2023	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)		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	$922.00	**$182.00**	$20.56	$11.56	$880.00	**$86.00**	****	$20.56	$11.56	$800.00	**$15.00**	****	$20.56	$11.56
Self & Spouse	$1,854.00	**$445.00**	$43.17	$24.62	$1,769.00	**$260.00**	****	$43.17	$24.62	$1,607.00	**$110.00**	****	$43.17	$24.62
Self & Child	$1,540.00	**$370.00**	$43.17	$26.47	$1,470.00	**$215.00**	****	$43.17	$26.47	$1,335.00	**$95.00**	****	$43.17	$26.47
Family	$2,472.00	**$595.00**	$66.81	$43.12	$2,359.00	**$345.00**	****	$66.81	$43.12	$2,143.00	**$145.00**	****	$66.81	$43.12
Employee Out-of-Pocket	***In-Network* Embedded***				***In-Network* Non-Embedded***					***In-Network* Embedded***				
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				$1,500					$3,000				
Annual Family Deductible	$2,400				$3,000					$6,000				
Coinsurance	20%				20%					20%				
Individual Maximum Out-of-Pocket	$3,500				$3,000					$6,000				
Family Maximum Out-of-Pocket	$7,000				$6,000					$12,000				
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														
Health Savings Account	Not available				$3,850 Employee Only; $7,750 Families					$3,850 Employee Only; $7,750 Families				
FSA	$3,050				$3,050 (Dental & Vision only)					$3,050 (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.

**Office visit co-pays do not apply to the deductible

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

Unused portions of account will roll over from one year to the next.