



ESSENTIAL PLAN 3000 AND ESSENTIAL PLAN 4500

Uniform Health Plan Benefits & 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 3000 and 4500 These plans are underwritten by Blue Shield of California Life & Health Insurance Company.		
	Essential Plan 3000	Essential Plan 4500
DEDUCTIBLE	\$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
CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Some services do not apply.)	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
LIFETIME MAXIMUM	\$6,000,000	\$6,000,000

Essential plan benefits provided before you need to meet the deductible are shown in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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 (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
	Essential Plan 3000	Essential Plan 4500	
PROFESSIONAL SERVICES			
– Office visits (First 3 visits per calendar year. Subsequent visits are subject to the deductible.)	\$40 (until deductible is met then no charge)	\$40 (until deductible is met then no charge)	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	\$40 ²	Not Covered
OUTPATIENT SERVICES			
– Non-Emergency services and procedures	No Charge	No Charge	50% ^{2,3}
– Outpatient surgery in hospital	No Charge	No Charge	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	No Charge	No Charge	50%

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
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HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No Charge	No Charge	50%
– Inpatient semiprivate room and board, services and supplies, and subacute care	No Charge	No Charge	50% ^{2,3}
EMERGENCY HEALTH COVERAGE			
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission (\$100 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$100 ²	\$100 ²	\$100 ²
– ER Physician visits	No Charge	No Charge	No Charge
AMBULANCE SERVICES (Surface or Air)			
	No Charge	No Charge	No Charge
Essential Plans 3000 and 4500			
PRESCRIPTION DRUG COVERAGE⁴ (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
	Essential Plan 3000	Essential Plan 4500	
DURABLE MEDICAL EQUIPMENT⁵			
	No Charge	No Charge	50%
		With MHPA Participating Providers,^{1,6} you pay	With MHPA Non-Participating Providers,^{1,6} you pay
MENTAL HEALTH SERVICES			
– Inpatient Hospital Facility Services	No Charge	No Charge	50% ^{2,3}
– Inpatient Physician Services	No Charge	No Charge	50%
– Outpatient visits for severe mental health conditions (First 3 visits per calendar year. Subsequent visits subject to the deductible.)	\$40 (until deductible is met then no charge)	\$40 (until deductible is met then no charge)	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	No Charge	No Charge	Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)			
– Inpatient Hospital Facility Services for medical acute detoxification	No Charge	No Charge	50% ^{2,3}
– Inpatient Physician Services for medical acute detoxification	No Charge	No Charge	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	No Charge	No Charge	Not Covered

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers ¹ , you pay		With Non-Preferred Providers ¹ , you pay
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HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	No Charge	No Charge	Not Covered
OTHER			
Pregnancy and Maternity Care			
– Outpatient prenatal and postnatal care	Not Covered	Not Covered	Not Covered
– Delivery and all necessary inpatient hospital services	Not Covered	Not Covered	Not Covered
Family Planning			
– Consultations, tubal ligation, vasectomy, elective abortion	No Charge	No Charge	Not Covered
Rehabilitation Services (up to 20 visits per calendar year combined with Speech Therapy visits)			
– Physical, occupational, or respiratory therapy	No Charge	No Charge	50%
Chiropractic Services	Not Covered	Not Covered	Not Covered
Out-of-State Services (Plan benefits covered nationwide with the BlueCard program)	No Charge with BlueCard participating providers	No Charge with BlueCard participating providers	50% with all other providers
DENTAL SERVICES⁷			
Preventive and diagnostic (Including routine oral exams, X-rays and cleaning)	No Charge	No Charge	All charges above the allowable amount
Minor restorative (Not subject to medical deductible. Subject to \$50 dental deductible. Including amalgam and resin based fillings.)	\$35 - \$100 (depending on procedure)	\$35 - \$100 (depending on procedure)	Member reimbursed per procedure reimbursement schedule
VISION SERVICES⁸			
Vision exam	\$5 ²	\$5 ²	\$5 ²

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation. Essential Plan 3000 and Essential Plan 4500 are subject to regulatory approval.

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 Prescription coverage differs for Home-Self Injectables. Please review the Policy before you purchase the plan.

5 All covered orthoses have a combined benefit maximum of \$500 per member per calendar year. All covered prosthetics have a combined benefit maximum of \$2,000 per member per calendar year. See Policy for details.

6 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.

7 Dental services provided through Dental Benefit Providers (DBP). Benefits limited to \$500 per calendar year. Three month waiting period following the effective date of coverage for minor restorative services.

8 Vision exam provided through MESVision network.

BLUE SHIELD RATING REGIONS

These rates are Blue Shield's "Tier 1" rates, and are offered to individuals in good health. Other rates may apply depending on underwriting determination. The rates are effective April 1, 2006. Rates are pending regulatory approval and are subject to change.

Blue Shield Rate Guarantee

Our rate guarantee program¹ now offers new IFP members a rate guarantee for the first consecutive six (6) months of coverage from the member's original effective date (OED).

To find the rates that apply to you:

- 1** Locate your county of residence in one of the Blue Shield Rating Regions, then find the column for your region.
- 2** On the chart you'll see that rates are listed separately for single and YouthCareSM coverage. Locate the category that applies to you.
- 3** Under the type of coverage you've selected (individual or YouthCare), find the age range of the person who will be the applicant. The rates that apply for the plan are in this row.

Essential Plan 3000[†] and Essential Plan 4500[†] Rating Regions

Region 1: Alpine, Butte, Del Norte, Imperial, Inyo, Kern, Plumas, San Luis Obispo, Sonoma, Stanislaus, Trinity, Yolo and the following Santa Barbara ZIP codes: 93254, 93427, 93429, 93434, 93436-38, 93440-41, 93454-58, 93460, 93463-64

Region 2: Colusa, Kings, Madera, Mendocino, Merced, San Benito, San Joaquin, Siskiyou, Tulare

Region 3: Amador, Calaveras, Glenn, Modoc, Nevada, Placer, Sacramento, Shasta, Sierra, Tuolumne

Region 4: Alameda, Contra Costa, Santa Clara

Region 5: Marin, San Francisco, San Mateo

Region 6: El Dorado, Fresno, Humboldt, Lake, Lassen, Mariposa, Mono, Monterey, Napa, Santa Cruz, Solano, Sutter, Tehama, Yuba

Region 7: San Bernardino, San Diego, Santa Barbara except the ZIP codes listed in Rating Region 1

Region 8: Orange, Riverside, Ventura and the following Los Angeles ZIP codes: 91023, 91301, 91310, 91321-22, 91350-51, 91354-55, 91376-77, 91380-87, 91390, 91711, 91750, 91765-69, 91773, 91788-89, 91795, 91797, 91799, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93563, 93584, 93586, 93590-91, 93599

Region 9: Los Angeles except the ZIP codes listed in Rating Region 8

To learn about current rates for Guaranteed Issue plans, call **(800) 431-2809**.

Please Note: The rating regions are subject to change. Call Blue Shield to verify which rating region you are in.

[†]Underwritten by Blue Shield of California Life & Health Insurance Company. The rates for Essential Plan 3000 and Essential Plan 4500 have been filed with the Department of Insurance and are currently pending regulatory approval.

¹Does not apply to Guaranteed Issue Plans, rate actions based on age-band changes, rate actions based on a change in location to another rating region, or on plan transfers within the first six months of enrollment.

ESSENTIAL PLAN 3000[†]

Age Range	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
YOUTHCARE – Monthly Dues for Blue Shield									
Under 1	\$122	\$122	\$122	\$125	\$133	\$132	\$111	\$115	\$133
1 to 18	83	83	83	85	90	88	76	79	90
SINGLE – Monthly Dues for Blue Shield									
19 to 29	\$91	\$91	\$91	\$94	\$99	\$98	\$84	\$88	\$100
30 to 34	105	105	105	107	113	112	95	100	114
35 to 39	118	118	118	122	129	127	108	112	129
40 to 44	137	137	137	141	149	147	122	131	151
45 to 49	174	174	174	179	190	188	155	166	192
50 to 54	221	221	221	226	241	238	196	209	243
55 to 59	311	311	311	319	340	336	273	294	343
60 to 64	411	411	411	421	447	444	359	386	453

ESSENTIAL PLAN 4500[†]

Age Range	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
YOUTHCARE – Monthly Dues for Blue Shield									
Under 1	\$110	\$110	\$110	\$112	\$118	\$118	\$97	\$103	\$119
1 to 18	77	77	77	79	83	82	71	75	85
SINGLE – Monthly Dues for Blue Shield									
19 to 29	\$84	\$84	\$84	\$87	\$91	\$90	\$77	\$81	\$93
30 to 34	93	93	93	96	101	99	85	91	102
35 to 39	104	104	104	107	113	112	95	101	115
40 to 44	117	117	117	120	127	126	106	113	129
45 to 49	157	157	157	161	170	169	139	150	173
50 to 54	198	198	198	201	213	212	174	188	218
55 to 59	276	276	276	282	299	297	241	262	306
60 to 64	362	362	362	370	392	389	316	344	402

[†]Underwritten by Blue Shield of California Life & Health Insurance Company

Please note: Two-Party and Family coverage not available with Essential plans.