



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, call us at 1-844-282-3025 or visit us on the web at <https://www.christushealthplan.org/>. 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 <http://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	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
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 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	No charge	Not Covered	Including office services, other than those specifically shown below.
	Specialist visit	No charge	Not Covered	Including office services, other than those specifically shown below.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	No charge	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	No charge	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	No charge	Not Covered	
	Non-preferred brand drugs	No charge	Not Covered	
	Specialty drugs	No charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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.
If you need immediate medical attention	Emergency room care	No charge	No charge	None.
	Emergency medical transportation	No charge	No charge	
	Urgent care	No charge	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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/>

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not Covered	None.
	Inpatient services	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
If you are pregnant	Office visits	No charge	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	No charge	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	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 60 visits/calendar year.
	Rehabilitation services	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Habilitation services	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Skilled nursing care	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Durable medical equipment	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Hospice services	No charge	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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* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.christushealthplan.org/>

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 .)		
• Abortion • Acupuncture • Bariatric Surgery • Cosmetic Surgery	• Dental Care (Adult) • Infertility Treatment • Long-term Care	• 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.)		
• Chiropractic care (35 visit limit) • Hearing aids (1 hearing aid in each ear every 3 years)	• Routine eye care for adults (1 exam every 24 months)	• 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).

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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: , . **1-844-282-3025 (TTY: 1-800-735-2989)**

Arabic: (رقم 1-844-282-3025) وللبائع للصم (رقم 1-800-735-2989). إذا كنت تريد خدمات الترجمة، يمكنك الاتصال بـ 1-844-282-3025 (TTY: 1-800-735-2989).

Urdu: آپ اردو بولتے ہیں تو آپ کو زبان کی مدد کی خدمات فہت ہیں سہیل اب ہوں کالکریں **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: پلس 1-844-282-3025 (TTY: 1-800-735-2989). هتق نشما هتسرس در کونند می صحت ریگان ، زبان کمک خدمات فارسی شما اگر

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: ພາສາລາວ: ພາສາລາວ ພາສາລາວ ພາສາລາວ, ພາສາລາວ ພາສາລາວ ພາສາລາວ, ພາສາລາວ ພາສາລາວ ພາສາລາວ. ພາສາລາວ

1-844-282-3025 (TTY: 1-800-735-2989)

Hindi: हंद: सावधाना: यदं आप दं तां बोलेत , ता अणुत्त भाषा स ायेता संवोआ स लाभ उठा सैकैत । **1-844-282-3025 पर कॉल कर (टाटावा: 1-800-735-2989)**

જરાત: સાવધાન: જો તમે જૈરાતી બોલતા હોવ તો, તમે મફત ભાષા સહાય સવાચોમાથી લાભ મે લી શકો છો. **1-844-282-3025 પર કોલ કરો (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)

n The plan's overall deductible	\$0
n Specialist copayment	\$0
n Hospital (facility) copayment	\$0
n Other coinsurance	0%

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
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In this example, Peg would pay:

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

Managing Joe's type 2 Diabetes

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

n The plan's overall deductible	\$0
n Specialist copayment	\$0
n Hospital (facility) copayment	\$0
n Other coinsurance	0%

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
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In this example, Joe would pay:

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

Mia's Simple Fracture

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

n The plan's overall deductible	\$0
n Specialist copayment	\$0
n Hospital (facility) copayment	\$0
n Other coinsurance	0%

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	\$1,900
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In this example, Mia would pay:

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