CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Standard Silver 94

Coverage Period: 01/01/2023 – 12/31/2023

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at 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	$1,700, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$3,400, 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	No charge	Not covered
Specialist Office Visit	$10 copayment per visit	Not covered
Other Practitioner Office Visit	$10 copayment per visit	Not covered
Chiropractic Services	No charge (35 visit limit per calendar year, combined with rehabilitation services)	Not covered
Autism Spectrum Disorder	No charge	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	25% coinsurance	Not covered
Diagnostic Test (X-Ray)	25% coinsurance	Not covered
Imaging (CT, PET, MRI)	25% coinsurance	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	No charge	Not covered
Non-Preferred Generics	No charge	Not covered
Preferred Brand Drugs	$15 copayment per prescription 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	$50 copayment per prescription 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	$150 copayment per prescription 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	25% coinsurance	Not covered
Outpatient Physician Surgeon Fee	25% coinsurance	Not covered
Emergency Room Services	25% coinsurance	Same as Participating Providers
Emergency Transportation	25% coinsurance	Same as Participating Providers
Urgent Care	$5 copayment per visit	Not covered
Inpatient Facility Fee	25% coinsurance	Not covered
Inpatient Physician Surgeon	25% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: No charge Outpatient facility: 25% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	25% coinsurance	Not covered
Prenatal and Postnatal Care	$10 copayment per visit	Not covered
Delivery and Inpatient Services	25% coinsurance	Not covered
Home Health Care	25% coinsurance (60 visit limit per calendar year)	Not covered
Rehabilitation Services	No charge (35 visit limit per calendar year, combined with chiropractic care)	Not covered
Habilitation Services	No charge	Not covered
Skilled Nursing Facility	25% coinsurance (25 day limit per calendar year)	Not covered
Durable Medical Equipment	25% coinsurance	Not covered
Hospice Service	25% coinsurance	Not covered
Children’s Eye Exam	No charge (1 exam per year limit)	Not covered
Children’s Glasses	No charge (1 pair per year limit)	Not covered
Children’s Dental Check-Up	No charge	Not covered

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 **coinsurance** amounts.