CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Silver 87 + Dental & Vision ($0 PCP, $0 Preferred Generic Rx, $0 Virtual Urgent Care)

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

If you have any questions about your coverage and costs, please visit www.christushealthplan.org or by calling 1-844-282-3025.

Medical and Prescription Drug Deductibles and Out-of-Pocket Limits	**Member Cost Share**	
Medical Deductible - Individual	$2,100	
Medical Deductible - Family	$4,200	
Pharmacy Deductible - Individual	$250	
Pharmacy Deductible - Family	$500	
Overall Out-of-Pocket Limit - Individual	$2,650, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$5,300, 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	No charge, deductible does not apply	Not covered
Specialist Office Visit	No charge, deductible does not apply	Not covered
Other Practitioner Office Visit	No charge, deductible does not apply	Not covered
Chiropractic Services	No charge, deductible does not apply (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	No charge, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	$35 copayment per visit, deductible does not apply	Not covered
Diagnostic Test (X-Ray)	$35 copayment per visit, deductible does not apply	Not covered
Imaging (CT, PET, MRI)	$400 copayment per visit after deductible	Not covered

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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	$20 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	$60 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	$500 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
Outpatient Facility Fee	40% co-pay percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	40% co-pay percentage after deductible	Not covered
Emergency Room Services	$950 copayment per visit after deductible	Same as Participating Providers
Emergency Transportation	40% co-pay percentage after deductible	Same as Participating Providers
Urgent Care	No charge, 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	$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: No charge, deductible does not apply Outpatient facility: 40% 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	No charge, deductible does not apply	Not covered
Delivery and Inpatient Services	$950 copayment per stay after deductible	Not covered
Home Health Care	40% co-pay percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	No charge, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	No charge, deductible does not apply	Not covered
Skilled Nursing Facility	40% co-pay percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	40% co-pay percentage after deductible	Not covered
Hospice Service	40% co-pay percentage after deductible	Not covered
Children's Eye Exam	No charge (1 exam per year limit)	Not covered

Covered Services	Participating Providers	Non-Participating Providers
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 (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.

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Adult Vision* (Ages 19 years of age and older, does not include Pediatric Vision Coverage)

Adult Vision Covered Services	Participating Providers	Non-Participating Providers
Adult Eye Exam	No charge (1 exam per year)	Not covered
Adult Glasses	No charge (1 item per year. Up to $130 per person for glasses or contacts)	Not covered

Adult Dental* (Ages 19 years of age and older, does not include Pediatric Dental Coverage)

Annual Maximum Dental Benefit: $1,000 per covered person per calendar year for all benefits listed below
Waiting Period: Major Dental Care Services are limited to Adult Enrollees who have been enrolled under the dental for 12 consecutive months.

Adult Dental Covered Services	Participating Providers	Non-Participating Providers
Adult Routine Dental Services	No charge (1 cleaning and exam per six months limit)	
Adult Basic Dental Care	20% co-pay percentage	
Adult Major Dental Care	50% co-pay percentage	
Adult Orthodontia	Not covered	

*Adult vision and dental benefits do not apply to plan deductible and out-of-pocket maximum listed on page 1.