CHRISTUS Health Plan

# *Schedule of Benefits*

Plan Type: CHRISTUS Gold Plus HD-2 Free PCP;$10 PCP;$35 SPE;$0 Rx Ded;Adult vision,dental,fitness

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 | |
|---|---|---|
| Medical Deductible - Individual | $1,700 | |
| Medical Deductible - Family | $3,400 | |
| Pharmacy Deductible - Individual | $0 | |
| Pharmacy Deductible - Family | $0 | |
| Overall Out-of-Pocket Limit - Individual | $9,100, Medical and Pharmacy Combined | |
| Overall Out-of-Pocket Limit - Family | $18,200, 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 | 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% coinsurance 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% coinsurance, deductible does not apply<br>(Not to exceed $150 per prescription for a standard 30-day supply) | Not covered |
| Outpatient Facility Fee | 30% coinsurance after deductible | Not covered |
| Outpatient Physician Surgeon Fee | 30% coinsurance after deductible | Not covered |
| Emergency Room Services | $950 copayment per visit after deductible | Same as Participating Providers |
| Emergency Transportation | 30% coinsurance after deductible | Same as Participating Providers |
| Urgent Care | $35 copayment per visit, deductible does not apply | 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<br>Outpatient facility: 30% coinsurance 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% coinsurance after deductible | Not covered |
| Rehabilitation Services | $30 copayment per visit after deductible | Not covered |
| Habilitation Services | $30 copayment per visit after deductible | Not covered |
| Skilled Nursing Facility | 30% coinsurance after deductible | Not covered |
| Durable Medical Equipment | 30% coinsurance after deductible | Not covered |
| Hospice Service | 30% coinsurance after deductible | Not covered |
| Attention Deficit Disorder | $10 copayment per visit, deductible does not apply | Not covered |
| Cleft Lip/Cleft Palate | 30% coinsurance after deductible | Not covered |

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| Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Dental Anesthesia | 30% coinsurance after deductible | Not covered |
| Oral Surgery Benefits | 30% coinsurance after deductible | Not covered |
| Private-Duty Nursing | 30% coinsurance after deductible | Not covered |
| Sleep Studies | 30% coinsurance after deductible | Not covered |
| Pre-Admission Testing | 30% coinsurance after deductible | Not covered |
| Routine Foot Care | $10 copayment per visit, deductible does not apply | 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 |

- **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**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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**Adult Vision* (Ages 19 years of age and older, does not include Pediatric Vision Coverage)**

| Adult Vision Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Adult Eye Exam | No charge (1 exam per year) | Not covered |
| Adult Glasses | No charge (1 item per year. Up to $130 per person for glasses or contacts) | Not covered |

**Adult Dental* (Ages 19 years of age and older, does not include Pediatric Dental Coverage)**

**Annual Maximum Dental Benefit**: $1,000 per covered person per calendar year for all benefits listed below

| Adult Dental Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Adult Routine Dental Services | No charge | Not covered |
| Adult Basic Dental Care | 80% coinsurance, deductible does not apply | Not covered |
| Adult Major Dental Care | 50% coinsurance, deductible does not apply | Not covered |
| Adult Orthodontia | Not covered | Not covered |

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

| Adult Fitness Covered Services | Participating Providers | Non-Participating Providers |
|---|---|---|
| Adult Fitness Benefit | Trinity Fitness Center - No charge | $20 monthly reimbursement for all other fitness centers |

*Adult Vision, Dental Services, and Fitness Benefit do not apply to plan deductible and out-of-pocket maximum listed on page 1.