

Schedule of Benefits

Plan Type: CHRISTUS Bronze Essential + Dental & Vision (2 Free PCP Visits, \$0 Preferred Generic Rx, \$0 Virtual Urgent Care)

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

If you have any questions about your coverage and costs, please visit www.christushealthplan.org or by calling 1-844-282-3025.

| Medical and Prescription Drug Deductibles and Out-of-Pocket Limits | Member Cost Share | |
|--|--|-----------------------------|
| Overall Deductible - Individual | \$7,450, Medical and Pharmacy Combined | |
| Overall Deductible - Family | \$14,900, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Individual | \$9,200, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Family | \$18,400, 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 | \$60 copayment per visit after first two free visits, deductible does not apply | Not covered |
| Specialist Office Visit | \$80 copayment per visit, deductible does not apply | Not covered |
| Other Practitioner Office Visit | \$80 copayment per visit, deductible does not apply | Not covered |
| Chiropractic Services | \$60 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with rehabilitation services) | Not covered |
| Autism Spectrum Disorder | \$60 copayment per visit, deductible does not apply | Not covered |
| Preventive Care, Screenings, and Immunizations | No charge | |
| Diagnostic Test (Blood Work) | 50% co-pay percentage after deductible | Not covered |
| Diagnostic Test (X-Ray) | 50% co-pay percentage after deductible | 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 | \$30 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 | \$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 |
| Non-Preferred Brand Drugs | 50% co-pay percentage after deductible | Not covered |
| Specialty Drugs | 50% co-pay percentage after deductible | Not covered |
| Outpatient Facility Fee | 50% co-pay percentage after deductible | Not covered |
| Outpatient Physician Surgeon Fee | 50% co-pay percentage after deductible | Not covered |
| Emergency Room Services | \$950 copayment per visit after deductible | Same as Participating Providers |
| Emergency Transportation | 50% co-pay percentage after deductible | Same as Participating Providers |
| Urgent Care | \$80 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: \$60 copayment per visit, deductible does not apply Outpatient facility: 50% co-pay percentage 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 | \$80 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% co-pay percentage after deductible (60 visit limit per calendar year) | Not covered |
| Rehabilitation Services | \$60 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care) | Not covered |
| Habilitation Services | \$60 copayment per visit, deductible does not apply | Not covered |
| Skilled Nursing Facility | 50% co-pay percentage after deductible (25 day limit per calendar year) | Not covered |
| Durable Medical Equipment | 50% co-pay percentage after deductible | Not covered |
| Hospice Service | 50% co-pay percentage after deductible | Not covered |
| Children's Eye Exam | No charge (1 exam per year limit) | Not covered |

| Covered Services | Participating Providers | Non-Participating Providers |
|--|--|-----------------------------|
| Children's Glasses | No charge (1 pair per year limit) | Not covered |
| Dental Diagnostic and Preventive Services for Children | No charge (1 cleaning and exam per six months limit) | |
| Basic Dental Care – Child | 20% co-pay percentage | |
| Major Dental Care – Child | 50% co-pay percentage | |
| Orthodontia – Child | 50% co-pay percentage (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.
- **Co-pay percentage** 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 **co-pay percentage** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, please contact us.
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **co-pay percentage** amounts.

Adult Vision* (Ages 19 years of age and older, does not include Pediatric Vision Coverage)

| Adult Vision Covered Services | Participating Providers | Non-Participating Providers |
|-------------------------------|---|-----------------------------|
| Adult Eye Exam | No charge (1 exam per year) | Not covered |
| Adult Glasses | No charge (1 item per year. Up to \$130 per person for glasses or contacts) | Not covered |

Adult Dental* (Ages 19 years of age and older, does not include Pediatric Dental Coverage)

Annual Maximum Dental Benefit: \$1,000 per covered person per calendar year for all benefits listed below.

Waiting Period: Major Dental Care Services are limited to Adult Enrollees who have been enrolled under the dental for 12 consecutive months.

| Adult Dental Covered Services | Participating Providers | Non-Participating Providers |
|-------------------------------|--|-----------------------------|
| Adult Routine Dental Services | No charge (1 cleaning and exam per six months limit) | |
| Adult Basic Dental Care | 20% co-pay percentage | |
| Adult Major Dental Care | 50% co-pay percentage | |
| Adult Orthodontia | Not covered | |

*Adult vision and dental benefits do not apply to plan deductible and out-of-pocket maximum listed on page 1.