### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$450/individual or $900/family</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. <strong>Preventive care</strong> and primary care services are covered before you meet your <strong>deductible</strong>.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without <strong>cost sharing</strong> and before you meet your <strong>deductible</strong>. See a list of covered <strong>preventive services</strong> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. <strong>Prescription drugs</strong> -- $100/individual or $200/family. There are no other specific <strong>deductibles</strong>.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$2,500/individual or $5,000/family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td><strong>Premiums</strong>, <strong>balance-billing</strong> charges, and health care this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>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 <strong>network providers</strong>.</td>
<td>This <strong>plan</strong> uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the <strong>plan's network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the <strong>provider's</strong> charge and what your <strong>plan</strong> pays (balance billing). Be aware, your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $10 **copayment/**visit; <strong>deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>No cost sharing for the first two primary care physician visits.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>Network Provider (You will pay the least): $35 **copayment/**visit; <strong>deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>Including office services, other than those specifically shown below.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>Network Provider (You will pay the least): No charge. <strong>Deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: Network Provider (You will pay the least): $30 **copayment/**visit and <strong>deductible</strong> does not apply. 40% <strong>coinsurance</strong> for laboratory tests.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Network Provider (You will pay the least): $400 **copayment/**visit; <strong>deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>Preauthorization is required. If you don’t get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong> More information about prescription drug coverage is available at <a href="http://www.christushealthplan.org">www.christushealthplan.org</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred generic drugs</td>
<td>Network Provider (You will pay the least): No charge. <strong>Deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred generic drugs</td>
<td>Network Provider (You will pay the least): $5 **copayment/**prescription. <strong>Deductible</strong> does not apply.</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>Cost sharing for a 90-day supply by mail order is triple the <strong>cost sharing</strong> for a standard 30-day supply. Prescriptions for birth control are not subject to <strong>deductible</strong>, and do not have a <strong>copayment</strong>.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Network Provider (You will pay the least): $60 **copayment/**prescription</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Network Provider (You will pay the least): $95 **copayment/**prescription</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Network Provider (You will pay the least): 45% <strong>coinsurance</strong></td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 40% <strong>coinsurance</strong></td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [https://www.christushealthplan.org/](https://www.christushealthplan.org/).
<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>$950 copayment/visit</td>
<td>$950 copayment/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$35 copayment/visit; deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copayment/visit; deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$950 copayment/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 copayment/visit; deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$950 copayment/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$35 copayment/visit; deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$950 copayment/stay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 60 visits/calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 copayment/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 35 visits/calendar year, combined with chiropractic care.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30 copayment/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 25 visits/calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required for durable medical equipment over $500. If you don’t get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Limited to one exam per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Limited to one pair of glasses per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>None.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [https://www.christushealthplan.org/](https://www.christushealthplan.org/)
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Abortion</td>
</tr>
<tr>
<td>- Acupuncture</td>
</tr>
<tr>
<td>- Bariatric surgery</td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
</tr>
<tr>
<td>- Dental Care – Basic and Major (Children)</td>
</tr>
<tr>
<td>- Infertility treatment</td>
</tr>
<tr>
<td>- Long-term care</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>- Private-duty nursing</td>
</tr>
<tr>
<td>- Routine foot care</td>
</tr>
<tr>
<td>- Weight loss programs</td>
</tr>
</tbody>
</table>

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Chiropractic care (35 visits per year, combined with rehabilitation services)</td>
</tr>
<tr>
<td>- Dental Care (Adult – item and visit limits apply. $1,000 annual benefit maximum)</td>
</tr>
<tr>
<td>- Hearing aids (1 hearing aid in each ear every 3 years)</td>
</tr>
<tr>
<td>- Routine eye care (Adult – 1 item and 1 visit per year. Up to $130 per person for glasses or contacts.)</td>
</tr>
</tbody>
</table>

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.

Language Access Services:
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)。
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$450</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$35</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$950</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>40%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>Total Example Cost</th>
<th>$5,600</th>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
<td>In this example, Joe would pay:</td>
<td></td>
<td>In this example, Mia would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
<td>Cost Sharing</td>
<td></td>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$450</td>
<td>Deductibles</td>
<td>$550</td>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
<td>Copayments</td>
<td>$1,000</td>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
<td>Coinsurance</td>
<td>$200</td>
<td>Coinsurance</td>
<td>$300</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td>What isn’t covered</td>
<td></td>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>Limits or exclusions</td>
<td>$20</td>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$2,510</td>
<td>The total Joe would pay is</td>
<td>$1,770</td>
<td>The total Mia would pay is</td>
<td>$1,750</td>
</tr>
</tbody>
</table>

The plan would be responsible for the other costs of these EXAMPLE covered services.