| The amounts listed in this chart are the amounts you will pay when receiving services. | CHI 2021 STANDARD MEDICAL PLANS | | | | | |
|---|---|---|---|---|---|---|
| | Standard Health Plan | | | Standard HDHP/HSA | | |
| | Enhanced<br>(CommonSpirit facility ONLY) | In-Network | Out-of-Network | Enhanced<br>(CommonSpirit facility ONLY) | In-Network | Out-of-Network |
| **CommonSpirit Health Contribution to Health Savings Account (HSA)** | Not applicable | | | $600 Individual/$1,200 Family<br>(spread across all pay periods)<br>Plus, wellness incentive dollars earned if you participate<br>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:<br>$3,600 Individual/$7,200 Family<br>Additional $1,000 if age 55 or older<br>The total of your contributions, CommonSpirit contributions and any wellness incentive contributions combined cannot exceed the IRS limits. | | |
| **Annual Deductible**<br>Individual<br>Family | <br>$0<br>$0 | <br>$1,750<br>$3,500 | <br>$3,500<br>$7,000 | <br>$2,800<br>$5,600 | | <br>$6,000<br>$12,000 |
| **Calendar Year Out-of-Pocket (OOP) Maximum**<br>Individual<br>Family | <br>$3,750<br>$7,500 | | <br>$12,000<br>$24,000 | <br>$5,000<br>$10,000 | | <br>$12,000<br>$24,000 |
| **Preventive Care Services** | 100% covered | | | 100% covered | | |
| **Office Visit - Primary Care Physician** | Not applicable | 25% coinsurance<br>(NO deductible) | 60% coinsurance<br>(AFTER deductible) | Not applicable | 20% coinsurance<br>(AFTER deductible) | 60% coinsurance<br>(AFTER deductible) |
| **Office Visit - Specialist** | | 30% coinsurance<br>(NO deductible) | | | 25% coinsurance<br>(AFTER deductible) | |
| **Emergency Room Visit** (waived if admitted) | $200 copay (NO deductible) | | | $200 copay (AFTER deductible) | | |
| **Urgent Care Visit** | $75 copay (NO deductible) | | | $75 copay (AFTER deductible) | | |
| **Ambulance*** (medically necessary) | 100% covered (NO deductible) | | | 100% covered (AFTER deductible) | | |
| **Inpatient and Outpatient Care/Services**<br><br>- Chiropractor (20 visit limit per person per year)<br>- Therapy - Physical, Occupational and Speech<br>(30 visit limit per person per year, does not apply to CommonSpirit facilities)<br>- Home Health Care<br>- Hospice<br>- Durable Medical Equipment | 15% coinsurance<br>(NO deductible) for FACILITY charges billed on UB form | 30% coinsurance<br>(AFTER deductible) | 60% coinsurance<br>(AFTER deductible) | 15% coinsurance<br>(AFTER deductible) for FACILITY charges billed on UB form | 25% coinsurance<br>(AFTER deductible) | 60% coinsurance<br>(AFTER deductible) |
| **Mental and Nervous - Outpatient Office Visit** | | 25% coinsurance<br>(NO deductible) | | | 20% coinsurance<br>(AFTER deductible) | |
| **Mental and Nervous - Inpatient and Outpatient Facility** | | 30% coinsurance<br>(NO deductible) | | | 25% coinsurance<br>(AFTER deductible) | |
| **Prescription Drugs**** | | | | | | |
| **COMMONSPIRIT PHARMACY (if available)** | | | | | | |
| **RETAIL 30-DAY PRESCRIPTION** | **NO deductible<br>Applies to in-network OOP max** | | Not applicable | **AFTER deductible<br>Applies to in-network OOP max** | | Not applicable |
| - Generic<br>- Preferred Brand Formulary<br>- Non-Preferred Brand Non-Formulary | $5 copay<br>15% coinsurance ($20 min/$55 max)<br>25% coinsurance ($32.50 min/$80 max) | | | $5 copay<br>15% coinsurance ($20 min/$55 max)<br>25% coinsurance ($32.50 min/$80 max) | | |
| **HOME DELIVERY 90-DAY PRESCRIPTION** | **NO deductible<br>Applies to in-network OOP max** | | | **AFTER deductible<br>Applies to in-network OOP max** | | |
| - Generic<br>- Preferred Brand Formulary<br>- Non-Preferred Brand Non-Formulary | $12.50 copay<br>15% coinsurance ($50 min/$87.50 max)<br>25% coinsurance ($80 min/$162.50 max) | | | $12.50 copay<br>15% coinsurance ($50 min/$87.50 max)<br>25% coinsurance ($80 min/$162.50 max) | | |
| **OptumRx Pharmacy Network** | | | | | | |
| **RETAIL 30-DAY PRESCRIPTION** | **NO deductible<br>Applies to in-network OOP max** | | 60% coinsurance<br>(AFTER deductible) | **AFTER deductible<br>Applies to in-network OOP max** | | 60% coinsurance<br>(AFTER deductible) |
| - Generic<br>- Preferred Brand Formulary<br>- Non-Preferred Brand Non-Formulary | $10 copay<br>30% coinsurance ($40 min/$110 max)<br>50% coinsurance ($65 min/$160 max) | | | $10 copay<br>30% coinsurance ($40 min/$110 max)<br>50% coinsurance ($65 min/$160 max) | | |
| **HOME DELIVERY 90-DAY PRESCRIPTION** | **NO deductible<br>Applies to in-network OOP max** | | Not applicable | **AFTER deductible<br>Applies to in-network OOP max** | | Not applicable |
| - Generic<br>- Preferred Brand Formulary<br>- Non-Preferred Brand Non-Formulary | $25 copay<br>30% coinsurance ($100 min/$175 max)<br>50% coinsurance ($160 min/$325 max) | | | $25 copay<br>30% coinsurance ($100 min/$175 max)<br>50% coinsurance ($160 min/$325 max) | | |

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

**With the exception of the Fargo divisions, all maintenance medications will be filled through your local CommonSpirit pharmacy or the CommonSpirit home delivery pharmacy. If you work at a location without a CommonSpirit-owned pharmacy or no access to CommonSpirit home delivery pharmacy, you will use the OptumRx home delivery.

Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your specialty medication, your prescription will be routed to the OptumRx Specialty Pharmacy.

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 EmployeeCentral > MyBenefits > Benefit Resources > Plan Information.