CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Gold Essential Limited ($0 Rx Deductible, $5 PCP, $0 Virtual Urgent Care)

Coverage Period: 01/01/2026 – 12/31/2026

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	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $3,750		
Medical Deductible - Family	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $7,500		
Pharmacy Deductible – Individual	$0		
Pharmacy Deductible – Family	$0		
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	$5 copayment per visit, deductible does not apply	Not covered
Specialist Office Visit	No charge	$35 copayment per visit, deductible does not apply	Not covered
Other Practitioner Office Visit	No charge	$35 copayment per visit, deductible does not apply	Not covered
Chiropractic Services	No charge (35 visit limit per calendar year, combined with rehabilitation services)	$25 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)	Not covered

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Covered Services	IHCP In-Network Provider	Non-IHCP In-Network Provider	Non-IHCP Out-of-Network Provider
Autism Spectrum Disorder	No charge	$5 copayment per visit, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge	No charge	Not covered
Diagnostic Test (Blood Work)	No charge	$30 copayment per visit, deductible does not apply	Not covered
Diagnostic Test (X-Ray)	No charge	$20 copayment per visit, deductible does not apply	Not covered
Imaging (CT, PET, MRI)	No charge	$200 copayment per visit after deductible	Not covered
Preferred Generic Drugs	No charge	No charge	Not covered
Non-Preferred Generic Drugs	No charge	$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	No charge	$50 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
Non-Preferred Brand Drugs	No charge	$60 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
Specialty Drugs	No charge	45% co-pay percentage, deductible does not apply	Not covered
Outpatient Facility Fee	No charge	30% co-pay percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	No charge	30% co-pay percentage after deductible	Not covered
Emergency Room Services	No charge	$950 copayment per visit after deductible	Same as Participating Providers
Emergency Transportation	No charge	30% co-pay percentage after deductible	Same as Participating Providers
Urgent Care	No charge	$35 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: $25 copayment per visit, deductible does not apply Outpatient facility: 30% co-pay percentage 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	$35 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 (60 visit limit per calendar year)	30% co-pay percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	No charge (35 visit limit per calendar year, combined with chiropractic care)	$25 copayment per visit, deductible does not apply (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	No charge	$25 copayment per visit, deductible does not apply	Not covered
Skilled Nursing Facility	No charge (25 day limit per calendar year)	30% co-pay percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	No charge	30% co-pay percentage after deductible	Not covered
Hospice Service	No charge	30% co-pay percentage after deductible	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
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.