

## Schedule of Benefits

Plan Type: CHRISTUS Standard Silver 70 Limited (\$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 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$6,400, Medical and Pharmacy Combined  |                                                                                                                          |                                  |
| Overall Deductible - Family                                        | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$12,800, Medical and Pharmacy Combined |                                                                                                                          |                                  |
| Overall Out-of-Pocket Limit - Individual                           | \$10,300, Medical and Pharmacy Combined                                                                              |                                                                                                                          |                                  |
| Overall Out-of-Pocket Limit - Family                               | \$20,600, 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)                                       | \$40 copayment per visit, deductible does not apply<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)                                       | \$80 copayment per visit, deductible does not apply<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)      | \$80 copayment per visit, deductible does not apply<br>(Telemedicine and telehealth services have the same cost sharing)                                                                            | Not covered                      |
| Chiropractic Services                          | No charge (35 visit limit per calendar year, combined with rehabilitation services) | \$40 copayment per visit, deductible does not apply<br>(35 visit limit per calendar year, combined with rehabilitation services)                                                                    | 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% co-pay percentage after deductible                                                                                                                                                              | Not covered                      |
| Diagnostic Test (X-Ray)                        | No charge                                                                           | 40% co-pay percentage after deductible                                                                                                                                                              | Not covered                      |
| Imaging (CT, PET, MRI)                         | No charge                                                                           | 40% co-pay percentage after deductible                                                                                                                                                              | Not covered                      |
| 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                                                                           | \$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                        | No charge                                                                           | 40% co-pay percentage after deductible                                                                                                                                                              | Not covered                      |
| Outpatient Physician Surgeon Fee               | No charge                                                                           | 40% co-pay percentage after deductible                                                                                                                                                              | Not covered                      |
| Emergency Room Services                        | No charge                                                                           | 40% co-pay percentage after deductible                                                                                                                                                              | Same as Participating Providers  |
| Emergency Transportation                       | No charge                                                                           | 40% co-pay percentage 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                      |

| Covered Services                                                         | IHCP In-Network Provider                                                                   | Non-IHCP In-Network Provider                                                                                                     | Non-IHCP Out-of-Network Provider                  |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Inpatient Facility Fee                                                   | No charge                                                                                  | 40% co-pay percentage after deductible                                                                                           | Not covered                                       |
| Inpatient Physician Surgeon Fee                                          | No charge                                                                                  | 40% co-pay percentage 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% co-pay percentage after deductible | Not covered                                       |
| Mental Health, Behavioral Health and Substance Abuse Inpatient Services  | No charge                                                                                  | 40% co-pay percentage after deductible                                                                                           | Not covered                                       |
| Prenatal and Postnatal Care                                              | No charge                                                                                  | \$80 copayment per visit, deductible does not apply                                                                              | Not covered                                       |
| Delivery and Inpatient Services                                          | No charge                                                                                  | 40% co-pay percentage after deductible                                                                                           | Not covered                                       |
| Home Health Care                                                         | No charge (60 visit limit per calendar year)                                               | 40% co-pay percentage after deductible (60 visit limit per calendar year)                                                        | Not covered                                       |
| Rehabilitation Services                                                  | No charge (35 visit limit per calendar year, combined with chiropractic care)              | \$40 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)          | Not covered                                       |
| Habilitation Services                                                    | No charge                                                                                  | \$40 copayment per visit, deductible does not apply                                                                              | Not covered                                       |
| Skilled Nursing Facility                                                 | No charge (25 day limit per calendar year)                                                 | 40% co-pay percentage after deductible (25 day limit per calendar year)                                                          | Not covered                                       |
| Durable Medical Equipment                                                | No charge                                                                                  | 40% co-pay percentage after deductible                                                                                           | Not covered                                       |
| Hospice Service                                                          | No charge                                                                                  | 40% co-pay percentage after deductible                                                                                           | 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                                       |
| 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. 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.