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?	$3,600/individual or $7,200/family	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?	Yes. Prescription drugs -- $300/ individual or $600/family. There are no other specific deductibles.	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?	$6,300 /individual or $12,600/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 specialist you choose without a referral.

All copayment shown in this chart are **before** your deductible, and all coinsurance cost 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	$10 copayment/visit; deductible does not apply	Not Covered	Including office services, other than those specifically shown below.
	Specialist visit	$35 copayment/visit; deductible does not apply	Not Covered	Including office services, other than those specifically shown below.
	Preventive care/screening/ immunization	No charge. Deductible does not apply	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)	$30 copayment/visit. 20% coinsurance for laboratory tests.	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	$250 copayment/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	$5 copayment/prescription. Deductible does not apply.	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	$60 copayment	Not Covered	
	Non-preferred brand drugs	$95 copayment	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	$950 copayment	$950 copayment	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	

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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)	
	Urgent care	$35 copayment/visit. Deductible does not apply.	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1000 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.
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	$1000 copayment/Stay	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you are pregnant	Office visits	$35 copayment/visit. Deductible does not apply.	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	$1000 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	$30 copayment	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Habilitation services	$30 copayment	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Skilled nursing care	20% coinsurance	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.

* 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)	
	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. Deductible does not apply	Not Covered	Limited to one exam per year.
	Children's glasses	No charge. Deductible does not apply	Not Covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge. Deductible does not apply	Not Covered	None.

* 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).

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 (TTY1-800-735-2989)。

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

Urdu: خبردار: 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: اگر به زبان فارسی گفتگو می کنید، خدمات کمک زبانی، رایگان تحت می کنند در دسترس شما است. تماس بگیرید با **1-844-282-3025 (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: □□□□: □□□□ □□□□□□□□□ □□, □□□□□□□□□□□□□□□□□□□, □□□□□□□□, □□□□□□□□□□□□□. □□

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

Hindi: हंद: सावधाना: यद आप दं ा ा बोलैंत , ता आुफ्त भाषा स ायेता संवोआ स लाभ उठा सैकंत । 1-844-282-3025 पर कालें कर (टाटावा: 1-800-735-2989)

Gu જરાત: સાવધાન: જો તમ ગૅજરાતી બોલતા હોવ તો, તમ મફત ભાષા સહાય સવાઓમાથી લાભ મ વી શકો છો. 1-844-282-3025 પર કૉલ 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.------------------------

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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.

n The plan's overall deductible	$3,600
n Specialist copayment	$35
n Hospital (facility) copayment	$1,000
n 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:

Cost Sharing	
Deductibles	$3,600
Copayments	$1,100
Coinsurance	$700
What isn't covered	
Limits or Exclusions	$60
The total Peg would pay is	**$5,460**

n The plan's overall deductible	$3,600
n Specialist copayment	$35
n Hospital (facility) copayment	$1,000
n 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:

Cost Sharing	
Deductibles	$1,800
Copayments	$1,100
Coinsurance	$400
What isn't covered	
Limits or Exclusions	$60
The total Joe would pay is	**$3,360**

n The plan's overall deductible	$3,600
n Specialist copayment	$35
n Hospital (facility) copayment	$1,000
n 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,200
Coinsurance	$200
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$1,900**