

Schedule of Benefits

Plan Type: CHRISTUS Silver LD 94 - 2 free PCP visits, includes Virtual; \$0 Ded

Coverage Period: 01/01/2023 – 12/31/2023

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	\$0, Medical and Pharmacy Combined	
Overall Deductible - Family	\$0, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	\$750, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	\$1,500, 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	30% coinsurance after first two free visits	Not covered
Specialist Office Visit	30% coinsurance	Not covered
Other Practitioner Office Visit	30% coinsurance	Not covered
Chiropractic Services	30% coinsurance (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	30% coinsurance	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	30% coinsurance	Not covered
Diagnostic Test (X-Ray)	30% coinsurance	Not covered
Imaging (CT, PET, MRI)	30% coinsurance	Not covered

Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	30% coinsurance	Not covered
Non-Preferred Generics	30% coinsurance	Not covered
Preferred Brand Drugs	30% coinsurance	Not covered
Non-Preferred Drugs	30% coinsurance	Not covered
Specialty Drugs	30% coinsurance	Not covered
Outpatient Facility Fee	30% coinsurance	Not covered
Outpatient Physician Surgeon Fee	30% coinsurance	Not covered
Emergency Room Services	30% coinsurance	Same as Participating Providers
Emergency Transportation	30% coinsurance	Same as Participating Providers
Urgent Care	30% coinsurance	Not covered
Inpatient Facility Fee	30% coinsurance	Not covered
Inpatient Physician Surgeon	30% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: 30% coinsurance Outpatient facility: 30% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	30% coinsurance	Not covered
Prenatal and Postnatal Care	30% coinsurance	Not covered
Delivery and Inpatient Services	30% coinsurance	Not covered
Home Health Care	30% coinsurance (60 visit limit per calendar year)	Not covered
Rehabilitation Services	30% coinsurance (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	30% coinsurance	Not covered
Skilled Nursing Facility	30% coinsurance (25 day limit per calendar year)	Not covered
Durable Medical Equipment	30% coinsurance	Not covered
Hospice Service	30% coinsurance	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 Check-Up	No charge	Not covered

- **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**.
- 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 **coinsurance** amounts.