

Schedule of Benefits

Plan Type: CHRISTUS Standard Silver 94 (\$0 Deductible, \$0 PCP, \$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	\$0, Medical and Pharmacy Combined		
Overall Deductible - Family	\$0, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Individual	\$2,000, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Family	\$4,000, 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	No charge	Not covered	
Specialist Office Visit	\$10 copayment per visit	Not covered	
Other Practitioner Office Visit	\$10 copayment per visit	Not covered	
Chiropractic Services	No charge (35 visit limit per calendar year, combined with rehabilitation services)	Not covered	
Autism Spectrum Disorder	No charge	Not covered	
Preventive Care, Screenings, and Immunizations	No charge	Not covered	
Diagnostic Test (Blood Work)	25% co-pay percentage	Not covered	
Diagnostic Test (X-Ray)	25% co-pay percentage	Not covered	
Imaging (CT, PET, MRI)	25% co-pay percentage	Not covered	

CHPTX25STS9 1



Covered Services	Participating Providers	Non-Participating Providers
Generic Drugs	No charge	Not covered
Preferred Brand Drugs	\$15 copayment per prescription per prescription 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 copayment per prescription per prescription 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 per prescription 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	25% co-pay percentage	Not covered
Outpatient Physician Surgeon Fee	25% co-pay percentage	Not covered
Emergency Room Services	25% co-pay percentage	Same as Participating Providers
Emergency Transportation	25% co-pay percentage	Same as Participating Providers
Urgent Care	\$5 copayment per visit	Not covered
Urgent Care (Virtual)	No charge at CHRISTUS Facilities Not covered at non-CHRISTUS Facilities	Not covered
Inpatient Facility Fee	25% co-pay percentage	Not covered
Inpatient Physician Surgeon Fee	25% co-pay percentage	Not covered
Mental Health, Behavioral Health and	Office visit: No charge	
Substance Abuse Outpatient Services	Outpatient facility: 25% co-pay percentage	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	25% co-pay percentage	Not covered
Prenatal and Postnatal Care	\$10 copayment per visit	Not covered
Delivery and Inpatient Services	25% co-pay percentage	Not covered
Home Health Care	25% co-pay percentage (60 visit limit per calendar year)	Not covered
Rehabilitation Services	No charge (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	No charge	Not covered
Skilled Nursing Facility	25% co-pay percentage (25 day limit per calendar year)	Not covered
Durable Medical Equipment	25% co-pay percentage	Not covered
Hospice Service	25% co-pay percentage	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

CHPTX25STS9 2



Covered Services	Participating Providers	Non-Participating Providers	
Dental Diagnostic and Preventive Services for	No charge (1 cleaning and exam per six months limit)		
Children			
Basic Dental Care – Child	20% co-pay percentage		
Major Dental Care – Child	50% co-pay percentage		
Orthodontia – Child	50% co-pay percentage		
Orthodoritia – Cillid	(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 **providers** by charging you lower **deductibles**, **copayments** and **co-pay percentage** amounts.

CHPTX25STS9 3