CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS American Indian Zero Cost Sharing + Fitness

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	$0, Medical and Pharmacy Combined	
Overall Deductible - Family	$0, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	Not Applicable	
Overall Out-of-Pocket Limit - Family	Not Applicable	
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	**Indian Health Care and Participating Providers**	**Non-Participating Providers**
Primary Care Office Visit	No charge	Not covered
Specialist Office Visit	No charge	Not covered
Other Practitioner Office Visit	No charge	Not covered
Chiropractic Services	No charge (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	No charge	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	No charge	Not covered
Diagnostic Test (X-Ray)	No charge	Not covered
Imaging (CT, PET, MRI)	No charge	Not covered

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

Covered Services	Indian Health Care and Participating Providers	Non-Participating Providers
Dental Diagnostic and Preventive Services for Children	No charge (1 cleaning and exam per six months limit)	
Basic Dental Care – Child	No charge	
Major Dental Care – Child	No charge	
Orthodontia – Child	No charge (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.

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 plan deductible and out-of-pocket maximum listed on page 1.