CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Gold with Fitness ($0 Deductible, $5 PCP, $0 Generic Rx, $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, Medical and Pharmacy Combined	
Overall Deductible - Family	$0, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Individual	$9,950, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$19,900, 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	$5 copayment per visit (Telemedicine and telehealth services have the same cost sharing)	Not covered
Specialist Office Visit	$60 copayment per visit (Telemedicine and telehealth services have the same cost sharing)	Not covered
Other Practitioner Office Visit	$60 copayment per visit (Telemedicine and telehealth services have the same cost sharing)	Not covered
Chiropractic Services	$60 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)	$60 copayment per visit	Not covered
Diagnostic Test (X-Ray)	$60 copayment per visit	Not covered
Imaging (CT, PET, MRI)	$400 copayment per visit	Not covered

CHRISTUS Health Plan

Covered Services	Participating Providers	Non-Participating Providers
Preferred Generic Drugs	No charge	Not covered
Non-Preferred Generic Drugs	No charge	Not covered
Preferred Brand Drugs	$60 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 Brand Drugs	$80 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
Specialty Drugs	$350 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
Outpatient Facility Fee	40% co-pay percentage	Not covered
Outpatient Physician Surgeon Fee	40% co-pay percentage	Not covered
Emergency Room Services	$950 copayment per visit	Same as Participating Providers
Emergency Transportation	40% co-pay percentage	Same as Participating Providers
Urgent Care	$60 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 Fee	No charge	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: $60 copayment per visit Outpatient facility: 40% co-pay percentage	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	$950 copayment per stay	Not covered
Prenatal and Postnatal Care	$60 copayment per visit	Not covered
Delivery and Inpatient Services	$950 copayment per stay	Not covered
Home Health Care	40% co-pay percentage	Not covered
Rehabilitation Services	$60 copayment per visit	Not covered
Habilitation Services	$60 copayment per visit	Not covered
Skilled Nursing Facility	40% co-pay percentage	Not covered
Durable Medical Equipment	40% co-pay percentage	Not covered
Hospice Service	40% co-pay percentage	Not covered
Children’s Eye Exam	No charge (1 exam per year limit)	Not covered

CHRISTUS Health Plan

Covered Services	Participating Providers	Non-Participating Providers
Children's Glasses	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.
- 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.

Adult Fitness Benefit* (Ages 18 years of age and older)

Adult Fitness Covered Services	Participating Providers	Non-Participating Providers
Adult Fitness Benefit	No charge	Not covered

*Adult fitness benefit does not apply to the plan out-of-pocket maximum listed on page 1

*For access to a network of participating fitness centers, please visit https://www.activeandfitdirect.com/