CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Platinum

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**	
Overall Deductible - Individual	$0, Medical and Pharmacy Combined	
Overall Deductible - Family	$0, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	$2,250, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$4,500, 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	$5 copayment per visit after first two free visits	Not covered
Specialist Office Visit	$20 copayment per visit	Not covered
Other Practitioner Office Visit	$20 copayment per visit	Not covered
Chiropractic Services	$20 copayment per visit	Not covered
Autism Spectrum Disorder	$5 copayment per visit	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	20% co-pay percentage	Not covered
Diagnostic Test (X-Ray)	20% co-pay percentage	Not covered
Imaging (CT, PET, MRI)	$100 copayment per visit	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	No charge	Not covered
Non-Preferred Generics	$3 copayment per prescription 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
Preferred Brand Drugs	$20 copayment per prescription 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 Drugs	45% co-pay percentage	Not covered
Specialty Drugs	45% co-pay percentage	Not covered
Outpatient Facility Fee	20% co-pay percentage	Not covered
Outpatient Physician Surgeon Fee	20% co-pay percentage	Not covered
Emergency Room Services	$950 copayment per visit	Same as Participating Providers
Emergency Transportation	20% co-pay percentage	Same as Participating Providers
Urgent Care	$20 copayment per visit	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	Not covered
Inpatient Physician Surgeon	No charge	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: $20 copayment per visit Outpatient facility: 20% co-pay percentage	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	$950 copayment per stay	Not covered
Prenatal and Postnatal Care	$20 copayment per visit	Not covered
Delivery and Inpatient Services	$950 copayment per stay	Not covered
Home Health Care	20% co-pay percentage	Not covered
Rehabilitation Services	$20 copayment per visit	Not covered
Habilitation Services	$20 copayment per visit	Not covered
Skilled Nursing Facility	$20 copayment per visit	Not covered
Durable Medical Equipment	20% co-pay percentage	Not covered
Hospice Service	20% co-pay percentage	Not covered
Children’s Eye Exam	No charge	Not covered
Children’s Glasses	No charge	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
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.
- 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.
- Each basic health care service HMO may establish one or more reasonable **copayment** options. A reasonable **copayment** option may not exceed 50 percent of the total cost of services provided.
- A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the **copayments** made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that **copayments** in that amount have been paid in that year.