




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> ?                                | \$0 at Indian Health Care Provider (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; \$7,100/individual or \$14,200/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="http://www.healthcare.gov/coverage/preventive-care-benefits/">http://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> ? | \$8,150/individual or \$16,300/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/find-a-provider">https://www.christushealthplan.org/find-a-provider</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](#) 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  |
|--|--|--|--|---|---|
|  |  | Your Cost if You Use an Indian Health Care Provider IHCP | 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 office</a> or clinic   | Primary care visit to treat an injury or illness       | No Charge  | \$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.        | Not Covered                                     | No <a href="#">cost sharing</a> for the first two <a href="#">primary care physician</a> visits.  |
|  | <a href="#">Specialist</a> visit                       | No Charge  | \$60 <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  | No charge. <a href="#">Deductible</a> does not apply.                                    | Not Covered                                     | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)    | No Charge  | 50% <a href="#">coinsurance</a>  | Not Covered                                     | None.   |
|  | Imaging (CT/PET scans, MRIs)                           | No Charge  | \$400 <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<br>More information about <a href="#">Prescription drug coverage</a> is available at <a href="http://www.christushealthplan.org">www.christushealthplan.org</a> | Preferred generic drugs                                | No Charge  | No charge. <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> . |
|  | Non-preferred generic drugs                            | No Charge  | \$25 <a href="#">copayment</a> /prescription. <a href="#">Deductible</a> does not apply. | Not Covered                                     |   |
|  | Preferred brand drugs                                  | No Charge  | \$100 <a href="#">copayment</a> /prescription  | Not Covered                                     |   |
|  | Non-preferred brand drugs                              | No Charge  | 50% <a href="#">coinsurance</a>  | Not Covered                                     |   |
|  | <a href="#">Specialty drugs</a>                        | No Charge  | 50% <a href="#">coinsurance</a>  | Not Covered                                     |   |

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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   |
|---|--|--|---|---|--|
|   |  | Your Cost if You Use an Indian Health Care Provider IHCP | Network Provider (You will pay the least)   | Out-of-Network Provider (You will pay the most) |  |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | No Charge  | 50% <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                           | No Charge  | 50% <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>              | No Charge  | \$950 <a href="#">copayment</a> /visit  | \$950 <a href="#">copayment</a> /visit          | None.  |
|   | <a href="#">Emergency medical transportation</a> | No Charge  | 50% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                 |  |
|   | <a href="#">Urgent care</a>                      | No Charge  | \$60 <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)               | No Charge  | \$950 <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  | No Charge   | Not Covered                                     | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|--|---|---|--|
|   |   | Your Cost if You Use an Indian Health Care Provider IHCP | 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  | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply. | Not Covered                                     | MH/SUD office visits are subject to the listed <a href="#">cost sharing</a> , while MH/SUD facility outpatient treatments are subject to the outpatient facility <a href="#">coinsurance</a> .   |
|   | Inpatient services                        | No Charge  | \$950 <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                             | No Charge  | \$60 <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  | No Charge   | Not Covered                                     | None.  |
|   | Childbirth/delivery facility services     | No Charge  | \$950 <a href="#">copayment</a> /stay   | Not Covered                                     | <a href="#">Preauthorization</a> is required for inpatient care, except for: (1) forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery or ninety-six (96) hours of Inpatient care following an uncomplicated Cesarean section or (2) Post-Partum Care. If you don't get <a href="#">preauthorization</a> , benefits will be denied. |

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| Common Medical Event  | Services You May Need                     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|--|---|---|--|
|   |   | Your Cost if You Use an Indian Health Care Provider IHCP | Network Provider (You will pay the least)             | Out-of-Network Provider (You will pay the most) |  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge  | 50% <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>   | No Charge  | \$60 <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. Limited to 35 visits/calendar year. |
|   | <a href="#">Habilitation services</a>     | No Charge  | \$60 <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.                                     |
|   | <a href="#">Skilled nursing care</a>      | No Charge  | 50% <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 25 visits/calendar year. |
|   | <a href="#">Durable medical equipment</a> | No Charge  | 50% <a href="#">coinsurance</a>                       | Not Covered                                     | <a href="#">Preauthorization</a> is required for DME over \$500. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                  |
|   | <a href="#">Hospice services</a>          | No Charge  | 50% <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.                                     |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No Charge  | No charge. <a href="#">Deductible</a> does not apply. | Not Covered                                     | Limited to one exam per year.  |
|   | Children's glasses                        | No Charge  | 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  | 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><li>• Dental care (Adult)</li></ul>                             | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</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 visits per year)</li></ul>  | <ul style="list-style-type: none"><li>• Hearing aids (1 hearing aid in each ear every 3 years)</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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; 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)。

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 (والبكم الصم هاتف رقم) 1-800-735-2989).

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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.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$7,100
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Peg would pay is</b> | <b>\$0</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$7,100
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Joe would pay is</b> | <b>\$0</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$7,100
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.