



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, 1-844-282-3025. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-282-3025 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | \$0 | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and primary care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | \$3,500/individual or \$7,000/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See https://www.christushealthplan.org/provider-search or call 1-844-282-3025 for a list of network providers. | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the in-network specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$5 copayment /visit; deductible does not apply | Not Covered | None. |
| | Specialist visit | \$20 copayment /visit; deductible does not apply | Not Covered | None. |
| | Preventive care/Screening/Immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$100 copayment per visit | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| If you need drugs to treat your illness or condition More information about Prescription drug coverage is available at www.christushealthplan.org | Generic drugs | \$3 copayment /prescription | Not Covered | Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply. Prescriptions for birth control are not subject to deductible , and do not have a copayment . |
| | Preferred brand drugs | \$20 copayment | Not Covered | |
| | Non-preferred brand drugs | 45% coinsurance | Not Covered | |
| | Specialty drugs | 45% coinsurance | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Physician/Surgeon fees | 20% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| If you need immediate medical attention | Emergency Room Care | \$500 copayment /visit | \$500 copayment | None. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | \$20 copayment /visit | Not Covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$150 copayment /Stay | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Physician/Surgeon fees | No Charge | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |

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* For more information about limitations and exceptions, see the plan or policy document at <https://www.christushealthplan.org/>

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 copayment /visit; deductible does not apply. | Not Covered | None. |
| | Inpatient services | \$150 copayment /Stay | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| If you are pregnant | Office visits | \$20 copayment /visit | Not Covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | No Charge | Not Covered | None. |
| | Childbirth/delivery facility services | \$150 copayment | Not Covered | Preauthorization is required for inpatient care, except for: (1) forty-eight (48) hours of Inpatient care following a vaginal delivery or ninety-six (96) hours of Inpatient care following a Cesarean section or (2) Post-Partum Care. If you don't get preauthorization , benefits will be denied. |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 60 visits/calendar year. |
| | Rehabilitation services | \$20 copayment | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Habilitation services | \$20 copayment | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Skilled nursing care | \$20 copayment | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Durable medical equipment | 20% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Hospice services | 20% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limited to one exam per year. |
| | Children's glasses | No Charge | Not Covered | Limited to one pair of glasses per year. |
| | Children's dental check-up | No Charge | Not Covered | None. |

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Excluded services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---|--|---|
| <ul style="list-style-type: none">• Abortion• Acupuncture• Bariatric Surgery• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care (Adult)• Infertility Treatment• Long-term Care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the United States• Private-duty nursing• Weight Loss Programs |
| Other Covered Services (limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• Chiropractic care (35 visit limit)• Hearing aids for children | <ul style="list-style-type: none">• Routine eye care for adults (1 exam every 24 months) | <ul style="list-style-type: none">• Routine foot care for diabetic members |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: CHRISTUS Health Plan Customer Service at 1-844-282-3025; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>; Texas Health and Human Services Commission at 1-800-252-8263 or <http://www.hhsc.state.tx.us/medicaid>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: CHRISTUS Health Plan Customer Service at 1-844-282-3025 or The Texas Department of Insurance at 1-800-578-4677 or <http://www.tdi.texas.gov/index.html>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum value standards? Yes

If your [plan](#) doesn't meet the [Minimum value standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-282-3025 (TTY: 1-800-735-2989).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-282-3025 (TTY: 1-800-735-2989).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-282-3025 (TTY: 1-800-735-2989)。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-282-3025 (TTY: 1-800-735-2989)번으로 전화해 주십시오.

Arabic: ملحوظة: بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا 1-844-282-3025 برقم اتصل (والبيكم الصم هاتف رقم) 1-800-735-2989.

Urdu: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-844-282-3025 (TTY: 1-800-735-2989)۔

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-282-3025 (TTY: 1-800-735-2989).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-282-3025 (ATS : 1-800-735-2989).

Persian: هاستند شما دسترس در، کنند می صحبت رایگان، زبان کمک خدمات، فارسی شما اگر 1-844-282-3025 پاسخ (TTY: 1-800-735-2989).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-282-3025 (TTY: 1-800-735-2989).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-282-3025 (телетайп: 1-800-735-2989).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-282-3025 (TTY: 1-800-735-2989) まで、お電話にてご連絡ください。

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-844-282-3025 (TTY: 1-800-735-2989).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$172 |
| Coinsurance | \$688 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$60 |
| The total Peg would pay is | \$920 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$433 |
| Coinsurance | \$372 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$55 |
| The total Joe would pay is | \$861 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,868 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$640 |
| Coinsurance | \$172 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$0 |
| The total Mia would pay is | \$812 |