# Blue Shield Medical Benefits

| Medical Premiums | | | | |
|---|---|---|---|---|
| Coverage Tier | Total Monthly Cost | NU Monthly Cost | Employee Monthly Cost | Employee Pay Period Cost |
| **HDHP** | | | | |
| **Employee Only** | $847.13 | $802.13 | $45.00 | $22.50 |
| **Employee + Spouse** | $1,948.40 | $1,740.40 | $208.00 | $104.00 |
| **Employee + Child(ren)** | $1,567.21 | $1,450.21 | $117.00 | $58.50 |
| **Employee Family** | $2,795.51 | $2,437.51 | $358.00 | $179.00 |
| **PPO** | | | | |
| **Employee Only** | $863.36 | $761.36 | $102.00 | $51.00 |
| **Employee + Spouse** | $1,985.69 | $1,557.69 | $428.00 | $214.00 |
| **Employee + Child(ren)** | $1,597.18 | $1,323.18 | $274.00 | $137.00 |
| **Employee Family** | $2,849.04 | $2,236.04 | $613.00 | $306.50 |
| **EPO** | | | | |
| **Employee Only** | $946.36 | $823.36 | $123.00 | $61.50 |
| **Employee + Spouse** | $2,176.62 | $1,706.62 | $470.00 | $235.00 |
| **Employee + Child(ren)** | $1,750.75 | $1,427.75 | $373.00 | $186.50 |
| **Employee Family** | $3,122.96 | $2,412.96 | $710.00 | $355.00 |

| | EPO | PPO | | HDHP | |
|---|---|---|---|---|---|
| | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Calendar Year Deductible** | | | | | |
| **Individual** | $500 individual | $1,000 individual | | $2,250 per member | $4,500 per member |
| **Family** | $1,000 two-party<br>$1,500 per family | $1,000 individual $2,000 two or more/$3,000 for three or more | | $4,500 per Family | $9,000 per family |
| **Coinsurance** | 90% | 80% | 60% | 100% | 80% |
| **Calendar Year Maximum Out-of-Pocket** | | | | | |
| **Individual** | $4,000 | $4,000 | $8,000 | $3,000 | $8,000 |
| **Family** | $4,000 individual<br>$8,000 two or more<br>$12,000 family | $4,000 individual<br>$8,000 two or more<br>$12,000 family | $8,000 individual<br>$16,000 two or more/$24,000 for three or more | $6,000 family<br>$3,000 per member | $16,000 family<br>$8,000 per member |
| **Physician Office Visit** | | | | | |
| **Primary Care** | $20 copay (dw) | $20 copay (dw) | 60% after deductible | 100% after deductible | 80% after deductible |
| **Specialty Care** | $40 copay (dw) | $40 copay (dw) | 60% after deductible | 100% after deductible | 80% after deductible |
| **Preventive Care** | | | | | |
| **Adult Periodic Exams** | 100% | 100% | Not covered | 100% not subject to deductible | Not covered |
| **Well-Child Care** | 100% | 100% | Not covered | 100% not subject to deductible | Not covered |

| | EPO | PPO | | HDHP with HSA | |
|---|---|---|---|---|---|
| | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Diagnostic Services** | | | | | |
| **X-ray and Lab Tests** | 90% | 80% | 60% | 100% after deductible | 80% after deductible |
| **Complex Radiology** | $100 | 80% | 60% | 100% after deductible | 80% after deductible |
| **Urgent Care Facility** | $40 copay | $40 copay (dw) | 60% | 100% after deductible | 80% after deductible |
| **Emergency Room Facility Charges** | $250 copay/ visit waived if admitted | $250 copay waived if admitted | | $250 copay after deductible | |
| **Facility Services** | | | | | |
| **Inpatient Facility Charges** | $300 copay/day 3 day/admission | 80% after deductible | 60% after deductible | 100% after deductible | 80% after deductible |
| **Mental Health** | | | | | |
| **Inpatient** | $300 copay/day 3 day/admission | 80% after deductible | 60% after deductible | 100% after deductible | 80% after deductible |
| **Outpatient** | $20 copay | $20 copay | 60% after deductible | 100% after deductible | 80% after deductible |
| **Substance Abuse** | | | | | |
| **Inpatient** | $300 copay/day 3 day/admission | 80% after deductible | 60% after deductible | 100% after deductible | 80% after deductible |
| **Outpatient** | $20 copay | $20 copay | 60% after deductible | 100% after deductible | 80% after deductible |
| **Other Services** | | | | | |
| **Chiropractic** | $15 copay 30 visits/calendar year | 80% after deductible 30 visits/calendar year | 60% after deductible 30 visits/calendar year | 100% after deductible limited to 24 visits | 60% after deductible limited to 24 visits |
| **Retail Pharmacy (30 Day Supply)** | | | | | |
| **Generic (Tier 1)** | $10 copay | $10 copay | $10 copay | $10 copay | $10 copay |
| **Preferred (Tier 2)** | $20 copay | $20 copay | $20 copay | $30 copay | $30 copay |
| **Non-Preferred (Tier 3)** | $40 copay | $40 copay | $40 copay | $50 copay | $50 copay |
| **Preferred Specialty (Tier 4)** | $40 copay | $40 copay | NA | $50 copay | Not Covered |
| **Mail Order Pharmacy (90 Day Supply)** | | | | | |
| **Generic (Tier 1)** | $20 copay | $20 copay | Not Covered | $25 copay | Not covered |
| **Preferred (Tier 2)** | $40 copay | $40 copay | Not Covered | $75 copay | Not covered |
| **Non-Preferred (Tier 3)** | $80 copay | $80 copay | Not Covered | $125 copay | Not covered |
| **Preferred Specialty (Tier 4)** | $80 copay | $80 depending on availability | Not covered | Not covered | Not covered |