

## Blue Shield Medical Benefits

Medical Premiums				
Coverage level	Employee Cost	Employer Cost	Total Cost	% Employer Contribution
<b>HDHP</b>				
Employee Only	\$50.00	\$886.60	\$936.60	95%
Employee + Spouse	\$248.00	\$1,906.16	\$2,154.16	88%
Employee + Child(ren)	\$129.00	\$1,603.70	\$1,732.70	93%
Employee Family	\$394.00	\$2,696.72	\$3,090.72	87%
<b>PPO</b>				
Employee Only	\$116.00	\$838.54	\$954.54	88%
Employee + Spouse	\$528.00	\$1,667.38	\$2,195.38	76%
Employee + Child(ren)	\$312.00	\$1,453.84	\$1,765.84	82%
Employee Family	\$699.00	\$2,450.90	\$3,149.90	78%
<b>EPO</b>				
Employee Only	\$144.00	\$902.30	\$1,046.30	86%
Employee + Spouse	\$570.00	\$1,836.48	\$2,406.48	76%
Employee + Child(ren)	\$436.00	\$1,499.62	\$1,935.62	77%
Employee Family	\$831.00	\$2,621.74	\$3,452.74	76%

	EPO	PPO		HDHP	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>					
Individual	\$500 individual	\$1,000 individual		\$2,250 per member	\$4,500 per member
Family	\$1,000 two-party \$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%
<b>Calendar Year Maximum Out-of-Pocket</b>					
Individual	\$4,000	\$4,000	\$8,000	\$3,000	\$8,000
Family	\$4,000 individual \$8,000 two or more \$12,000 family	\$4,000 individual \$8,000 two or more \$12,000 family	\$8,000 individual \$16,000 two or more/\$24,000 for three or more	\$6,000 family \$3,000 per member	\$16,000 family \$8,000 per member
<b>Physician Office Visit</b>					
Primary Care	\$25 copay (dw)	\$25 copay (dw)	60% after deductible	100% after deductible	80% after deductible
Specialty Care	\$50 copay (dw)	\$50 copay (dw)	60% after deductible	100% after deductible	80% after deductible
<b>Preventive Care</b>					
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
<b>Diagnostic Services</b>					
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	\$50 copay (dw)	\$50 copay (dw)	60%	\$50 copay after deductible	80% after deductible
Emergency Room Facility Charges	\$250 copay/visit waived if admitted	\$250 copay waived if admitted		\$250 copay after deductible	
<b>Facility Services</b>					
Inpatient Facility Charges	\$300 copay/day 3 day/admission	80% after deductible	60% after deductible	100% after deductible	80% after deductible
<b>Mental Health</b>					
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
<b>Substance Abuse</b>					
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
<b>Other Services</b>					
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
<b>Retail Pharmacy (30 Day Supply)</b>					
Generic (Tier 1)	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Preferred (Tier 2)	\$40 copay	\$40 copay	\$40 copay	\$40 copay	\$40 copay
Non-Preferred (Tier 3)	\$60 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Preferred Specialty (Tier 4)	20% up to \$250	20% up to \$250	NA	20% up to \$250	N/A
<b>Mail Order Pharmacy (90 Day Supply)</b>					
Generic (Tier 1)	\$20 copay	\$20 copay	Not Covered	\$20 copay	Not covered
Preferred (Tier 2)	\$80 copay	\$80 copay	Not Covered	\$80 copay	Not covered
Non-Preferred (Tier 3)	\$120 copay	\$120 copay	Not Covered	\$120 copay	Not covered
Preferred Specialty (Tier 4)	Not covered	Not Covered	Not covered	Not covered	Not covered