

2022	PPO Plan				High Deductible Plan					High Deductible Plan				
	Healthy Me Copay D (Monthly)		Dental and Vision Benefits (Monthly)		Healthy Me HSA-A (Monthly)			Dental and Vision Benefits (Monthly)		NEW PLAN OFFERING 2022 Healthy Me HSA-C (Monthly)			Dental and Vision Benefits (Monthly)	
Plan Cost	Total	Employee	Dental (50/50)	Vision	Total	Employee	HSA Contributions	Dental (50/50)	Vision	Total	Employee	HSA Contributions	Dental (50/50)	Vision
Self	\$863.00	\$170.00	\$19.59	\$11.02	\$816.00	\$80.00	****	\$19.59	\$11.02	\$748.00	\$15.00	****	\$19.59	\$11.02
Self & Spouse	\$1,734.00	\$415.00	\$41.13	\$23.47	\$1,640.00	\$240.00	****	\$41.13	\$23.47	\$1,503.00	\$105.00	****	\$41.13	\$23.47
Self & Child	\$1,441.00	\$345.00	\$41.13	\$25.24	\$1,362.00	\$200.00	****	\$41.13	\$25.24	\$1,249.00	\$90.00	****	\$41.13	\$25.24
Family	\$2,313.00	\$555.00	\$63.65	\$41.11	\$2,186.00	\$320.00	****	\$63.65	\$41.11	\$2,005.00	\$140.00	****	\$63.65	\$41.11
Employee Out-of-Pocket	<i>In-Network* Embedded</i>				<i>In-Network* Non-Embedded</i>					<i>In-Network* Embedded</i>				
Medical Benefits	WI- UHC; MI- BCBS				WI- UHC; MI- BCBS					WI- UHC; MI- BCBS				
Preventive Care	0%				0%					0%				
Office Visit Co-pay**	Primary Care Physician \$35		Urgent Care/Specialist Office Visit \$60		Deductible and Coinsurance					Deductible and Coinsurance				
Annual Individual Deductible	\$1,200				\$1,400					\$2,800				
Annual Family Deductible	\$2,400				\$2,800					\$5,600				
Coinsurance	20%				20%					20%				
Individual Maximum Out-of-Pocket	\$3,500				\$2,800					\$5,400				
Family Maximum Out-of-Pocket	\$7,000				\$5,600					\$10,800				
Emergency Room	\$200 copay then Deductible				20% coinsurance after deductible					20% coinsurance after deductible				
Mental Health Benefits	WI - UHC; MI - BCBS Network				WI - UHC; MI - BCBS Network					WI - UHC; MI - BCBS Network				
Individual Counseling Sessions	\$35 copay				20% coinsurance after deductible					20% coinsurance after deductible				
Prescription (EMPIRX- WI) (Express Scripts- MI)	RETAIL		MAIL ORDER (90 day supply)		RETAIL		MAIL ORDER			RETAIL		MAIL ORDER		
Preventive	See copay structure below		See copay structure below		\$0 for generic preventive drugs					\$0 for generic preventive drugs				
Generic Drug Co-pay	\$10		\$25		\$10 copay after deductible		\$25 copay after deductible			\$10 copay after deductible		\$25 copay after deductible		
Formulary Brand	30% (Min. \$25; Max. \$75)		30% (Min. \$62.50; Max. \$187.50)		30% Coinsurance after deductible (Min. \$25; Max. \$75)		30% coinsurance after deductible (Min. \$62.50; Max. \$187.50)			30% Coinsurance after deductible (Min. \$25; Max. \$75)		30% coinsurance after deductible (Min. \$62.50; Max. \$187.50)		
Non-Formulary Brand	40% (Min. \$50; Max \$100)		40% (Min. \$125; Max. \$250)		40% coinsurance after deductible (Min. \$50; Max \$100)		40% coinsurance after deductible (Min. \$125; Max. \$250)			40% coinsurance after deductible (Min. \$50; Max \$100)		40% coinsurance after deductible (Min. \$125; Max. \$250)		
Optional Employee Pre-Tax	Not available				\$3,650 Employee Only; \$7,300 Families					\$3,650 Employee Only; \$7,300 Families				
Health Savings Account	Not available				\$3,650 Employee Only; \$7,300 Families					\$3,650 Employee Only; \$7,300 Families				
FSA	\$2,750				\$2,750 (Dental & Vision only)					\$2,750 (Dental & Vision only)				
Dependent Care FSA	\$5,000				\$5,000					\$5,000				

* For Out-of-Network costs please refer to the Healthcare page at www.concordiaplans.org.

****HSA Funds may be used to pay for medical, dental, and vision and other health expenses. See SPD for details