

# Essential Plans 1750, 3000, and 4500

## Uniform health plan benefits and coverage matrix

Effective February 1, 2007

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 plans†

	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500
<b>Deductible</b>	\$1,750	\$3,000	\$4,500
<b>Copayments</b>	\$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
<b>Calendar-year copayment/coinsurance maximum</b> (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: \$5,000	Services with preferred providers: \$4,500 (individual only) Services with all providers: \$6,500
<b>Lifetime maximum</b>	\$6,000,000	\$6,000,000	\$6,000,000

† These plans are underwritten by Blue Shield of California Life & Health Insurance Company.

- Plan benefits provided before you need to meet any medical deductible are shown below with a blue 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

	With preferred providers <sup>1</sup>			With non-preferred providers <sup>1</sup>
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
<b>Professional services</b>				
Office visits (First 3 visits/calendar year – subsequent visits are subject to the deductible)	\$40 (no charge after deductible) ●	\$40 (no charge after deductible) ●	\$40 (no charge after deductible) ●	50%
<b>Preventive care</b>				
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 <sup>2</sup> ●	\$40 <sup>2</sup> ●	\$40 <sup>2</sup> ●	Not covered
<b>Outpatient services</b> (The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.)				
Non-emergency services and procedures	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
Outpatient surgery in hospital	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
Outpatient surgery performed in an ambulatory surgery center (ASC) <sup>4</sup>	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2</sup>
Outpatient or out-of-hospital X-ray and laboratory	No charge after deductible	No charge after deductible	No charge after deductible	50%
<b>Hospitalization services</b>				
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No charge after deductible	No charge after deductible	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) <sup>5</sup>	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
<b>Emergency health coverage</b>				
Emergency room services (\$100 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit <sup>2</sup> ●	\$100/visit <sup>2</sup> ●	\$100/visit <sup>2</sup> ●	\$100/visit <sup>2</sup> ●
ER physician visits	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
<b>Ambulance services</b> (surface or air)				
	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
<b>Essential Plans 1750, 3000, and 4500</b>				
<b>Prescription drug coverage</b> (outpatient)		<b>At participating pharmacies</b> (up to a 30-day supply)		<b>Mail-service prescriptions</b> (up to a 60-day supply)
Generic formulary drugs	\$10/prescription <sup>2</sup> ●			\$20/prescription <sup>2</sup> ●
Formulary brand-name drugs	Not covered			Not covered
Non-formulary brand-name drugs	Not covered			Not covered
		<b>With preferred providers<sup>1</sup></b>		<b>With non-preferred providers<sup>1</sup></b>
		<b>Essential Plan 1750</b>	<b>Essential Plan 3000</b>	<b>Essential Plan 4500</b>
<b>Durable medical equipment<sup>6</sup></b>	No charge after deductible	No charge after deductible	No charge after deductible	50%

## Covered services

## Member copayments

	With MHSA participating providers <sup>1,7</sup>			With MHSA non-participating providers <sup>1,7</sup>
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
<b>Mental health services</b>				
Inpatient hospital facility services	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
Inpatient physician services	No charge after deductible	No charge after deductible	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) ●	\$40 (No charge after 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)	No charge after deductible <sup>8</sup>	No charge after deductible <sup>8</sup>	No charge after deductible <sup>8</sup>	Not covered <sup>8</sup>
<b>Chemical dependency services</b> (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	No charge after deductible	No charge after deductible	No charge after deductible	50% <sup>2,3</sup>
Inpatient physician services for medical acute detoxification	No charge after deductible	No charge after deductible	No charge after deductible	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	No charge after deductible <sup>8</sup>	No charge after deductible <sup>8</sup>	No charge after deductible <sup>8</sup>	Not covered <sup>8</sup>
	<b>With preferred providers<sup>1</sup></b>			<b>With non-preferred providers<sup>1</sup></b>
	<b>Essential Plan 1750</b>	<b>Essential Plan 3000</b>	<b>Essential Plan 4500</b>	
<b>Home health services</b> (up to 90 pre-authorized visits per calendar year)	No charge after deductible	No charge after deductible	No charge after deductible	Not covered
<b>Other</b>				
<b>Pregnancy and maternity care</b>				
Outpatient prenatal and postnatal care	Not covered	Not covered	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered	Not covered	Not covered
<b>Family planning</b>				
Consultations, tubal ligation, vasectomy, elective abortion	No charge after deductible	No charge after deductible	No charge after deductible	Not covered
<b>Rehabilitation services</b> (up to 20 visits per calendar year combined with Speech Therapy visits)				
Provided in the office of a physician or physical, occupational, or respiratory therapist	No charge after deductible	No charge after deductible	No charge after deductible	50%
<b>Chiropractic services</b>				
Out-of-state services (full plan benefits covered nationwide with the BlueCard® Program)	No charge after deductible with BlueCard participating providers	No charge after deductible with BlueCard participating providers	No charge after deductible with BlueCard participating providers	50% with all other providers

## Covered services

## Member copayments

	With preferred providers <sup>1</sup>			With non-preferred providers <sup>1</sup>
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
<b>Vision services<sup>9</sup></b>				
Vision exam	\$5 <sup>2</sup> ●	\$5 <sup>2</sup> ●	\$5 <sup>2</sup> ●	\$5 <sup>2</sup> ●
<b>Dental services are NOT subject to the plan medical deductible, but there is a \$50 dental deductible for some minor restorative services</b>				
<b>Dental services<sup>10</sup></b>				
Preventive and diagnostic (including routine oral exams, X-rays and cleaning)	No charge	No charge	No charge	All charges above the allowable amount
Minor restorative <sup>2</sup> (Subject to \$50 dental deductible, including amalgam and resin based fillings)	\$35 - \$100 (depending on procedure)	\$35 - \$100 (depending on procedure)	\$35 - \$100 (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.

- 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.
- These copayments do not count toward the copayment/coinsurance maximum, and will continue to be charged once the copayment/coinsurance maximum is reached.
- 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.
- Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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.
- 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.
- 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.
- For MHSA participating providers, initial visit treated as if the condition was a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.
- Vision exams are provided through MESVision network.
- 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.