

## Schedule of Benefits

Plan Type: CHRISTUS Gold with Fitness Limited (\$0 Deductible, \$5 PCP, \$0 Generic Rx, \$0 Virtual Urgent Care)

Coverage Period: 01/01/2027 – 12/31/2027

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                                    |                                                                                | \$0, Medical and Pharmacy Combined                                                            |                                  |
| Overall Deductible - Family                                        |                                                                                | \$0, Medical and Pharmacy Combined                                                            |                                  |
| Overall Out-of-Pocket Limit - Individual                           |                                                                                | \$9,950, Medical and Pharmacy Combined                                                        |                                  |
| Overall Out-of-Pocket Limit - Family                               |                                                                                | \$19,900, 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<br>(Telemedicine and telehealth services have the same cost sharing) | \$5 copayment per visit<br>(Telemedicine and telehealth services have the same cost sharing)  | Not covered                      |
| Specialist Office Visit                                            | No charge<br>(Telemedicine and telehealth services have the same cost sharing) | \$60 copayment per visit<br>(Telemedicine and telehealth services have the same cost sharing) | Not covered                      |

| Covered Services                               | IHCP In-Network Provider                                                       | Non-IHCP In-Network Provider                                                                                                                                           | Non-IHCP Out-of-Network Provider |
|------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Other Practitioner Office Visit                | No charge<br>(Telemedicine and telehealth services have the same cost sharing) | \$60 copayment per visit<br>(Telemedicine and telehealth services have the same cost sharing)                                                                          | Not covered                      |
| Chiropractic Services                          | No charge                                                                      | \$60 copayment per visit                                                                                                                                               | Not covered                      |
| Autism Spectrum Disorder                       | No charge                                                                      | \$5 copayment per visit                                                                                                                                                | Not covered                      |
| Preventive Care, Screenings, and Immunizations | No charge                                                                      | No charge                                                                                                                                                              | Not covered                      |
| Diagnostic Test (Blood Work)                   | No charge                                                                      | \$60 copayment per visit                                                                                                                                               | Not covered                      |
| Diagnostic Test (X-Ray)                        | No charge                                                                      | \$60 copayment per visit                                                                                                                                               | Not covered                      |
| Imaging (CT, PET, MRI)                         | No charge                                                                      | \$400 copayment per visit                                                                                                                                              | Not covered                      |
| Preferred Generic Drugs                        | No charge                                                                      | No charge                                                                                                                                                              | Not covered                      |
| Non-Preferred Generic Drugs                    | No charge                                                                      | No charge                                                                                                                                                              | Not covered                      |
| Preferred Brand Drugs                          | No charge                                                                      | \$60 copayment 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                      | No charge                                                                      | \$80 copayment 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                                | No charge                                                                      | \$350 copayment 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                        | No charge                                                                      | 40% co-pay percentage                                                                                                                                                  | Not covered                      |
| Outpatient Physician Surgeon Fee               | No charge                                                                      | 40% co-pay percentage                                                                                                                                                  | Not covered                      |
| Emergency Room Services                        | No charge                                                                      | \$950 copayment per visit                                                                                                                                              | Same as Participating Providers  |
| Emergency Transportation                       | No charge                                                                      | 40% co-pay percentage                                                                                                                                                  | Same as Participating Providers  |
| Urgent Care                                    | No charge                                                                      | \$60 copayment per visit                                                                                                                                               | 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                                                                      | \$950 copayment per stay                                                                                                                                               | Not covered                      |
| Inpatient Physician Surgeon Fee                | No charge                                                                      | No charge                                                                                                                                                              | Not covered                      |

| Covered Services                                                         | IHCP In-Network Provider                                                                   | Non-IHCP In-Network Provider                                                         | Non-IHCP Out-of-Network Provider                  |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------|
| Mental Health, Behavioral Health and Substance Abuse Outpatient Services | No charge                                                                                  | Office visit: \$60 copayment per visit<br>Outpatient facility: 40% co-pay percentage | Not covered                                       |
| Mental Health, Behavioral Health and Substance Abuse Inpatient Services  | No charge                                                                                  | \$950 copayment per stay                                                             | Not covered                                       |
| Prenatal and Postnatal Care                                              | No charge                                                                                  | \$60 copayment per visit                                                             | Not covered                                       |
| Delivery and Inpatient Services                                          | No charge                                                                                  | \$950 copayment per stay                                                             | Not covered                                       |
| Home Health Care                                                         | No charge                                                                                  | 40% co-pay percentage                                                                | Not covered                                       |
| Rehabilitation Services                                                  | No charge                                                                                  | \$60 copayment per visit                                                             | Not covered                                       |
| Habilitation Services                                                    | No charge                                                                                  | \$60 copayment per visit                                                             | Not covered                                       |
| Skilled Nursing Facility                                                 | No charge                                                                                  | 40% co-pay percentage                                                                | Not covered                                       |
| Durable Medical Equipment                                                | No charge                                                                                  | 40% co-pay percentage                                                                | Not covered                                       |
| Hospice Service                                                          | No charge                                                                                  | 40% co-pay percentage                                                                | Not covered                                       |
| Children's Eye Exam                                                      | No charge<br>(1 exam per year limit)                                                       | No charge (1 exam per year limit)                                                    | Not covered                                       |
| Children's Glasses                                                       | No charge<br>(1 pair per year limit)                                                       | No charge (1 pair per year limit)                                                    | Not covered                                       |
| Covered Services                                                         | Delta Dental DPO Provider                                                                  |                                                                                      | Delta Dental Premier or Non-Delta Dental Provider |
| 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.
- 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.



**Adult Fitness Benefit\* (Ages 18 years of age and older)**

| Adult Fitness Covered Services | Participating Providers | Non-Participating Providers |
|--------------------------------|-------------------------|-----------------------------|
| Adult Fitness Benefit          | No charge               | Not covered                 |

\*Adult fitness benefit does not apply to the plan out-of-pocket maximum listed on page 1  
\*For access to a network of participating fitness centers, please visit <https://www.activeandfitdirect.com/>