

## Schedule of Benefits

Plan Type: CHRISTUS Standard Silver 70 Limited (\$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                                                                                                    |                                                     |                                  |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------|
| Overall Deductible - Individual                                    | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$6,000, Medical and Pharmacy Combined  |                                                     |                                  |
| Overall Deductible - Family                                        | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$12,000, Medical and Pharmacy Combined |                                                     |                                  |
| Overall Out-of-Pocket Limit - Individual                           | \$8,900, Medical and Pharmacy Combined                                                                               |                                                     |                                  |
| Overall Out-of-Pocket Limit - Family                               | \$17,800, 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                                                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Specialist Office Visit                                            | No charge                                                                                                            | \$80 copayment per visit, deductible does not apply | Not covered                      |
| Other Practitioner Office Visit                                    | No charge                                                                                                            | \$80 copayment per visit, deductible does not apply | Not covered                      |
| Chiropractic Services                                              | No charge                                                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Autism Spectrum Disorder                                           | No charge                                                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Preventive Care, Screenings, and Immunizations                     | No charge                                                                                                            | No charge                                           | Not covered                      |
| Diagnostic Test (Blood Work)                                       | No charge                                                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Diagnostic Test (X-Ray)                                            | No charge                                                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Imaging (CT, PET, MRI)                                             | No charge                                                                                                            | 40% coinsurance after deductible                    | Not covered                      |

| Covered Services                                                         | IHCP In-Network Provider | Non-IHCP In-Network Provider                                                                                                                                                                        | Non-IHCP Out-of-Network Provider |
|--------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Generic Drugs                                                            | No charge                | \$20 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                                                    | No charge                | \$40 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                      |
| Non-Preferred Brand Drugs                                                | No charge                | \$80 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                                                          | No charge                | \$125 copayment per prescription after deductible for a standard 30-day supply                                                                                                                      | Not covered                      |
| Outpatient Facility Fee                                                  | No charge                | 40% coinsurance after deductible                                                                                                                                                                    | Not covered                      |
| Outpatient Physician Surgeon Fee                                         | No charge                | 40% coinsurance after deductible                                                                                                                                                                    | Not covered                      |
| Emergency Room Services                                                  | No charge                | 40% coinsurance after deductible                                                                                                                                                                    | Same as Participating Providers  |
| Emergency Transportation                                                 | No charge                | 40% coinsurance 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<br>Not covered at non-CHRISTUS Facilities                                                                                                                          | Not covered                      |
| Inpatient Facility Fee                                                   | No charge                | 40% coinsurance after deductible                                                                                                                                                                    | Not covered                      |
| Inpatient Physician Surgeon Fee                                          | No charge                | 40% coinsurance after deductible                                                                                                                                                                    | Not covered                      |
| Mental Health, Behavioral Health and Substance Abuse Outpatient Services | No charge                | Office visit: \$40 copayment per visit, deductible does not apply<br>Outpatient facility: 40% coinsurance after deductible                                                                          | Not covered                      |
| Mental Health, Behavioral Health and Substance Abuse Inpatient Services  | No charge                | 40% coinsurance 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                                                                            | \$80 copayment per visit, deductible does not apply | Not covered                      |
| Delivery and Inpatient Services            | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Home Health Care                           | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Rehabilitation Services                    | No charge                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Habilitation Services                      | No charge                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Skilled Nursing Facility                   | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Durable Medical Equipment                  | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Hospice Service                            | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Attention Deficit Disorder                 | No charge                                                                            | \$40 copayment per visit, deductible does not apply | Not covered                      |
| Cleft Lip/Cleft Palate                     | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Dental Anesthesia                          | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Oral Surgery Benefits                      | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Private-Duty Nursing                       | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Sleep Studies                              | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Pre-Admission Testing                      | No charge                                                                            | 40% coinsurance after deductible                    | Not covered                      |
| Routine Foot Care                          | No charge                                                                            | \$40 copayment per visit, deductible does not apply | 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                      |
| 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.