

Essential plans

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

Essential Plan 1750

Essential Plan 3000

Essential Plan 4500

Essential plans simplify getting the coverage you need by combining medical, dental, and vision benefits all in one plan.

Is an Essential plan right for you?

You're an individual who only wants coverage to protect you in case of major medical events, and also provides essential benefits for doctor visits. Our EssentialSM plans allow you to control the total annual amount you spend on copayments and deductibles, and include dental and vision coverage at no added cost. They are available for individuals only and offer essential benefits, so you don't pay for services you don't expect to use, like maternity care or brand-name drug benefits. By providing you with affordable coverage, including dental and vision, these plans offer you 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 (see Policy for details).

Affordable copayments for preventive care office visits (\$40) and generic prescription drugs at network pharmacies (\$10).

Choice of 3 annual deductibles (\$1,750, \$3,000 and \$4,500).

Outpatient X-ray and laboratory services are \$0 with preferred providers, once you meet the plan's out-of-pocket maximum.

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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 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 Services with all providers: \$8,000	Services with preferred providers: \$3,000 Services with all providers: \$8,000	Services with preferred providers: \$4,500 Services with all providers: \$8,000
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000

The benefits below apply to all Essential plans.

- 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.

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay	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}

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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
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 equipment⁴	No charge after deductible	50%
	With MHPA participating providers,^{1,7} you pay	With MHPA 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 services⁹		
Vision exam	\$5 ² ●	\$5 ² ● (and charges above the allowable amount)

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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 services¹⁰		
Preventive and diagnostic (including routine oral exams, X-rays, and teeth 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. See Policy for 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 a vision plan administrator.
 - 10 Dental services provided through a dental plan administrator. 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. Member is responsible for all charges that exceed \$500 per calendar year.