shipping easy Benefit Summary

ShippingEasy offers two **BlueCross BlueShield** Health Plans, and a voluntary GUARDIAN Dental/Vision plan.

The BlueCross BlueShield Health Plan benefits

BlueCross BlueShield of Texas

Plan ID	Benefit Information	EO	ES	EC	EF
RS30 Copay Plan	$30 Office Copay, $55 Urgent Care Copay, $5000 Combined Deductible, 100%/70% Coinsurance after calendar year deductible (In-Network/Out of Network), Prescription Drug Plan $10/$40/$60	$261.61	$629.78	$714.17	$1,082.35
RSH3 High Deductible Plan	HSA: No Copay, $5000/$10000 Deductible (In-Network/ Out of Network), 100%/70% Coinsurance after calendar year deductible (In-Network/Out of Network). Prescription Drug Plan 100% after calendar year deductible.	$180.39	$434.27	$492.45	$746.33

All dollar amounts are premiums per month. Full benefits package available.

- EO = Employee Only and is covered by ShippingEasy at 100%.
- ES = Employee + Spouse/Domestic Partner and is covered at 100% or up to $750 per month by ShippingEasy.
- EC =Employee + Child(ren) and is covered at 100% or up to $750 per month by ShippingEasy.
- EF = Employee + Family and is covered at up to $750 per month by ShippingEasy.

The GUARDIAN Dental/Vision plans

GUARDIAN℠

Dental: You may go to any dentist, however those who belong to the Dental - DentalGuard Pref - Texas network will be most cost effective. There is a calendar year deductible of $50, once the annual deductible is met by the individual or each of three family members (if on a family plan), no further deductibles apply.

Benefit Covered	In Network	Out of Network
Cleaning	100%	100%
Oral Exams	100%	100%
Basic Care		
Fillings (one surface)	100%	100%
General Anesthesia[1]	100%	100%
Single Crowns	60%	60%
Simple Extractions	60%	60%
Orthodontia	Not Available	Not Available

Full benefits package available.

- EO= $33.76 per month
- ES = $68.53 per month
- EC = $86.64 per month
- EF = $129.54 per month

Vision: You may go to any eye doctor however, if you go to a VSP network provider you will usually pay less. There is no calendar year deductible. Services are covered once a year under a $20 copay and any additional fees over the allowed amount for contact lenses or frames. Below is a brief view of benefits covered.

Benefit Covered	In Network	Out of Network
Co-Pay	$20	$20 + Amount over*
How often can I obtain service?	Exams: Once a year	Exams: Once a year
	Lenses: Once a year	Lenses: Once a year
	Frames: Once every other year	Frames: Once every other year
	Materials: Once a year	Materials: Once a year
Eye exams	Co-Pay applies	Amount over: $39*
Lenses		
- Single vision lenses	Co-Pay applies	Amount over: $23*
- Lined bifocal lenses	Co-Pay applies	Amount over: $37*
Contact Lenses		
- Conventional	Amount over: $150	Amount over: $100*
- Planned replacement and disposable	Amount over: $150	Amount over: $100*
Frames	$150, 20% discount on amount over $150	Amount over: $46*

Full benefits package available.

- EO= $9.79 per month
- EC = $16.81 per month
- ES = $16.48 per month
- EF = $26.60 per month

**All premiums are split between bi-weekly pay periods.