# Essential plans

**Essential Plan 1750**
**Essential Plan 3000**
**Essential Plan 4500**

Underwritten by Blue Shield of California Life & Health Insurance Company.

These PPO plans for individuals are among our lowest-cost options, and make getting the coverage you need simple by combining medical, dental, and vision all in one plan.

Our Essential℠ plans limit the total annual amount you spend on copayments and deductibles, and include dental and vision coverage at no added cost. You get the essential coverage you need.

**Essential plan advantages**

- Comprehensive coverage – includes medical, dental, and vision care.
- Affordable monthly rates.
- Manageable out-of-pocket medical costs.
  - Your copayment maximum equals the deductible.
  - You're covered at 100% after the deductible is met.
- Affordable copayments for preventive care office visits ($40) and generic prescription drugs at network pharmacies ($10).
- Choice of three annual deductibles ($1,750, $3,000, and $4,500).
- One of the largest PPO provider networks in California, so it's easy to find the doctor you want.
- LASIK discount program.*
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

## Is an Essential plan right for you?

You know you need coverage for predictable – and unpredictable – events. And we know you don't want to spend a lot on monthly rates, but you realize dental and vision are important to your overall health and well-being. That's why our Essential plans provide the affordable quality coverage you need while limiting your possible out-of-pocket costs. The plans are available for individuals only and don't include maternity care or brand-name drug benefits.

* This discount program is not a benefit of the plan, and is offered in addition to the benefits covered under the plan. Blue Shield reserves the right to terminate this program without notice.

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## Uniform Health Plan Benefits and Coverage Matrix

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *POLICY FOR INDIVIDUALS AND FAMILIES* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

| | Essential Plan 1750 | Essential Plan 3000 | Essential Plan 4500 |
|---|---|---|---|
| **Deductible** | $1,750 | $3,000 | $4,500 |
| **Copayments** | $40 with preferred providers Not applicable with non-preferred providers | $40 with preferred providers Not applicable with non-preferred providers | $40 with preferred providers Not applicable with non-preferred providers |
| **Calendar-year copayment/ coinsurance maximum** (includes the plan deductible – some services do not apply) | Services with preferred providers: $1,750 individual-only; Services with all providers: $8,000 | Services with preferred providers: $3,000 individual-only; Services with all providers: $8,000 | Services with preferred providers: $4,500 individual-only; Services with all providers: $8,000 |
| **Lifetime maximum** | $6,000,000 | $6,000,000 | $6,000,000 |

● Plan benefits provided before you need to meet any medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

The benefits below apply to all Essential plans.

| Covered services<br>Subject to the plan deductible, unless noted. | Member copayments<br>With preferred providers,[1] you pay | <br>With non-preferred providers,[1] you pay |
|---|---|---|
| **Professional services** | | |
| Office visits (first 3 visits/calendar year – subsequent visits are subject to the deductible) | $40 (no charge after deductible) ● | 50% |
| **Preventive care** | | |
| Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit) | $40[2] ● | Not covered |
| **Outpatient services** | | |
| Non-emergency services and procedures | No charge after deductible | 50%[2,3] |
| Outpatient surgery in hospital | No charge after deductible | 50%[2,3] |
| Outpatient surgery performed in an ambulatory surgery center (ASC)[4] | No charge after deductible | 50%[2] |
| Outpatient or out-of-hospital X-ray and laboratory | No charge after deductible | 50% |
| **Hospitalization services** | | |
| Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists | No charge after deductible | 50% |
| Inpatient semiprivate room and board, services and supplies, and subacute care | No charge after deductible | 50%[2,3] |
| Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5] | No charge after deductible | 50%[2,3] |

# Essential plans

| Covered services | Member copayments | |
|---|---|---|
| Subject to the plan deductible unless noted. | **With preferred providers,[1] you pay** | **With non-preferred providers,[1] you pay** |
| **Emergency health coverage** | | |
| Emergency room services ($100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient) | $100/visit[2] ● | $100/visit[2] ● |
| ER physician visits | No charge after deductible | No charge after deductible |
| **Ambulance services** (surface or air) | No charge after deductible | No charge after deductible |
| **Prescription drug coverage** (outpatient) | **At participating pharmacies** (up to a 30-day supply) | **Mail service prescriptions** (up to a 60-day supply) |
| Generic formulary drugs | $10/prescription[2] ● | $20/prescription[2] ● |
| Formulary brand-name drugs | Not covered | Not covered |
| Non-formulary brand-name drugs | Not covered | Not covered |
| | **With preferred providers,[1] you pay** | **With non-preferred providers,[1] you pay** |
| **Durable medical equipment[6]** | No charge after deductible | 50% |
| | **With MHSA participating providers,[1,7] you pay** | **With MHSA non-participating providers,[1,7] you pay** |
| **Mental health services** | | |
| Inpatient hospital facility services | No charge after deductible | 50%[2,3] |
| Inpatient physician services | No charge after deductible | 50% |
| Outpatient visits for severe mental health conditions (first 3 visits/ calendar year – subsequent visits subject to the deductible) | $40 (no charge after deductible) ● | 50% |
| Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[8] | No charge after deductible | Not covered |
| **Chemical dependency services** (substance abuse) | | |
| Inpatient hospital facility services for medical acute detoxification | No charge after deductible | 50%[2,3] |
| Inpatient physician services for medical acute detoxification | No charge after deductible | 50% |
| Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[8] | No charge after deductible | Not covered |
| | **With preferred providers,[1] you pay** | **With non-preferred providers,[1] you pay** |
| **Home health services** (up to 60 pre-authorized visits per calendar year) | No charge after deductible | Not covered |
| **Other** | | |
| **Pregnancy and maternity care** | | |
| Outpatient prenatal and postnatal care | Not covered | Not covered |
| Delivery and all necessary inpatient hospital services | Not covered | Not covered |
| **Family planning** | | |
| Tubal ligation, vasectomy, elective abortion | Not covered | Not covered |
| **Rehabilitation services** (up to 15 visits per calendar year combined with speech therapy visits) | | |
| Provided in the office of a physician or physical therapist | No charge after deductible | 50% |
| **Chiropractic services** | Not covered | Not covered |
| **Out-of-state services** (full plan benefits covered nationwide with the BlueCard Program) | No charge after deductible with BlueCard participating providers | 50% with all other providers |
| **Vision services[9]** | | |
| Vision exam | $5[2] ● | $5[2] ● (and charges above the allowable amount) |

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| Covered services | Member copayments | |
|---|---|---|
| Subject to the plan deductible unless noted. | **With preferred providers,[1] you pay** | **With non-preferred providers,[1] you pay** |
| **Dental services are NOT subject to the plan medical deductible, but there is a $50 dental deductible for some minor restorative services** | | |
| **Dental services[10]** | | |
| Preventive and diagnostic (including routine oral exams, X-rays, and cleaning) | No charge[11] | All charges above the allowable amount |
| Minor restorative[2] (subject to $50 dental deductible, including amalgam and resin-based fillings) | $35-$100[11] (depending on procedure) | Member reimbursed per procedure reimbursement schedule |

**Please note:** Benefits are subject to modification for subsequently enacted state or federal legislation. Essential Plan 1750 is subject to regulatory approval.

- Plan benefits provided before you need to meet the medical deductible.

1 Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield allowable amounts as payment in full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum.

2 These copayments do not count toward the copayment/coinsurance maximum, and will continue to be charged once the copayment/coinsurance maximum is reached.

3 For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to $250 per day. Members are responsible for all charges that exceed $250 per day.

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 All covered orthoses have a benefit maximum of $500 per member per calendar year, except those services covered under the Diabetes Care benefit. All covered prosthetics have a benefit maximum of $2,000 per member per calendar year. See Policy for details.

7 Blue Shield has contracted with a specialized healthcare service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.

8 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

9 Vision exams are provided through MESVision network.

10 Dental services provided through Dental Benefit Providers (DBP). Benefits limited to $500 per calendar year combined. Three-month waiting period following the effective date of coverage for minor restorative services. Calendar-year medical deductible does not apply to preventive dental services.

11 Blue Shield's payment is limited to $500 per calendar year for Preventive and Diagnostic and Minor Restorative. Members are responsible for all charges that exceed $500 per calendar year.