CHRISTUS Health Plan

Schedule of Benefits

Plan Type: CHRISTUS Silver LD 94 - 2 free PCP visits, includes Virtual; $0 Ded

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	$750, Medical and Pharmacy Combined	
Overall Out-of-Pocket Limit - Family	$1,500, 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	30% coinsurance after first two free visits	Not covered
Specialist Office Visit	30% coinsurance	Not covered
Other Practitioner Office Visit	30% coinsurance	Not covered
Chiropractic Services	30% coinsurance	Not covered
Autism Spectrum Disorder	30% coinsurance	Not covered
Preventive Care, Screenings, and Immunizations	No charge	Not covered
Diagnostic Test (Blood Work)	30% coinsurance	Not covered
Diagnostic Test (X-Ray)	30% coinsurance	Not covered
Imaging (CT, PET, MRI)	30% coinsurance	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Preferred Generics	30% coinsurance	Not covered
Non-Preferred Generics	30% coinsurance	Not covered
Preferred Brand Drugs	30% coinsurance	Not covered
Non-Preferred Drugs	30% coinsurance	Not covered
Specialty Drugs	30% coinsurance (Not to exceed $150 per prescription for a standard 30-day supply)	Not covered
Outpatient Facility Fee	30% coinsurance	Not covered
Outpatient Physician Surgeon Fee	30% coinsurance	Not covered
Emergency Room Services	30% coinsurance	Same as Participating Providers
Emergency Transportation	30% coinsurance	Same as Participating Providers
Urgent Care	30% coinsurance	Not covered
Inpatient Facility Fee	30% coinsurance	Not covered
Inpatient Physician Surgeon	30% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Outpatient Services	Office visit: 30% coinsurance Outpatient facility: 30% coinsurance	Not covered
Mental Health, Behavioral Health and Substance Abuse Inpatient Services	30% coinsurance	Not covered
Prenatal and Postnatal Care	30% coinsurance	Not covered
Delivery and Inpatient Services	30% coinsurance	Not covered
Home Health Care	30% coinsurance	Not covered
Rehabilitation Services	30% coinsurance	Not covered
Habilitation Services	30% coinsurance	Not covered
Skilled Nursing Facility	30% coinsurance	Not covered
Durable Medical Equipment	30% coinsurance	Not covered
Hospice Service	30% coinsurance	Not covered
Attention Deficit Disorder	30% coinsurance	Not covered
Cleft Lip/Cleft Palate	30% coinsurance	Not covered
Dental Anesthesia	30% coinsurance	Not Covered
Oral Surgery Benefits	30% coinsurance	Not covered
Private-Duty Nursing	30% coinsurance	Not covered

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Covered Services	Participating Providers	Non-Participating Providers
Sleep Studies	30% coinsurance	Not covered
Pre-Admission Testing	30% coinsurance	Not covered
Routine Foot Care	30% 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

- **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.