

2021		PPO Plan			2021		High Deductible Plan				
		Healthy Me Copay D FKA Healthy Me A (Monthly)		Dental and Vision Benefits (Monthly)				Healthy Me HSA-A FKA: Healthy Me B (Monthly)		Dental and Vision Benefits (Monthly)	
Plan Cost	Total	Employee	Dental (50/50)	Vision	Plan Cost	Total	Employee	HSA Contributions	Dental (50/50)	Vision	
Self	\$815.00	\$151.00	\$16.00	\$10.50	Self	\$771.00	\$66.00	****	\$16.00	\$10.50	
Self & Spouse	\$1,638.00	\$377.00	\$34.00	\$22.37	Self & Spouse	\$1,549.00	\$213.00	****	\$34.00	\$22.37	
Self & Child	\$1,361.00	\$314.00	\$34.00	\$24.05	Self & Child	\$1,287.00	\$179.00	****	\$34.00	\$24.05	
Family	\$2,184.00	\$502.00	\$53.00	\$39.17	Family	\$2,065.00	\$285.00	****	\$53.00	\$39.17	
<b>Employee Out-of-Pocket</b>		<b>In-Network*</b>			<b>Employee Out-of-Pocket</b>		<b>In-Network* Non-Embedded</b>				
<b>Medical Benefits</b>		<b>WI- UHC; MI- BCBS</b>			<b>Medical Benefits</b>		<b>WI- UHC; MI- BCBS</b>				
Preventive Care	0%				Preventive Care	0%					
Office Visit Co-pay**	Primary Care Physician \$35	Urgent Care/Specialist Office Visit \$60			Office Visit	Deductible and Coinsurance					
Annual Individual Deductible	\$1,200				Annual Individual Deductible	\$1,400					
Annual Family Deductible	\$2,400				Annual Family Deductible	\$2,800					
Coinsurance	20%				Coinsurance	20%					
Individual Maximum Out-of-Pocket	\$3,500				Individual Maximum Out-of-Pocket	\$2,800					
Family Maximum Out-of-Pocket	\$7,000				Family Maximum Out-of-Pocket	\$5,600					
Emergency Room	Life Threatening: \$200 copay then Deductible	Non- Life Threatening : \$450 copay then Deductible			Emergency Room	Life threatening: 20% coinsurance after deductible; Non-Life Threatening: 40% coinsurance after deductible					
<b>Mental Health Benefits</b>		<b>WI - UHC; MI - BCBS Network</b>			<b>Mental Health Benefits</b>		<b>WI - UHC; MI - BCBS Network</b>				
Individual Counseling Sessions	\$35 co-pay				Individual Counseling Sessions	20% coinsurance after deductible					
<b>Prescription (EMPIRX- WI) (Express Scripts- MI)</b>	<b>RETAIL</b>	<b>MAIL ORDER (90 day supply)</b>			<b>Prescription (EMPIRX- WI) (Express Scripts- MI)</b>	<b>RETAIL</b>	<b>MAIL ORDER (90 day supply)</b>				
Preventive	See copay structure below		See copay structure below		Preventive	\$0 for generic preventive drugs					
Generic Drug Co-pay	\$10	\$25			Generic Drug Co-pay	\$10 copay after deductible	\$25 copay after deductible				
Formulary Brand	30% (Min. \$25; Max. \$75)	30% (Min. \$62.50; Max. \$187.50)			Formulary Brand Co-pay	30% Coinsurance after deductible	30% coinsurance after deductible (Min. \$62.50; Max. \$187.50)				
Non-Formulary Brand	40% (Min. \$50; Max \$100)	40% (Min. \$125; Max. \$250)			Non-Formulary Brand Co-pay	40% coinsurance after deductible (Min. \$50; Max \$100)	40% coinsurance after deductible (Min. \$125; Max. \$250)				
<b>Optional Employee Pre-Tax</b>		<b>Optional Employee Pre-Tax</b>			<b>Optional Employee Pre-Tax</b>		<b>Optional Employee Pre-Tax</b>				
Health Savings Account	Not available				Health Savings Account	\$3,600 Employee Only; \$7,200 Families					
FSA	\$2,750				FSA	\$2,750 (Dental & Vision only)					
Dependent Care FSA	\$5,000				Dependent Care FSA	\$5,000					
* For Out-of-Network costs please refer to the Healthcare page at <a href="http://www.concordiaplans.org">www.concordiaplans.org</a> .					****HSA Funds may be used to pay for medical, dental, and vision and other health expenses. See SPD for details						
**Office visit co-pays do not apply to the deductible					Employees may also contribute the differences between HSA maximum and the employer contribution to the HSA.						