CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Gold

Coverage Period: 01/01/2024 – 12/31/2024

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	$4,200	
Medical Deductible - Family	$8,400	
Pharmacy Deductible - Individual	$0	
Pharmacy Deductible - Family	$0	
Overall Out-of-Pocket Limit - Individual	$9,450, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$18,900, 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	$10 copayment per visit after first two free visits, deductible does not apply	Not covered
Specialist Office Visit	$35 copayment per visit, deductible does not apply	Not covered
Other Practitioner Office Visit	$35 copayment per visit, deductible does not apply	Not covered
Chiropractic Services	$30 copayment per visit after deductible (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	$10 copayment per visit, deductible does not apply	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	30% co-pay percentage after deductible	Not covered
Diagnostic Test (X-Ray)	$20 copayment per visit, deductible does not apply	Not covered
Imaging (CT, PET, MRI)	$200 copayment per visit after deductible	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	No charge	Not covered
Non-Preferred Generics	$4 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	$35 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 Drugs	$75 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	45% co-pay percentage, deductible does not apply	Not covered
Outpatient Facility Fee	30% co-pay percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	30% co-pay percentage after deductible	Not covered
Emergency Room Services	$950 copayment per visit after deductible	Same as Participating Providers
Emergency Transportation	30% co-pay percentage after deductible	Same as Participating Providers
Urgent Care	$35 copayment per visit, deductible does not apply	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 after deductible	Not covered
Inpatient Physician Surgeon	No charge after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: $20 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	$950 copayment per stay after deductible	Not covered
Prenatal and Postnatal Care	$35 copayment per visit, deductible does not apply	Not covered
Delivery and Inpatient Services	$950 copayment per stay after deductible	Not covered
Home Health Care	30% co-pay percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	$30 copayment per visit after deductible (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	$30 copayment per visit after deductible	Not covered
Skilled Nursing Facility	30% co-pay percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	30% co-pay percentage after deductible	Not covered
Hospice Service	30% co-pay percentage after deductible	Not covered
Children’s Eye Exam	No charge (1 exam per year limit)	Not covered

Covered Services	Participating Providers	Non-Participating Providers
Children's Glasses	No charge (1 pair per year limit)	Not covered
Diagnostic and Preventive Services – Child	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.