

Schedule of Benefits

Plan Type: CHRISTUS Silver 70 Limited (\$5 PCP, \$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 | | |
|--|---|---|----------------------------------|
| Medical Deductible - Individual | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$8,200 | | |
| Medical Deductible - Family | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$16,400 | | |
| Pharmacy Deductible – Individual | \$850 | | |
| Pharmacy Deductible - Family | \$1,700 | | |
| 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 | IHCP In-Network Provider | Non-IHCP In-Network Provider | Non-IHCP Out-of-Network Provider |
| Primary Care Office Visit | No charge | \$5 copayment per visit, deductible does not apply | Not covered |
| Specialist Office Visit | No charge | \$60 copayment per visit, deductible does not apply | Not covered |
| Other Practitioner Office Visit | No charge | \$60 copayment per visit, deductible does not apply | Not covered |
| Chiropractic Services | No charge (35 visit limit per calendar year, combined with rehabilitation services) | \$50 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with rehabilitation services) | Not covered |
| Autism Spectrum Disorder | No charge | \$5 copayment per visit, deductible does not apply | Not covered |

| Covered Services | IHCP In-Network Provider | Non-IHCP In-Network Provider | Non-IHCP Out-of-Network Provider |
|--|--------------------------|--|----------------------------------|
| Preventive Care, Screenings, and Immunizations | No charge | No charge | Not covered |
| Diagnostic Test (Blood Work) | No charge | \$40 copayment per visit, deductible does not apply | Not covered |
| Diagnostic Test (X-Ray) | No charge | \$40 copayment per visit, deductible does not apply | Not covered |
| Imaging (CT, PET, MRI) | No charge | \$400 Copayment per visit after deductible | Not covered |
| Preferred Generic Drugs | No charge | No charge | Not covered |
| Non-Preferred Generic Drugs | No charge | \$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 | No charge | \$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 | No charge | \$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 | No charge | \$500 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 |
| Outpatient Facility Fee | No charge | 50% co-pay percentage after deductible | Not covered |
| Outpatient Physician Surgeon Fee | No charge | 50% co-pay percentage after deductible | Not covered |
| Emergency Room Services | No charge | \$950 copayment per visit after deductible | Same as Participating Providers |
| Emergency Transportation | No charge | 50% co-pay percentage after deductible | Same as Participating Providers |
| Urgent Care | No charge | \$60 copayment per visit, deductible does not apply | Not covered |
| Urgent Care (Virtual) | No charge | No charge at CHRISTUS Facilities Not covered at non-CHRISTUS Facilities | Not covered |
| Inpatient Facility Fee | No charge | \$950 copayment per stay after deductible | Not covered |
| Inpatient Physician Surgeon Fee | No charge | No charge after deductible | Not covered |
| Mental Health, Behavioral Health and Substance Abuse Outpatient Services | No charge | Office visit: \$50 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 | No charge | \$950 copayment per stay after deductible | Not covered |

| Covered Services | IHCP In-Network Provider | Non-IHCP In-Network Provider | Non-IHCP Out-of-Network Provider |
|--|--|--|----------------------------------|
| Prenatal and Postnatal Care | No charge | \$60 copayment per visit, deductible does not apply | Not covered |
| Delivery and Inpatient Services | No charge | \$950 copayment per stay after deductible | Not covered |
| Home Health Care | No charge (60 visit limit per calendar year) | 50% co-pay percentage after deductible (60 visit limit per calendar year) | Not covered |
| Rehabilitation Services | No charge (35 visit limit per calendar year, combined with chiropractic care) | \$50 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care) | Not covered |
| Habilitation Services | No charge | \$50 copayment per visit, deductible does not apply | Not covered |
| Skilled Nursing Facility | No charge (25 day limit per calendar year) | 50% co-pay percentage after deductible (25 day limit per calendar year) | Not covered |
| Durable Medical Equipment | No charge | 50% co-pay percentage after deductible | Not covered |
| Hospice Service | No charge | 50% co-pay percentage after deductible | Not covered |
| Children's Eye Exam | No charge (1 exam per year limit) | No charge (1 exam per year limit) | Not covered |
| Children's Glasses | No charge (1 pair per year limit) | 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.