	$4,500	$7,900	$15,800	40%	50%	$45	$80	30%	40%	$250	$250	Embedded	No	BH-CM	BH-CR	BH-CH	855
Silver HDHP[2]	$2,300	$4,600	$6,650	$13,300	30%	50%	30%	30%	30%	30%	N/A	N/A	Non-Embedded	Yes	BH-BP	BH-BT	BH-B7	551
Bronze HDHP	$6,650	$13,300	$6,650	$13,300	0%	0%	0%	0%	0%	0%	N/A	N/A	Embedded	Yes	BH-BQ	BH-BU	BH-B8	856
State Mirrored PPO/EPO															**Select Plus**	**Core**	**Navigate[5]**	
Platinum	N/A	$1,000	$3,350	$8,000	10%	50%	$15	$30	$150	10%	N/A	N/A	Embedded	No	AV-68	AU-SO	AU-SU	354
Gold	N/A	$1,000	$7,200	$13,500	20%	50%	$30	$55	$325	20%	N/A	N/A	Embedded	No	BH-BV	BH-BZ	BH-B9	397
Silver	$2,000	$4,000	$7,550	$14,000	20%	50%	$45	$80	$350	20%	N/A	N/A	Embedded	No	BH-BW	BH-B2	BH-CA	853
Bronze[6]	$6,300	$12,600	$7,550	$14,000	100%	0%	$75	$105	100%	100%	N/A	N/A	Embedded	No	BH-BX	BH-B3	BH-CB	733
Bronze HDHP	$6,000	$9,600	$6,650	$13,100	40%	50%	40%	40%	40%	40%	N/A	N/A	Embedded	Yes	BH-BY	BH-B4	BH-CC	399
Non-Differential PPO															**Non-Differential PPO**			
Silver	$2,250.00	0%	$7,350	0%	30%	N/A	30%	30%	30%	30%	N/A	N/A	Embedded	No	AU-SH			405

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CA Small Business 1-100 HMO Plans

Metallic Level	Deductible[1]	Out-Of-Pocket Maximum[2]	PCP	Spec	ER	Inpatient Hospital	Outpatient Surgery	Deductible Type	Combined Med/Rx Ded	HMO Plan Codes					Pharmacy Plan Code
										Signature Value	Advantage	Focus	Alliance	Harmony	
HMO															
Platinum[7]	N/A	$2,500	$20	$40	$400	$500	$250	N/A	No	BH-GR	BH-GX	BH-G5	BH-HB	BK-DY	407
Platinum	N/A	$3,000	$20	$40	20%	20%	20%	N/A	No	BH-GS	BH-GY	BH-G6	BH-HC	BK-DZ	407
Gold[7]	N/A	$6,000	$30	$60	$500	$1,000	$500	N/A	No	BH-GT	BH-GZ	BH-G7	BH-HD	BK-D2	859
Gold	$250	$6,000	$30	$60	$500	20%	20%	Embedded	No	BH-GU	BH-G2	BH-G8	BH-HE	BK-D3	860
Gold	$1,000	$6,000	$30	$60	30%	30%	30%	Embedded	No	BH-GV	BH-G3	BH-G9	BH-HF	BK-D4	860
Silver	$2,250	$7,900	$50	$75	40%	40%	40%	Embedded	No	BH-GW	BH-G4	BH-HA	BH-HG	BK-D5	861
Silver	$2,200	$7,900	30%	30%	30%	30%	30%	Embedded	No	N/A	N/A	N/A	BH-HH	N/A	861
Bronze HDHP	$6,500	$6,500	0%	0%	0%	0%	0%	Embedded	Yes	N/A	N/A	N/A	BJ-US	N/A	409
State Mirrored HMO															
Platinum	N/A	$3,350	$15	$30	$150	10%	10%	N/A	No	BJ-UT	BJ-UU	BJ-UV	BJ-UW	N/A	356
Gold	N/A	$7,200	$30	$55	$325	20%	20%	N/A	No	BH-HQ	BH-HS	BH-HU	BH-HW	N/A	410
Silver	$2,000	$7,550	$45	$80	$350	20%	20%	Embedded	No	BH-HR	BH-HT	BH-HV	BH-HX	N/A	863
Bronze HDHP	$6,000	$6,650	40%	40%	40%	40%	40%	Embedded	Yes	N/A	N/A	N/A	BH-HY	N/A	412

1 Refer to the benefit summary for the Family Deductible amount. For HMO plans, refer to the Schedule of Benefits for a detailed list of benefits subject to the Deductible.

2 Refer to the benefit summary for the Family Out-of-Pocket Maximum amount. Deductibles and member cost share for covered services, including office visits and pharmacy, apply to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum follows the Deductible Type for each plan, except for plans BH-BP, BH-BT and BH-B7 which have an embedded Family Out-of-Pocket Maximum.

3 Benefits with coinsurance (%) responsibility are subject to the Deductible.

4 The Per Occurrence Deductible is separate from the Annual Deductible and accrues toward the Out-of-Pocket Maximum. The Outpatient Per Occurrence Deductible may be waived for outpatient services received at an in-network independent, non-hospital affiliated provider.

5 Navigate is an In-Network product only, and does not cover Out-of-Network services. Only Select Plus and Core plans include benefit coverage for both In-Network and Out-of-Network services.

6 An annual combined limit of 3 visits apply to PCP, Specialist, Urgent Care, Mental Health and Substance Use Disorder office visits at the specified Copayment. Subsequent visits are subject to the plan Deductible and Copayment for the remainder of the Calendar Year.

7 Inpatient Hospital Copayment is applicable per day, up to a maximum of 4 days per stay.

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Pharmacy Plans - PPO

Deductible[1]		Member Copay				Mail Order (90 Day Supply)	Plan Code
Individual	Family	Tier 1	Tier 2	Tier 3	Tier 4		
N/A	N/A	$5	$15	$25	10% (max $250)	2.5x	354
N/A	N/A	$15	$55	$75	20% (max $250)	2.5x	397
Same as Medical		40% (max $500)	40% (max $500)	40% (max $500)	40% (max $500)	2.5x	399
$200	$400	$20	$50	$100	25% (max $250)	2.5x	405
Same as Medical		$20	$50	$100	25% (max $250)	2.5x	551
$500	$1,000	100% (max $500)	100% (max $500)	100% (max $500)	100% (max $500)	2.5x	733
N/A	N/A	$15	$40	$80	25% (max $250)	2.5x	852
$200	$400	$15	$55	$85	20% (max $250)	2.5x	853
N/A	N/A	$10	$35	$70	25% (max $250)	2.5x	854
$250	$500	$20	$50	$100	25% (max $250)	2.5x	855
Same as Medical		No Copay	No Copay	No Copay	No Copay	No Copay	856

Pharmacy Plans - HMO

Deductible[1]		Member Copay				Mail Order (90 Day Supply)	Plan Code
Individual	Family	Tier 1	Tier 2	Tier 3	Tier 4		
N/A	N/A	$5	$15	$25	10% (max $250)	2x	356
N/A	N/A	$15	$35	$70	25% (max $250)	2x	407
Same as Medical		No Copay	No Copay	No Copay	No Copay	No Copay	409
N/A	N/A	$15	$55	$75	20% (max $250)	2x	410
Same as Medical		40% (max $500)	40% (max $500)	40% (max $500)	40% (max $500)	2x	412
$100	$200	$15	$40	$80	25% (max $250)	2x	859
$250	$500	$15	$40	$80	25% (max $250)	2x	860
$250	$500	$20	$50	$100	25% (max $250)	2x	861
$200	$400	$15	$55	$85	20% (max $250)	2x	863

1 Does not apply to Tier 1, except for pharmacy plans subject to the Medical Deductible and pharmacy plans 733, 853 and 863.

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