




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 <a href="#">deductible</a> ?	\$2,500/individual or \$5,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,300/individual or \$12,600/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.christushealthplan.org/provider-search">https://www.christushealthplan.org/provider-search</a> or call 1-844-282-3025 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Including office services, other than those specifically shown below.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Including office services, other than those specifically shown below.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copayment</a> /visit. 35% <a href="#">coinsurance</a> for laboratory tests.	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">copayment</a> /visit	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
If you need drugs to treat your illness or condition More information about <a href="#">Prescription drug coverage</a> is available at <a href="http://www.christushealthplan.org">www.christushealthplan.org</a>	Generic drugs	\$5 <a href="#">copayment</a> /prescription. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Cost sharing</a> for a 90-day supply by mail order is triple the <a href="#">cost sharing</a> for a standard 30-day supply. Prescriptions for birth control are not subject to <a href="#">deductible</a> , and do not have a <a href="#">copayment</a> .
	Preferred brand drugs	\$60 <a href="#">copayment</a>	Not Covered	
	Non-preferred brand drugs	\$95 <a href="#">copayment</a>	Not Covered	
	<a href="#">Specialty drugs</a>	45% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	Physician/surgeon fees	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$950 <a href="#">copayment</a>	\$950 <a href="#">copayment</a>	None.
	<a href="#">Emergency medical transportation</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	

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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)	
	<a href="#">Urgent care</a>	\$35 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1000 <a href="#">copayment</a> /Stay	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	Physician/surgeon fees	No Charge	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.	Not Covered	None.
	Inpatient services	\$1000 <a href="#">copayment</a> /Stay	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
If you are pregnant	Office visits	\$35 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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 <a href="#">copayment</a>	Not Covered	<a href="#">Preauthorization</a> 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 <a href="#">preauthorization</a> , benefits will be denied.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 60 visits/calendar year.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copayment</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copayment</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	<a href="#">Skilled nursing care</a>	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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)	
	<a href="#">Durable medical equipment</a>	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	<a href="#">Hospice services</a>	35% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
If your child needs dental or eye care	Children's eye exam	No charge. <a href="#">Deductible</a> does not apply	Not Covered	Limited to one exam per year.
	Children's glasses	No charge. <a href="#">Deductible</a> does not apply	Not Covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge. <a href="#">Deductible</a> does not apply	Not Covered	None.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental Care (Adult)</li><li>• Infertility Treatment</li><li>• Long-term Care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the United States</li><li>• Private-duty nursing</li><li>• Weight Loss Programs</li></ul>
Other Covered Services (limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care (35 visit limit)</li><li>• Hearing aids (1 hearing aid in each ear every 3 years)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care for adults (1 exam every 24 months)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care for diabetic members</li></ul>

**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](http://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)。

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

Arabic: وليکم للصم (مف رقم) 1-844-282-3025 بـرقم لـصم لـبـالـمـجـانـلـكـتـفـلـرـالـغـيـة لـمـن اـعـدـة خـدمـاتـفـان لـلـغـة اـلـكـرـيـتـحـدث لـتـفـت اـذا : لـحـوـظـة

Urdu: 1-844-282-3025 (TTY: 1-800-735-2989) نـمـر دـار: 1-844-282-3025 اـپ اـر دـو بـلـتـمـے وں تـو اـپـکـو نـبـان کـی مـدکـی خـدمـات فـت وں سـنـی اـب وں کـال کـی وں

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: 1-844-282-3025 (TTY: 1-800-735-2989) اـپـلـس خ . هـتـمـن دـش مـا هـتـمـس دـر کـو نـمـد مـی صـبـت رـیـگـان ، نـبـان کـم ک خـدمـات فـارسی شـم اـگـر

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

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

Hindi: हंद: सावधाना: यदं आप दं ा बोलेत , ता अुपत्त भाषा स ायेता संवोआ स लाभ उठा सैकत । 1-844-282-3025 पर कॉल कर (टाटावा: 1-

800-735-2989)

જરાત: સાવધાન: જો તમ ગૈજરાતી બોલતા હોવ તો, તમ મફત ભાષા સહાય સવાઓમાથી વાલ મ વી 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.-----



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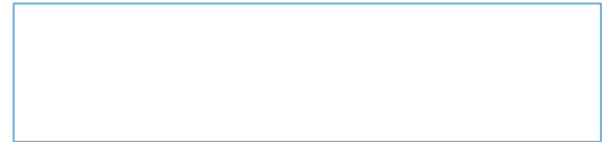
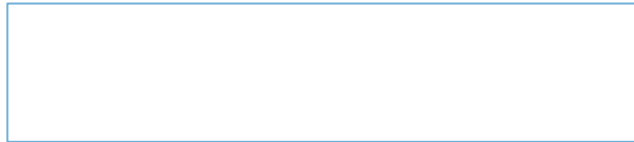
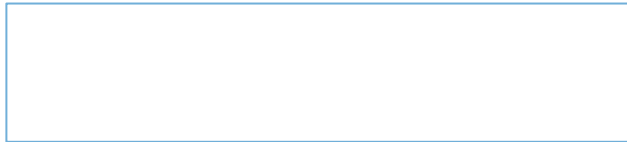
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About these Coverage Examples:

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 \$2,500
- n Specialist copayment \$35
- n Hospital (facility) copayment \$1,000
- n Other coinsurance 35%

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 \$2,500
- Copayments \$1,100
- Coinsurance \$1,100

*What isn't covered*

- Limits or Exclusions \$60
- The total Peg would pay is \$4,760

- n The plan's overall deductible \$2,500
- n Specialist copayment \$35
- n Hospital (facility) copayment \$1,000
- n Other coinsurance 35%

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 \$2,500
- Copayments \$1,100
- Coinsurance \$700

*What isn't covered*

- Limits or Exclusions \$60
- The total Joe would pay is \$4,360

- n The plan's overall deductible \$2,500
- n Specialist copayment \$35
- n Hospital (facility) copayment \$1,000
- n Other coinsurance 35%

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 \$400
- Copayments \$1,200
- Coinsurance \$300

*What isn't covered*

- Limits or Exclusions \$0
- The total Mia would pay is \$1,900