CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Silver Essential 87 + Dental & Vision ($0 Deductible, $5 PCP, $0 Generic Rx, $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	$0, Medical and Pharmacy Combined	
Overall Deductible - Family	$0, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	$3,050, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$6,100, 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	$5 copayment per visit	Not covered
Specialist Office Visit	$35 copayment per visit	Not covered
Other Practitioner Office Visit	$35 copayment per visit	Not covered
Chiropractic Services	$35 copayment per visit	Not covered
Autism Spectrum Disorder	$5 copayment per visit	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	$60 copayment per visit	Not covered
Diagnostic Test (X-Ray)	$60 copayment per visit	Not covered
Imaging (CT, PET, MRI)	$400 copayment per visit	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generic Drugs	No Charge	Not covered
Non-Preferred Generic Drugs	No Charge	Not covered
Preferred Brand Drugs	$60 copayment per prescription 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	$80 copayment per prescription 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 for a standard 30-day supply	Not covered
Outpatient Facility Fee	50% coinsurance	Not covered
Outpatient Physician Surgeon Fee	50% coinsurance	Not covered
Emergency Room Services	$950 copayment per visit	Same as Participating Providers
Emergency Transportation	50% coinsurance	Same as Participating Providers
Urgent Care	$35 copayment per visit	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	Not covered
Inpatient Physician Surgeon Fee	No Charge	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: $35 copayment per visit Outpatient facility: 50% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	$950 copayment per stay	Not covered
Prenatal and Postnatal Care	$35 copayment per visit	Not covered
Delivery and Inpatient Services	$950 copayment per stay	Not covered
Home Health Care	50% coinsurance	Not covered
Rehabilitation Services	$35 copayment per visit	Not covered
Habilitation Services	$35 copayment per visit	Not covered
Skilled Nursing Facility	50% coinsurance	Not covered
Durable Medical Equipment	50% coinsurance	Not covered
Hospice Service	50% coinsurance	Not covered
Attention Deficit Disorder	$5 copayment per visit	Not covered
Cleft Lip/Cleft Palate	50% coinsurance	Not covered
Dental Anesthesia	50% coinsurance	Not covered
Oral Surgery Benefits	50% coinsurance	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Private-Duty Nursing	50% coinsurance	Not covered
Sleep Studies	50% coinsurance	Not covered
Pre-Admission Testing	50% coinsurance	Not covered
Routine Foot Care	$5 copayment per visit	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.

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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's Dental – Basic (Class A)	No charge (1 cleaning and exam per six months limit)	
Adult's Dental – Intermediate (Class B)	20% coinsurance	
Adult's Dental – Major (Class C)	50% coinsurance	
Adult's Dental – Orthodontia (Class D)	Not covered	

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