CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Bronze Essential + Dental & Vision Limited (2 Free PCP Visits, $0 Preferred 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 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $7,450, Medical and Pharmacy Combined		
Overall Deductible - Family	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $14,900, 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	**IHCP In-Network Provider**	**Non-IHCP In-Network Provider**	**Non-IHCP Out-of-Network Provider**
Primary Care Office Visit	No charge	$60 copayment per visit after first two free visits, deductible does not apply	Not covered
Specialist Office Visit	No charge	$80 copayment per visit, deductible does not apply	Not covered
Other Practitioner Office Visit	No charge	$80 copayment per visit, deductible does not apply	Not covered
Chiropractic Services	No charge	$60 copayment per visit, deductible does not apply	Not covered
Autism Spectrum Disorder	No charge	$60 copayment per visit, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge	No charge	Not covered

Covered Services	IHCP In-Network Provider	Non-IHCP In-Network Provider	Non-IHCP Out-of-Network Provider
Diagnostic Test (Blood Work)	No charge	50% coinsurance after deductible	Not covered
Diagnostic Test (X-Ray)	No charge	50% coinsurance after deductible	Not covered
Imaging (CT, PET, MRI)	No charge	$400 copayment per visit after deductible	Not covered
Preferred Generic Drugs	No charge	No charge	Not covered
Non-Preferred Generic Drugs	No charge	$30 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	No charge	$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
Non-Preferred Brand Drugs	No charge	50% coinsurance after deductible	Not covered
Specialty Drugs	No charge	50% coinsurance after deductible (Not to exceed $150 per prescription for a standard 30-day supply)	Not covered
Outpatient Facility Fee	No charge	50% coinsurance after deductible	Not covered
Outpatient Physician Surgeon Fee	No charge	50% coinsurance after deductible	Not covered
Emergency Room Services	No charge	$950 copayment per visit after deductible	Same as Participating Providers
Emergency Transportation	No charge	50% coinsurance after deductible	Same as Participating Providers
Urgent Care	No charge	$80 copayment per visit, deductible does not apply	Not covered
Urgent Care (Virtual)	No charge	No charge at CHRISTUS Facilities Not covered at non-CHRISTUS Facilities	Not covered
Inpatient Facility Fee	No charge	$950 copayment per stay after deductible	Not covered
Inpatient Physician Surgeon Fee	No charge	No charge after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	No charge	Office visit: $60 copayment per visit, deductible does not apply Outpatient facility: 50% coinsurance after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	No charge	$950 copayment per stay after deductible	Not covered

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Covered Services	IHCP In-Network Provider	Non-IHCP In-Network Provider	Non-IHCP Out-of-Network Provider
Prenatal and Postnatal Care	No charge	$80 copayment per visit, deductible does not apply	Not covered
Delivery and Inpatient Services	No charge	$950 copayment per stay after deductible	Not covered
Home Health Care	No charge	50% coinsurance after deductible	Not covered
Rehabilitation Services	No charge	$60 copayment per visit, deductible does not apply	Not covered
Habilitation Services	No charge	$60 copayment per visit, deductible does not apply	Not covered
Skilled Nursing Facility	No charge	50% coinsurance after deductible	Not covered
Durable Medical Equipment	No charge	50% coinsurance after deductible	Not covered
Hospice Service	No charge	50% coinsurance after deductible	Not covered
Attention Deficit Disorder	No charge	$60 copayment per visit, deductible does not apply	Not covered
Cleft Lip/Cleft Palate	No charge	50% coinsurance after deductible	Not covered
Dental Anesthesia	No charge	50% coinsurance after deductible	Not covered
Oral Surgery Benefits	No charge	50% coinsurance after deductible	Not covered
Private-Duty Nursing	No charge	50% coinsurance after deductible	Not covered
Sleep Studies	No charge	50% coinsurance after deductible	Not covered
Pre-Admission Testing	No charge	50% coinsurance after deductible	Not covered
Routine Foot Care	No charge	$60 copayment per visit, deductible does not apply	Not covered
Children's Eye Exam	No charge (1 exam per year limit)	No charge (1 exam per year limit)	Not covered
Children's Glasses	No charge (1 pair per year limit)	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	IHCP In-Network Provider	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	IHCP In-Network Provider	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.