CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Standard Expanded Bronze ($0 Virtual Urgent Care)

Coverage Period: 01/01/2025-12/31/2025

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	$7,500, Medical and Pharmacy Combined	
Overall Deductible - Family	$15,000, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	$9,200, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$18,400, 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 *Evidence of Coverage*	Yes	
Covered Services	**Participating Providers**	**Non-Participating Providers**
Primary Care Office Visit	$50 copayment per visit, deductible does not apply	Not covered
Specialist Office Visit	$100 copayment per visit, deductible does not apply	Not covered
Other Practitioner Office Visit	$100 copayment per visit, deductible does not apply	Not covered
Chiropractic Services	$50 copayment per visit, deductible does not apply	Not covered
Autism Spectrum Disorder	$50 copayment per visit, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	50% coinsurance after deductible	Not covered
Diagnostic Test (X-Ray)	50% coinsurance after deductible	Not covered
Imaging (CT, PET, MRI)	50% coinsurance after deductible	Not covered

CHRISTUS Health Plan

Covered Services	Participating Providers	Non-Participating Providers
Generic Drugs	$25 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	$50 copayment per prescription after deductible 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	$100 copayment per prescription after deductible 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	$150 copayment per prescription after deductible for a standard 30-day supply	Not covered
Outpatient Facility Fee	50% coinsurance after deductible	Not covered
Outpatient Physician Surgeon Fee	50% coinsurance after deductible	Not covered
Emergency Room Services	50% coinsurance after deductible	Same as Participating Providers
Emergency Transportation	50% coinsurance after deductible	Same as Participating Providers
Urgent Care	$75 copayment per visit, deductible does not apply	Not covered
Urgent Care (Virtual)	No charge at CHRISTUS Facilities Not covered at non-CHRISTUS Facilities	Not covered
Inpatient Facility Fee	50% coinsurance after deductible	Not covered
Inpatient Physician Surgeon Fee	50% coinsurance after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: $50 copayment per visit, deductible does not apply Outpatient facility: 50% coinsurance after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	50% coinsurance after deductible	Not covered
Prenatal and Postnatal Care	$100 copayment per visit, deductible does not apply	Not covered
Delivery and Inpatient Services	50% coinsurance after deductible	Not covered
Home Health Care	50% coinsurance after deductible	Not covered
Rehabilitation Services	$50 copayment per visit, deductible does not apply	Not covered

CHRISTUS® Health Plan

Covered Services	Participating Providers	Non-Participating Providers
Habilitation Services	$50 copayment per visit, deductible does not apply	Not covered
Skilled Nursing Facility	50% coinsurance after deductible	Not covered
Durable Medical Equipment	50% coinsurance after deductible	Not covered
Hospice Service	50% coinsurance after deductible	Not covered
Attention Deficit Disorder	$50 copayment per visit, deductible does not apply	Not covered
Cleft Lip/Cleft Palate	50% coinsurance after deductible	Not covered
Dental Anesthesia	50% coinsurance after deductible	Not covered
Oral Surgery Benefits	50% coinsurance after deductible	Not covered
Private-Duty Nursing	50% coinsurance after deductible	Not covered
Sleep Studies	50% coinsurance after deductible	Not covered
Pre-Admission Testing	50% coinsurance after deductible	Not covered
Routine Foot Care	$50 copayment per visit, deductible does not apply	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 – 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 (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.