CHRISTUS Health Plan

# *Schedule of Benefits*

Plan Type: CHRISTUS Standard Expanded Bronze ($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 or by calling 1-844-282-3025.

| **Medical and Prescription Drug Deductibles and Out-of-Pocket Limits** | **Member Cost Share** | |
|---|---|---|
| Overall Deductible - Individual | $7,500, Medical and Pharmacy Combined | |
| Overall Deductible - Family | $15,000, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Individual | $10,000, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Family | $20,000, 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 | $50 copayment per visit, deductible does not apply | Not covered |
| Specialist Office Visit | $100 copayment per visit, deductible does not apply | Not covered |
| Other Practitioner Office Visit | $100 copayment per visit, deductible does not apply | Not covered |
| Chiropractic Services | $50 copayment per visit, deductible does not apply | Not covered |
| Autism Spectrum Disorder | $50 copayment per visit, deductible does not apply | Not covered |
| Preventive Care, Screenings, and Immunizations | No charge | Not covered |
| Diagnostic Test (Blood Work) | 50% coinsurance after deductible | Not covered |
| Diagnostic Test (X-Ray) | 50% coinsurance after deductible | Not covered |
| Imaging (CT, PET, MRI) | 50% coinsurance after deductible | Not covered |

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| Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Generic Drugs | $25 copayment per prescription for a standard 30-day supply, deductible does not apply<br>(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 after deductible for a standard 30-day supply<br>(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 | $100 copayment per prescription after deductible for a standard 30-day supply<br>(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 after deductible for a standard 30-day supply | Not covered |
| Outpatient Facility Fee | 50% coinsurance after deductible | Not covered |
| Outpatient Physician Surgeon Fee | 50% coinsurance after deductible | Not covered |
| Emergency Room Services | 50% coinsurance after deductible | Same as Participating Providers |
| Emergency Transportation | 50% coinsurance after deductible | Same as Participating Providers |
| Urgent Care | $75 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 | 50% coinsurance after deductible | Not covered |
| Inpatient Physician Surgeon Fee | 50% coinsurance after deductible | Not covered |
| Mental Health, Behavioral Health and Substance Abuse Outpatient Services | Office visit: $50 copayment per visit, deductible does not apply<br>Outpatient facility: 50% coinsurance after deductible | Not covered |
| Mental Health, Behavioral Health and Substance Abuse Inpatient Services | 50% coinsurance after deductible | Not covered |
| Prenatal and Postnatal Care | $100 copayment per visit, deductible does not apply | Not covered |
| Delivery and Inpatient Services | 50% coinsurance after deductible | Not covered |
| Home Health Care | 50% coinsurance after deductible | Not covered |
| Rehabilitation Services | $50 copayment per visit, deductible does not apply | Not covered |

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| Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Habilitation Services | $50 copayment per visit, deductible does not apply | Not covered |
| Skilled Nursing Facility | 50% coinsurance after deductible | Not covered |
| Durable Medical Equipment | 50% coinsurance after deductible | Not covered |
| Hospice Service | 50% coinsurance after deductible | Not covered |
| Attention Deficit Disorder | $50 copayment per visit, deductible does not apply | Not covered |
| Cleft Lip/Cleft Palate | 50% coinsurance after deductible | Not covered |
| Dental Anesthesia | 50% coinsurance after deductible | Not covered |
| Oral Surgery Benefits | 50% coinsurance after deductible | Not covered |
| Private-Duty Nursing | 50% coinsurance after deductible | Not covered |
| Sleep Studies | 50% coinsurance after deductible | Not covered |
| Pre-Admission Testing | 50% coinsurance after deductible | Not covered |
| Routine Foot Care | $50 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.