



## Schedule of Benefits

Plan Type: CHRISTUS Gold Essential + Dental & Vision (\$0 Rx Deductible, \$5 PCP, \$0 Virtual Urgent Care)

Coverage Period: 01/01/2026 – 12/31/2026

**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](http://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                                    | \$3,750                                             |                             |
| Medical Deductible - Family                                        | \$7,500                                             |                             |
| Pharmacy Deductible - Individual                                   | \$0                                                 |                             |
| Pharmacy Deductible - Family                                       | \$0                                                 |                             |
| 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                                          | \$5 copayment per visit, deductible does not apply  | Not covered                 |
| Specialist Office Visit                                            | \$35 copayment per visit, deductible does not apply | Not covered                 |
| Other Practitioner Office Visit                                    | \$35 copayment per visit, deductible does not apply | Not covered                 |
| Chiropractic Services                                              | \$25 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)                                       | \$30 copayment per visit, deductible does not apply | Not covered                 |
| Diagnostic Test (X-Ray)                                            | \$20 copayment per visit, deductible does not apply | Not covered                 |
| Imaging (CT, PET, MRI)                                             | \$200 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                                              | \$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                                                    | \$50 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 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                     |
| Specialty Drugs                                                          | \$150 copayment per prescription for a standard 30-day supply, deductible does not apply                                                                                                         | Not covered                     |
| Outpatient Facility Fee                                                  | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Outpatient Physician Surgeon Fee                                         | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Emergency Room Services                                                  | \$950 copayment per visit after deductible                                                                                                                                                       | Same as Participating Providers |
| Emergency Transportation                                                 | 30% coinsurance after deductible                                                                                                                                                                 | Same as Participating Providers |
| Urgent Care                                                              | \$35 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |
| Urgent Care (Virtual)                                                    | No charge at CHRISTUS Facilities<br>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: \$25 copayment per visit, deductible does not apply<br>Outpatient facility: 30% 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                                              | \$35 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |
| Delivery and Inpatient Services                                          | \$950 copayment per stay after deductible                                                                                                                                                        | Not covered                     |
| Home Health Care                                                         | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Rehabilitation Services                                                  | \$25 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |
| Habilitation Services                                                    | \$25 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |
| Skilled Nursing Facility                                                 | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Durable Medical Equipment                                                | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Hospice Service                                                          | 30% coinsurance after deductible                                                                                                                                                                 | Not covered                     |
| Attention Deficit Disorder                                               | \$5 copayment per visit, deductible does not apply                                                                                                                                               | Not covered                     |

| Covered Services                           | Participating Providers                                                              | Non-Participating Providers |
|--------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------|
| Cleft Lip/Cleft Palate                     | 30% coinsurance after deductible                                                     | Not covered                 |
| Dental Anesthesia                          | 30% coinsurance after deductible                                                     | Not covered                 |
| Oral Surgery Benefits                      | 30% coinsurance after deductible                                                     | Not covered                 |
| Private-Duty Nursing                       | 30% coinsurance after deductible                                                     | Not covered                 |
| Sleep Studies                              | 30% coinsurance after deductible                                                     | Not covered                 |
| Pre-Admission Testing                      | 30% 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<br>(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.

**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's Dental – Basic (Class A)        | No charge (1 cleaning and exam per six months limit) |                             |
| Adult's Dental – Intermediate (Class B) | 20% coinsurance                                      |                             |
| Adult's Dental – Major (Class C)        | 50% coinsurance                                      |                             |
| Adult's Dental – Orthodontia (Class D)  | Not covered                                          |                             |

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