CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Elite Silver – Two Free PCP Visits

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**	
Overall Deductible - Individual	$5,300, Medical and Pharmacy Combined	
Overall Deductible - Family	$10,600, Medical and Pharmacy Combined	
Other Specific Deductibles	No	
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	$35 copayment per visit after first two free visits, deductible does not apply	Not covered
Specialist Office Visit	$60 copayment per visit, deductible does not apply	Not covered
Other Practitioner Office Visit	$60 copayment per visit, deductible does not apply	Not covered
Chiropractic Services	$30 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	$35 copayment per visit, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge, deductible does not apply	Not covered
Diagnostic Test (Blood Work)	$35 copayment per visit, deductible does not apply	Not covered
Diagnostic Test (X-Ray)	$30 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 Generics	No charge, deductible does not apply	Not covered
Non-Preferred Generics	$10 copayment per prescription (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	$55 copayment per prescription after deductible (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 Drugs	$90 copayment per prescription after deductible (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	40% copayment percentage per prescription after deductible	Not covered
Outpatient Facility Fee	35% copayment percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	35% copayment percentage after deductible	Not covered
Emergency Room Services	$950 copayment after deductible	Same as Participating Providers
Emergency Transportation	35% copayment percentage after deductible	Same as Participating Providers
Urgent Care	$60 copayment per visit, deductible does not apply	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: $50 copayment per visit, deductible does not apply Outpatient facility: 35% copayment 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	$60 copayment per visit, deductible does not apply	Not covered
Delivery and Inpatient Services	$950 copayment per stay after deductible	Not covered
Home Health Care	35% copayment percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	$30 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	$30 copayment per visit, deductible does not apply	Not covered
Skilled Nursing Facility	35% copayment percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	35% copayment percentage after deductible	Not covered
Hospice Service	35% copayment percentage after deductible	Not covered
Children's Eye Exam	No charge, deductible does not apply (1 exam per year limit)	Not covered
Children's Glasses	No charge, deductible does not apply (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% copayment percentage	
Major Dental Care – Child	50% copayment percentage	

Covered Services	Participating Providers	Non-Participating Providers
Orthodontia – Child	50% copayment 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.
- **Copayment 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 **copayment 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 **copayment percentage** amounts.