




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 ? | \$550/individual or \$1,100/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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$2,400/individual or \$4,800/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/find-a-provider 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 | \$10 copayment /visit; deductible does not apply. | Not covered | No cost sharing for the first two primary care physician visits. |
| | 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) | X-ray: \$30 copayment /visit and deductible does not apply. 40% coinsurance for laboratory tests. | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$400 copayment /visit; deductible does not apply. | 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 | Preferred generic drugs | No charge. 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 . |
| | Non-preferred generic drugs | \$5 copayment /prescription. Deductible does not apply. | Not covered | |
| | Preferred brand drugs | \$60 copayment /prescription | Not covered | |
| | Non-preferred brand drugs | \$95 copayment /prescription | Not covered | |
| | Specialty drugs | 45% coinsurance | 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 |
|---|--|---|--|--|
| | | 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) | 40% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Physician/surgeon fees | 40% 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 /visit | \$950 copayment /visit | None. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | |
| | Urgent care | \$35 copayment /visit; deductible does not apply. | Not covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$950 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 | \$30 copayment /visit; deductible does not apply. | Not covered | Office visits are subject to the listed cost sharing , while facility outpatient treatments are subject to the outpatient facility coinsurance . |
| | Inpatient services | \$950 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). |

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| 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) | |
| | Childbirth/delivery professional services | No charge | Not covered | None. |
| | Childbirth/delivery facility services | \$950 copayment /stay | Not covered | Preauthorization 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 preauthorization , benefits will be denied. |
| If you need help recovering or have other special health needs | Home health care | 40% 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 /visit | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 35 visits/calendar year, combined with chiropractic care. |
| | Habilitation services | \$30 copayment /visit | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Skilled nursing care | 40% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 25 visits/calendar year. |
| | Durable medical equipment | 40% coinsurance | Not covered | Preauthorization is required for durable medical equipment over \$500. If you don't get preauthorization , benefits will be denied. |
| | Hospice services | 40% 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. |

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| 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) | |
| | Children's dental check-up | No charge. Deductible does not apply. | Not covered | None. |

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 • Dental Care (Adult) | <ul style="list-style-type: none"> • Dental Care – Basic and Major (Children) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • Routine foot care • 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 visits per year, combined with rehabilitation services) | <ul style="list-style-type: none"> • Hearing aids (1 hearing aid in each ear every 3 years) |
|---|--|

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 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 on how 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.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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](#).

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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](#) \$550
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 40%

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 | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$550 |
| Copayments | \$600 |
| Coinsurance | \$1,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,510 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$550
- [Specialist copayment](#) 35
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 40%

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 | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$550 |
| Copayments | \$1,000 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,870 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$550
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 40%

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 | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$550 |
| Copayments | \$1,000 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,850 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.