

## Schedule of Benefits

Plan Type: CHRISTUS Silver Essential 73 (\$5 PCP, \$0 Preferred Generic Rx, \$0 Virtual Urgent Care)

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

If you have any questions about your coverage and costs, please visit [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                                    | \$6,900, Medical and Pharmacy Combined                                                                                           |                             |
| Overall Deductible - Family                                        | \$13,800, Medical and Pharmacy Combined                                                                                          |                             |
| Overall Out-of-Pocket Limit - Individual                           | \$7,850, Medical and Pharmacy Combined                                                                                           |                             |
| Overall Out-of-Pocket Limit - Family                               | \$15,700, 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                                            | \$50 copayment per visit, deductible does not apply                                                                              | Not covered                 |
| Other Practitioner Office Visit                                    | \$50 copayment per visit, deductible does not apply                                                                              | Not covered                 |
| Chiropractic Services                                              | \$50 copayment per visit, deductible does not apply<br>(35 visit limit per calendar year, combined with rehabilitation services) | 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)                                       | \$60 copayment per visit, deductible does not apply                                                                              | Not covered                 |
| Diagnostic Test (X-Ray)                                            | \$60 copayment per visit, deductible does not apply                                                                              | Not covered                 |
| Imaging (CT, PET, MRI)                                             | \$400 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                                                    | \$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                     |
| Non-Preferred Brand Drugs                                                | \$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                                                          | \$350 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                     |
| Outpatient Facility Fee                                                  | 50% co-pay percentage after deductible                                                                                                                                                           | Not covered                     |
| Outpatient Physician Surgeon Fee                                         | 50% co-pay percentage after deductible                                                                                                                                                           | Not covered                     |
| Emergency Room Services                                                  | \$950 copayment per visit after deductible                                                                                                                                                       | Same as Participating Providers |
| Emergency Transportation                                                 | 50% co-pay percentage after deductible                                                                                                                                                           | Same as Participating Providers |
| Urgent Care                                                              | \$50 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: \$50 copayment per visit, deductible does not apply<br>Outpatient facility: 50% co-pay percentage 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                                              | \$50 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |
| Delivery and Inpatient Services                                          | \$950 copayment per stay after deductible                                                                                                                                                        | Not covered                     |
| Home Health Care                                                         | 50% co-pay percentage after deductible<br>(60 visit limit per calendar year)                                                                                                                     | Not covered                     |
| Rehabilitation Services                                                  | \$50 copayment per visit, deductible does not apply<br>(35 visit limit per calendar year, combined with chiropractic care)                                                                       | Not covered                     |
| Habilitation Services                                                    | \$50 copayment per visit, deductible does not apply                                                                                                                                              | Not covered                     |

| Covered Services                                       | Participating Providers                                                                    | Non-Participating Providers |
|--------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------|
| Skilled Nursing Facility                               | 50% co-pay percentage after deductible<br>(25 day limit per calendar year)                 | Not covered                 |
| Durable Medical Equipment                              | 50% co-pay percentage after deductible                                                     | Not covered                 |
| Hospice Service                                        | 50% 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                 |
| 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                                                                      |                             |
| Major Dental Care – Child                              | 50% co-pay percentage                                                                      |                             |
| Orthodontia – Child                                    | 50% co-pay percentage<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.
- **Co-pay percentage** 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 **co-pay percentage** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, please contact us.
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **co-pay percentage** amounts.