

Schedule of Benefits

Plan Type: CHRISTUS Standard Silver 87 (\$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	\$500, Medical and Pharmacy Combined		
Overall Deductible - Family	\$1,000, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Individual	\$3,000, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Family	\$6,000, 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 Evidence of Coverage	Yes		
Covered Services	Participating Providers	Non-Participating Providers	
Primary Care Office Visit	\$20 copayment per visit, deductible does not apply	Not covered	
Specialist Office Visit	\$40 copayment per visit, deductible does not apply	Not covered	
Other Practitioner Office Visit	\$40 copayment per visit, deductible does not apply	Not covered	
Chiropractic Services	\$20 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with rehabilitation services)	Not covered	
Autism Spectrum Disorder	\$20 copayment per visit, deductible does not apply	Not covered	
Preventive Care, Screenings, and Immunizations	No charge	Not covered	
Diagnostic Test (Blood Work)	30% co-pay percentage after deductible	Not covered	
Diagnostic Test (X-Ray)	30% co-pay percentage after deductible	Not covered	
Imaging (CT, PET, MRI)	30% co-pay percentage after deductible	Not covered	

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Covered Services	Participating Providers	Non-Participating Providers
Generic Drugs	\$10 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	\$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
Non-Preferred Brand Drugs	\$60 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	\$250 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	30% co-pay percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	30% co-pay percentage after deductible	Not covered
Emergency Room Services	30% co-pay percentage after deductible	Same as Participating Providers
Emergency Transportation	30% co-pay percentage after deductible	Same as Participating Providers
Urgent Care	\$30 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	30% co-pay percentage after deductible	Not covered
Inpatient Physician Surgeon Fee	30% co-pay percentage after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: \$20 copayment per visit, deductible does not apply Outpatient facility: 30% co-pay percentage after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	30% co-pay percentage after deductible	Not covered
Prenatal and Postnatal Care	\$40 copayment per visit, deductible does not apply	Not covered
Delivery and Inpatient Services	30% co-pay percentage after deductible	Not covered
Home Health Care	30% co-pay percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	\$20 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	\$20 copayment per visit, deductible does not apply	Not covered
Skilled Nursing Facility	30% co-pay percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	30% co-pay percentage after deductible	Not covered
Hospice Service	30% co-pay percentage after deductible	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

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Covered Services	Participating Providers	Non-Participating Providers	
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	20% co-pay percentage	
Major Dental Care – Child	50% co-pay percentage	50% co-pay percentage	
Orthodontia – Child	50% co-pay percentage (Medically necessary services only; prior authorization required	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.
- <u>Co-pay percentage</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>co-pay percentage</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, please contact us.
- This plan may encourage you to use participating <u>providers</u> by charging you lower <u>deductibles</u>, <u>copayments</u> and <u>co-pay percentage</u> amounts.

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