CommonSpirit

CommonSpirit Health 2024 Standard Medical Plan			
The amounts listed in this chart are the amounts you will pay when receiving services.	**Enhanced (CommonSpirit facility ONLY)**	**Standard Health Plan In-Network**	**Out-of-Network**
Individual	$0	$1,750	$3,500
Family	$0	$3,500	$7,000
Calendar Year Out-of-Pocket (OOP) Maximum			
Individual	$3,750		$12,000
Family	$7,500		
Preventive Care Services	100% covered		
Office Visit - Primary Care Physician (includes Mental and Nervous office visits)	Not applicable	25% coinsurance (NO deductible)	60% coinsurance (AFTER deductible)
Office Visit - Specialist		30% coinsurance (NO deductible)	
Emergency Room Visit (waived if admitted)	$200 copay (NO deductible)		
Urgent Care Visit	$75 copay (NO deductible)		
Ambulance (medically necessary) *	100% covered (NO deductible)		
Inpatient and Outpatient Care/Services **- Chiropractor (20 visit limit per person per year)** **- Therapy - Physical, Occupational, and Speech (30 visit limit per person per year, does not apply to CommonSpirit Health facilities)** **- Home Health Care** **- Hospice** **- Durable Medical Equipment**	15% coinsurance (NO deductible) for FACILITY charges billed on UB form	30% coinsurance (AFTER deductible)	60% coinsurance (AFTER deductible)
Mental and Nervous – Outpatient Office Visit		25% coinsurance (NO deductible)	
Mental and Nervous - Inpatient and Outpatient Facility		30% coinsurance (NO deductible)	
Prescription Drugs **			
CommonSpirit Pharamcy (if available)			
RETAIL 30-DAY PRESCRIPTION	NO deductible, applies to in-network OOP max		
- Generic **- Preferred Brand Formulary** **- Non-Preferred Brand Non-Formulary**	**$5 copay** **15% coinsurance ($20 min/$55 max)** **25% coinsurance ($32.50 min/$80 max)**		
HOME DELIVERY 90-DAY PRESCRIPTION	NO deductible, applies to in-network OOP max		Not applicable
- Generic **- Preferred Brand Formulary** **- Non-Preferred Brand Non-Formulary**	$12.50 copay 15% coinsurance ($50 min/$87.50 max) 25% coinsurance ($80 min/$162.50 max)		
Capital Rx Pharmacy Network			
RETAIL 30-DAY PRESCRIPTION	NO deductible, applies to in-network OOP max		
- Generic **- Preferred Brand Formulary** **- Non-Preferred Brand Non-Formulary**	$10 copay 30% coinsurance ($40 min/$110 max) 50% coinsurance ($65 min/$160 max)		60% coinsurance
HOME DELIVERY 90-DAY PRESCRIPTION	NO deductible, applies to in-network OOP max		
- Generic **- Preferred Brand Formulary** **- Non-Preferred Brand Non-Formulary**	$25 copay 30% coinsurance ($100 min/$175 max) 50% coinsurance ($160 min/$325 max)		Not applicable

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

**Maintenance medications may be filled through your local CommonSpirit pharmacy/the CommonSpirit home delivery pharmacy/OptumRx Home Delivery or you may fill at a Walgreen retail location. Specialty prescriptions must be processed through the CHI Health Specialty Pharmacy or the CommonSpirit Health Specialty Pharmacy. If they 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 Document located within your local HR or at http://chibenefitplans.net/