CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Value Silver 70 Plus Dental & Vision Limited ($0 Virtual Urgent Care)

Coverage Period: 01/01/2027 – 12/31/2027

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	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $6,500, Medical and Pharmacy Combined		
Overall Deductible - Family	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $13,000, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Individual	$6,500, Medical and Pharmacy Combined		
Overall Out-of-Pocket Limit - Family	$13,000, 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 (Telemedicine and telehealth services have the same cost sharing)	No charge after deductible (Telemedicine and telehealth services have the same cost sharing)	Not covered
Specialist Office Visit	No charge (Telemedicine and telehealth services have the same cost sharing)	No charge after deductible (Telemedicine and telehealth services have the same cost sharing)	Not covered

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Covered Services	IHCP In-Network Provider	Non-IHCP In-Network Provider	Non-IHCP Out-of-Network Provider
Other Practitioner Office Visit	No charge (Telemedicine and telehealth services have the same cost sharing)	No charge after deductible (Telemedicine and telehealth services have the same cost sharing)	Not covered
Chiropractic Services	No charge (35 visit limit per calendar year, combined with rehabilitation services)	No charge after deductible (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	No charge	No charge after deductible	Not covered
Preventive Care, Screenings, and Immunizations	No charge	No charge	Not covered
Diagnostic Test (Blood Work)	No charge	No charge after deductible	Not covered
Diagnostic Test (X-Ray)	No charge	No charge after deductible	Not covered
Imaging (CT, PET, MRI)	No charge	No charge after deductible	Not covered
Preferred Generic Drugs	No charge	No charge after deductible	Not covered
Non-Preferred Generic Drugs	No charge	No charge after deductible	Not covered
Preferred Brand Drugs	No charge	No charge after deductible	Not covered
Non-Preferred Brand Drugs	No charge	No charge after deductible	Not covered
Specialty Drugs	No charge	No charge after deductible	Not covered
Outpatient Facility Fee	No charge	No charge after deductible	Not covered
Outpatient Physician Surgeon Fee	No charge	No charge after deductible	Not covered
Emergency Room Services	No charge	No charge after deductible	Same as Participating Providers
Emergency Transportation	No charge	No charge after deductible	Same as Participating Providers
Urgent Care	No charge	No charge after deductible	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	No charge 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: No charge after deductible Outpatient facility: No charge 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
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	No charge	No charge after deductible	Not covered
Prenatal and Postnatal Care	No charge	No charge after deductible	Not covered
Delivery and Inpatient Services	No charge	No charge after deductible	Not covered
Home Health Care	No charge (60 visit limit per calendar year)	No charge after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	No charge (35 visit limit per calendar year, combined with chiropractic care)	No charge after deductible (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	No charge	No charge after deductible	Not covered
Skilled Nursing Facility	No charge (25 day limit per calendar year)	No charge after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	No charge	No charge after deductible	Not covered
Hospice Service	No charge	No charge 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

Covered Services	Delta Dental DPO Provider	Delta Dental Premier or Non-Delta Dental Provider
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.

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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	Non-IHCP In-Network Provider	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	Delta Dental DPO Provider	Delta Dental Premier or Non-Delta Dental Provider
Adult Routine Dental Services	No charge (1 cleaning and exam per six months limit)	
Adult Basic Dental Care	20% co-pay percentage	
Adult Major Dental Care	50% co-pay percentage	
Adult Orthodontia	Not covered	

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