



Schedule of Benefits

Plan Type: CHRISTUS Silver 73 (\$5 PCP, \$0 Tier 1 Rx, \$0 Virtual Urgent Care)

Coverage Period: 01/01/2025 – 12/31/2025

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.christushealthplan.org or by calling 1-844-282-3025.

| Medical and Prescription Drug Deductibles and Out-of-Pocket Limits | Member Cost Share | |
|--|---|-----------------------------|
| Medical Deductible - Individual | \$4,000 | |
| Medical Deductible - Family | \$8,000 | |
| Pharmacy Deductible - Individual | \$850 | |
| Pharmacy Deductible - Family | \$1,700 | |
| Overall Out-of-Pocket Limit - Individual | \$7,350, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Family | \$14,700, Medical and Pharmacy Combined | |
| Out-of-Pocket Exclusions | No | |
| Annual Plan Limit | No | |
| Provider Network Required | Yes | |
| Specialist Referral Needed | No | |
| Services Not Covered, refer to <i>Evidence of Coverage</i> | Yes | |
| Covered Services | Participating Providers | Non-Participating Providers |
| Primary Care Office Visit | \$5 copayment per visit, deductible does not apply | Not covered |
| Specialist Office Visit | \$60 copayment per visit, deductible does not apply | Not covered |
| Other Practitioner Office Visit | \$60 copayment per visit, deductible does not apply | Not covered |
| Chiropractic Services | \$50 copayment per visit, deductible does not apply | Not covered |
| Autism Spectrum Disorder | \$5 copayment per visit, deductible does not apply | Not covered |
| Preventive Care, Screenings, and Immunizations | No charge | Not covered |
| Diagnostic Test (Blood Work) | \$40 copayment per visit, deductible does not apply | Not covered |
| Diagnostic Test (X-Ray) | \$40 copayment per visit, deductible does not apply | Not covered |
| Imaging (CT, PET, MRI) | \$400 copayment per visit after deductible | Not covered |



| Covered Services | Participating Providers | Non-Participating Providers |
|--|--|---------------------------------|
| Preferred Generic Drugs | No charge | Not covered |
| Non-Preferred Generic Drugs | \$20 copayment per prescription for a standard 30-day supply, deductible does not apply (Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply) | Not covered |
| Preferred Brand Drugs | \$50 copayment per prescription after deductible for a standard 30-day supply (Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply) | Not covered |
| Non-Preferred Brand Drugs | \$100 copayment per prescription after deductible for a standard 30-day supply (Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply) | Not covered |
| Specialty Drugs | \$150 copayment per prescription for a standard 30-day supply, deductible does not apply | Not covered |
| Outpatient Facility Fee | 50% coinsurance after deductible | Not covered |
| Outpatient Physician Surgeon Fee | 50% coinsurance after deductible | Not covered |
| Emergency Room Services | \$950 copayment per stay after deductible | Same as Participating Providers |
| Emergency Transportation | 50% coinsurance after deductible | Same as Participating Providers |
| Urgent Care | \$60 copayment per visit, deductible does not apply | Not covered |
| Urgent Care (Virtual) | No charge at CHRISTUS Facilities Not covered at non-CHRISTUS Facilities | Not covered |
| Inpatient Facility Fee | \$950 copayment per stay after deductible | Not covered |
| Inpatient Physician Surgeon Fee | No charge after deductible | Not covered |
| Mental Health, Behavioral Health and Substance Abuse Outpatient Services | Office visit: \$50 copayment per visit, deductible does not apply Outpatient facility: 50% coinsurance after deductible | Not covered |
| Mental Health, Behavioral Health and Substance Abuse Inpatient Services | \$950 copayment per stay after deductible | Not covered |
| Prenatal and Postnatal Care | \$60 copayment per visit, deductible does not apply | Not covered |
| Delivery and Inpatient Services | \$950 copayment per stay after deductible | Not covered |
| Home Health Care | 50% coinsurance after deductible | Not covered |
| Rehabilitation Services | \$50 copayment per visit, deductible does not apply | Not covered |
| Habilitation Services | \$50 copayment per visit, deductible does not apply | Not covered |
| Skilled Nursing Facility | 50% coinsurance after deductible | Not covered |
| Durable Medical Equipment | 50% coinsurance after deductible | Not covered |
| Hospice Service | 50% coinsurance after deductible | Not covered |



| Covered Services | Participating Providers | Non-Participating Providers |
|---|--|-----------------------------|
| Attention Deficit Disorder | \$5 copayment per visit, deductible does not apply | Not covered |
| Cleft Lip/Cleft Palate | 50% coinsurance after deductible | Not covered |
| Dental Anesthesia | 50% coinsurance after deductible | Not covered |
| Oral Surgery Benefits | 50% coinsurance after deductible | Not covered |
| Private-Duty Nursing | 50% coinsurance after deductible | Not covered |
| Sleep Studies | 50% coinsurance after deductible | Not covered |
| Pre-Admission Testing | 50% coinsurance after deductible | Not covered |
| Routine Foot Care | \$5 copayment per visit, deductible does not apply | Not covered |
| Children’s Eye Exam | No charge (1 exam per year limit) | Not covered |
| Children’s Glasses | No charge (1 pair per year limit) | Not covered |
| Children’s Dental – Basic (Class A) | No charge (1 cleaning and exam per six months limit) | |
| Children’s Dental – Intermediate (Class B) | 20% coinsurance | |
| Children’s Dental – Major (Class C) | 50% coinsurance | |
| Children’s Dental – Orthodontia (Class D) | 50% coinsurance | |
| (Medically necessary services only; prior authorization required) | | |

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- With the exception of emergency services, coverage at Non-Participating Providers is not covered under this plan unless (1) a participating provider is not available in the service area and CHRISTUS grants approval for the member to use a Non-Participating Provider or (2) a member is at a participating facility and receives services from a Non-Participating Provider without knowledge or consent. In either of these two provided situations, the member would be billed as if they received care at a participating provider.
- The **Allowable Charge** is the amount that the plan has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be either a rate agreed upon by the plan and the Non-Participating Provider or based upon the plan’s out-of-network fee schedule. The plan’s out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in costs, and is consistent with nationally recognized and generally accepted bundling edits and logic. These Non-Participating Providers generally may not balance bill you for amounts not paid by the plan. If you receive a balance bill from a Non-Participating Provider, contact the plan.