Community Connections Inc. - 2022 Employer Sponsored Health Plans Rates
with Friday Health Plans, and Delta Dental and VSP Plans and Rates, effective date: 1/1/2022

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	Option 1	*Friday SG Platinum*		Option 2	*Friday SG Gold Rx Copay*	
Deductible		**In Network**	**Out of Network**		**In Network**	**Out of Network**
Individual		$250	Not Covered		$950	Not Covered
Family		$500	Not Covered		$1,900	Not Covered
Out of Pocket Maximum						
Individual		$4,500	Not Covered		$8,250	Not Covered
Family		$9,000	Not Covered		$16,500	Not Covered
Coinsurance		10%	Not Covered		20%	Not Covered
Physician Services						
PCP In Office		No Charge	Not Covered		$20, deductible waived	Not Covered
Specialist Copay		$20, deductible waived	Not Covered		$40	Not Covered
Hospital Services						
Inpatient Facility		10%	Not Covered		20%	Not Covered
Inpatient Physician		10%	Not Covered		20%	Not Covered
Emergency Room Copay		$250, deductible waived	$250		50%	50%
Urgent Care copay		$50, deductible waived	$50		$75, deductible waived	$75
Preventive Care		No Charge	Not Covered		No Charge	Not Covered
Prescription Drugs		$0/ $20/ $50/ $300			$0 / $250 / $350 / $685	
Lab copay		10%	Not Covered		20%	Not Covered
X-Ray copay		10%	Not Covered		20%	Not Covered
Current Enrollment	Total Monthly Cost of Benefit / CCI Contribution for EE SG Platinum	Employee Cost Per Month		Total Monthly Cost of Benefit / CCI Contribution for EE SG Gold Rx Copay	Employee Cost Per Month	
Employee (EE) Only	$1,049.31/ $530	$519.31		$854.42 / $530	$324.42	
EE & Spouse	$2,098.61 / $530	$1,568.61		$1,708.84 / $530	$1,178.84	
EE & Child(ren)	$1,941.22 / $530	$1,411.22		$1,580.68 / $530	$1,050.68	
EE & Family	$2,990.52 / $530	$2,460.52		$2,435.10 / $530	$1,905.10	

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	Option 3	*Friday SG Gold Copay*		Option 4	*Friday SG Gold*	
Deductible		In Network	Out of Network		In Network	Out of Network
Individual		$2,300	Not Covered		$2,300	Not Covered
Family		$4,600	Not Covered		$4,600	Not Covered
Out of Pocket Maximum						
Individual		$8,250	Not Covered		$8,250	Not Covered
Family		$16,500	Not Covered		$16,500	Not Covered
Coinsurance		20%	Not Covered		20%	Not Covered
Physician Services						
PCP In Office		No Charge	Not Covered		No Charge	Not Covered
Specialist Copay		$60, deductible waived	Not Covered		20%	Not Covered
Hospital Services						
Inpatient Facility		20%	Not Covered		20%	Not Covered
Inpatient Physician		20%	Not Covered		20%	Not Covered
Emergency Room Copay		50%	50%		50%	50%
Urgent Care copay		$75, deductible waived	$75		$75, deductible waived	$75
Preventive Care		No Charge	Not Covered		No Charge	Not Covered
Prescription Drugs		$10/ $40/ $75/ $300			$0 / 20% / 50% / $50%	
Lab copay		20%	Not Covered		20%	Not Covered
X-Ray copay		$100, deductible waived	Not Covered		20%	Not Covered
Current Enrollment	Total Monthly Cost of Benefit / CCI Contribution for EE SG Gold Copay	Employee Cost Per Month		Total Monthly Cost of Benefit / CCI Contribution for EE SG Gold	Employee Cost Per Month	
Employee (EE) Only	$832.59 / $530	$302.59		$792.56 / $530	$262.56	
EE & Spouse	$1,665.17 / $530	$1,135.17		$1,585.13 / $530	$1,055.13	
EE & Child(ren)	$1,540.29 / $530	$1,010.29		$1,466.24/ $530	$936.24	
EE & Family	$2,372.87 / $530	$1,842.87		$2,258.81 / $530	$1,728.81	

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	Option 5	*Friday SG Silver HSA*		Option 6	*Friday Silver Rx Copay*	
Deductible		In Network	Out of Network		In Network	Out of Network
Individual		$3,250	Not Covered		$5,000	Not Covered
Family		$6,500	Not Covered		$10,000	Not Covered
Out of Pocket Maximum						
Individual		$7,000	Not Covered		$8,700	Not Covered
Family		$14,000	Not Covered		$17,400	Not Covered
Coinsurance		30%	Not Covered		20%	Not Covered
Physician Services						
PCP In Office		30%	Not Covered		$40, deductible waived	Not Covered
Specialist Copay		30%	Not Covered		$80, deductible waived	Not Covered
Hospital Services						
Inpatient Facility		30%	Not Covered		20%	Not Covered
Inpatient Physician		30%	Not Covered		20%	Not Covered
Emergency Room Copay		50%	50%		50%	50%
Urgent Care copay		$75	$75		$75, deductible waived	$75
Preventive Care		No Charge	Not Covered		No Charge	Not Covered
Prescription Drugs		$0/ 30% / 50% / 50%			$0 / $250 / $350 / $725	
Lab copay		30%	Not Covered		20%	Not Covered
X-Ray copay		30%	Not Covered		20%	Not Covered
Current Enrollment	Total Monthly Cost of Benefit / CCI Contribution for EE SG Silver HSA	Employee Cost Per Month		Total Monthly Cost of Benefit / CCI Contribution for EE SG Silver Rx Copay	Employee Cost Per Month	
Employee (EE) Only	$599.64/ $530	$69.64		$631.84 / $530	$101.84	
EE & Spouse	$1,199.29 / $530	$669.29		$1,263.67 / $530	$733.67	
EE & Child(ren)	$1,109.34 / $530	$579.34		$1,168.90 / $530	$638.90	
EE & Family	$1,708.99 / $530	$1,178.99		$1,800.74 / $530	$1,270.74	

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	Option 7	*Friday SG Silver Copay*		Option 8	*Friday SG Silver*	
Deductible		In Network	Out of Network		In Network	Out of Network
Individual		$5,500	Not Covered		$5,500	Not Covered
Family		$11,000	Not Covered		$11,000	Not Covered
Out of Pocket Maximum						
Individual		$8,700	Not Covered		$8,700	Not Covered
Family		$17,400	Not Covered		$17,400	Not Covered
Coinsurance		30%	Not Covered		20%	Not Covered
Physician Services						
PCP In Office		No Charge	Not Covered		No Charge	Not Covered
Specialist Copay		$80, deductible waived	Not Covered		20%	Not Covered
Hospital Services						
Inpatient Facility		30%	Not Covered		20%	Not Covered
Inpatient Physician		30%	Not Covered		20%	Not Covered
Emergency Room Copay		30%	30%		50%	50%
Urgent Care copay		$100, deductible waived	$100		$75, deductible waived	$75
Preventive Care		No Charge	Not Covered		No Charge	Not Covered
Prescription Drugs		$30/ $80 / $150 / $425			$0 / 20% / 50% / $50%	
Lab copay		30%	Not Covered		20%	Not Covered
X-Ray copay		$100, deductible waived	Not Covered		20%	Not Covered
Current Enrollment	Total Monthly Cost of Benefit / CCI Contribution for EE SG Silver Copay	Employee Cost Per Month		Total Monthly Cost of Benefit / CCI Contribution for EE SG Silver	Employee Cost Per Month	
Employee (EE) Only	$639.90 / $530	$109.90		$603.78 / $530	$73.78	
EE & Spouse	$1,279.80 / $530	$749.80		$1,207.56 / $530	$677.56	
EE & Child(ren)	$1,183.82 / $530	$653.82		$1,116.99 / $530	$586.99	
EE & Family	$1,823.72 / $530	$1,293.72		$1,720.77 / $530	$1,190.77	

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	Option 9	*Friday SG Bronze HSA*		Option 10	*Friday SG Bronze Rx Copay*	
Deductible		In Network	Out of Network		In Network	Out of Network
Individual		$7,000	Not Covered		$8,700	Not Covered
Family		$14,000	Not Covered		$17,400	Not Covered
Out of Pocket Maximum						
Individual		$7,000	Not Covered		$8,700	Not Covered
Family		$14,000	Not Covered		$17,400	Not Covered
Coinsurance		0%	Not Covered		0%	Not Covered
Physician Services						
PCP In Office		0%	Not Covered		No Charge	Not Covered
Specialist Copay		0%	Not Covered		0%	Not Covered
Hospital Services						
Inpatient Facility		0%	Not Covered		0%	Not Covered
Inpatient Physician		0%	Not Covered		0%	Not Covered
Emergency Room Copay		0%	0%		0%	0%
Urgent Care copay		0%	0%		$75, deductible waived	$75
Preventive Care		No Charge	Not Covered		No Charge	Not Covered
Prescription Drugs		$0/ 0% / 0% / 0%			$25 / $250 / $350 / $725	
Lab copay		0%	Not Covered		0%	Not Covered
X-Ray copay		0%	Not Covered		0%	Not Covered
Current Enrollment	Total Monthly Cost of Benefit / CCI Contribution for EE SG Bronze HSA	Employee Cost Per Month		Total Monthly Cost of Benefit / CCI Contribution for EE SG Bronze Rx Copay	Employee Cost Per Month	
Employee (EE) Only	$534.67 / $530	$4.67		$534.51 / $530	$4.51	
EE & Spouse	$1,069.33 / $530	$539.33		$1,069.03/ $530	$539.03	
EE & Child(ren)	$989.13 / $530	$459.13		$988.85 / $530	$458.85	
EE & Family	$1,523.80 / $530	$993.80		$1,523.37 / $530	$993.37	

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Network	Delta PPO Plus Premier	
Annual Deductible	$50 person/ $150 family	
Preventive Services	100%	
Basic Services***	80%	
Major Services***	50%	***No wait period
Orthodontics	Not Covered	
Endo/Perio Coverage	Basic	
Providers in area	50	
	Basic	
Employee (EE) Only	36.73	
EE & Spouse	$72.41	
EE & Child(ren)	$82.99	
EE & Family	$128.34	

Plan Carrier/Plan Type	VSP Plan C Standard	VSP Plan C Premier
Exam Copay	$10	$10
Rx Lens Copay	$25	$25
Frames Allowance	$130	$130
Contacts Allowance	$130 instead of glasses	$130 instead of glasses
		Includes Enhancements
Employee (EE) Only	$11.23	$16.31
EE + 1	$17.96	$26.10
EE/Children	$18.34	$26.65
EE/Family	$29.57	$42.96