CHRISTUS® Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Elite Gold Basic – Two Free PCP Visits

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	$1,500, Medical and Pharmacy Combined	
Overall Deductible - Family	$3,000, Medical and Pharmacy Combined	
Other Specific Deductibles	No	
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	20% copayment percentage after deductible. First two visits are free.	Not covered
Specialist Office Visit	20% copayment percentage after deductible	Not covered
Other Practitioner Office Visit	20% copayment percentage after deductible	Not covered
Chiropractic Services	20% copayment percentage after deductible (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	20% copayment percentage after deductible	Not covered
Preventive Care, Screenings, and Immunizations	No charge, deductible does not apply	Not covered
Diagnostic Test (Blood Work)	20% copayment percentage after deductible	Not covered
Diagnostic Test (X-Ray)	20% copayment percentage after deductible	Not covered
Imaging (CT, PET, MRI)	20% copayment percentage after deductible	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	20% copayment percentage after deductible	Not covered
Non-Preferred Generics	20% copayment percentage after deductible	Not covered
Preferred Brand Drugs	20% copayment percentage after deductible	Not covered
Non-Preferred Drugs	20% copayment percentage after deductible	Not covered
Specialty Drugs	20% copayment percentage after deductible	Not covered
Outpatient Facility Fee	20% copayment percentage after deductible	Not covered
Outpatient Physician Surgeon Fee	20% copayment percentage after deductible	Not covered
Emergency Room Services	20% copayment percentage after deductible	Same as Participating Providers
Emergency Transportation	20% copayment percentage after deductible	Same as Participating Providers
Urgent Care	20% copayment percentage after deductible	Not covered
Inpatient Facility Fee	20% copayment percentage after deductible	Not covered
Inpatient Physician Surgeon	20% copayment percentage after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: 20% copayment percentage after deductible Outpatient facility: 20% copayment percentage after deductible	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	20% copayment percentage after deductible	Not covered
Prenatal and Postnatal Care	20% copayment percentage after deductible	Not covered
Delivery and Inpatient Services	20% copayment percentage after deductible	Not covered
Home Health Care	20% copayment percentage after deductible (60 visit limit per calendar year)	Not covered
Rehabilitation Services	20% copayment percentage after deductible (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	20% copayment percentage after deductible	Not covered
Skilled Nursing Facility	20% copayment percentage after deductible (25 day limit per calendar year)	Not covered
Durable Medical Equipment	20% copayment percentage after deductible	Not covered
Hospice Service	20% copayment percentage after deductible	Not covered
Children's Eye Exam	No charge, deductible does not apply (1 exam per year limit)	Not covered
Children's Glasses	No charge, deductible does not apply (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% copayment percentage	
Major Dental Care – Child	50% copayment percentage	
Orthodontia – Child	50% copayment 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.
- **Copayment 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 **copayment 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 **copayment percentage** amounts.