Catholic Health Initiatives
Imagine better health.®

The amounts listed in this chart are the amounts you will pay when receiving services.	CHI 2019 INTEGRATED MEDICAL PLANS					
	Integrated Health Plan			Integrated HDHP/HSA		
	Enhanced (CIN Network)	**In-Network**	**Out-of-Network**	**Enhanced (CIN Network)**	**In-Network**	**Out-of-Network**
CHI Contribution to Health Savings Account (HSA)	Not applicable			$600 Individual/$1,200 Family (spread across all pay periods) Plus, wellness incentive dollars earned if you participate in the CHI Wellness Program.		
Employee Contribution to Health Savings Account (HSA)				You may put before-tax dollars into this account up to IRS limits: $3,500 Individual/$7,000 Family Additional $1,000 if age 55 or older The total of your contributions, CHI contributions and any wellness incentive contributions combined cannot exceed the IRS limits.		
Annual Deductible						
Individual	$0	$2,000	$6,000	$2,700		$6,000
Family	$0	$4,000	$12,000	$5,400		$12,000
Calendar Year Out-of-Pocket (OOP) Maximum						
Individual	$4,000	$6,450	$12,000	$4,000	$6,450	$12,000
Family	$8,000	$12,900	$24,000	$8,000	$12,900	$24,000
Preventive Care Services	100% covered			100% covered		
Office Visit - Primary Care Physician	$15 copay (NO deductible)	25% coinsurance (NO deductible)	60% coinsurance (AFTER deductible)	15% coinsurance (AFTER deductible)	20% coinsurance (AFTER deductible)	60% coinsurance (AFTER deductible)
Office Visit - Specialist	$30 copay (NO deductible)	30% coinsurance (NO deductible)		20% coinsurance (AFTER deductible)	25% coinsurance (AFTER deductible)	
Emergency Room Visit (waived if admitted)	$200 copay (NO deductible)			$200 copay (AFTER deductible)		
Urgent Care Visit	$50 copay (NO deductible)	$75 copay (NO deductible)		$50 copay (AFTER deductible)	$75 copay (AFTER deductible)	
Ambulance* (medically necessary)	100% covered (NO deductible)			100% covered (AFTER deductible)		
Inpatient and Outpatient Care/Services						
Other Covered Services - Chiropractor (20 visit limit per person per year) - Therapy - Physical, Occupational, Speech and Massage (30 visit limit per person per year, does not apply to the enhanced network) - Home Health Care - Hospice - Durable Medical Equipment	15% coinsurance (NO deductible)	30% coinsurance (AFTER deductible)	60% coinsurance (AFTER deductible)	15% coinsurance (AFTER deductible)	25% coinsurance (AFTER deductible)	60% coinsurance (AFTER deductible)
Mental and Nervous - Outpatient Office Visit	$15 copay (NO deductible)	25% coinsurance (NO deductible)			20% coinsurance (AFTER deductible)	
Mental and Nervous - Inpatient and Outpatient Facility	15% coinsurance (NO deductible)	30% coinsurance (NO deductible)			25% coinsurance (AFTER deductible)	
Prescription Drugs						
CHI PHARMACY (if available)						
RETAIL 30-DAY PRESCRIPTION	**NO deductible Applies to in-network OOP max**		Not applicable	**AFTER deductible Applies to in-network OOP max**		Not applicable
- Generic	$5 copay			$5 copay		
- Preferred Brand Formulary	15% coinsurance ($20 min/$55 max)			15% coinsurance ($20 min/$55 max)		
- Non-Preferred Brand Non-Formulary	25% coinsurance ($32.50 min/$80 max)			25% coinsurance ($32.50 min/$80 max)		
MAIL ORDER 90-DAY PRESCRIPTION	**NO deductible Applies to in-network OOP max**			**AFTER deductible Applies to in-network OOP max**		
- Generic	$12.50 copay			$12.50 copay		
- Preferred Brand Formulary	15% coinsurance ($50 min/$87.50 max)			15% coinsurance ($50 min/$87.50 max)		
- Non-Preferred Brand Non-Formulary	25% coinsurance ($80 min/$162.50 max)			25% coinsurance ($80 min/$162.50 max)		
CVS/Caremark Pharmacy Network						
RETAIL 30-DAY PRESCRIPTION	**NO deductible Applies to in-network OOP max**		60% coinsurance	**AFTER deductible Applies to in-network OOP max**		60% coinsurance
- Generic	$10 copay			$10 copay		
- Preferred Brand Formulary	30% coinsurance ($40 min/$110 max)			30% coinsurance ($40 min/$110 max)		
- Non-Preferred Brand Non-Formulary	50% coinsurance ($65 min/$160 max)			50% coinsurance ($65 min/$160 max)		
MAIL ORDER 90-DAY PRESCRIPTION	**NO deductible Applies to in-network OOP max**		Not applicable	**AFTER deductible Applies to in-network OOP max**		Not applicable
- Generic	$25 copay			$25 copay		
- Preferred Brand Formulary	30% coinsurance ($100 min/$175 max)			30% coinsurance ($100 min/$175 max)		
- Non-Preferred Brand Non-Formulary	50% coinsurance ($160 min/$325 max)			50% coinsurance ($160 min/$325 max)		

*Most ambulance services are out of network. You may be billed for amounts over the allowed charge.

The above medical plan design summarizes key aspects of the cost sharing components of the benefit. For more information or any questions, please refer to the Summary Plan Description located at InsideCHI > HR Payroll Connection > My Policies.
Under Browse Policies, click on the Health and Welfare Plan Documents folder.

imagine your **Best Self**