

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 <u>deductible</u> ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP <u>referral</u> at non-IHCP; \$1,100/individual or \$2,200/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <u>Prescription drugs</u> \$300/individual or \$600/family There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	\$8,350/individual or \$16,700/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> 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 <u>network</u> <u>provider</u> ?	Yes. See <u>https://www.christushealthplan.org/find-</u> <u>a-provider</u> or call 1-844-282-3025 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance</u> <u>billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay			
Common Medical Event	Services You May Need	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)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No charge	\$10 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	No <u>cost sharing</u> for the first two <u>primary care</u> <u>physician</u> visits. <u>Cost sharing</u> waived at non- IHCP with IHCP <u>referral</u> .
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	No charge	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	Including office services, other than those specifically shown below. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
lf you have a test	<u>Diagnostic test</u> (x- ray, blood work)	No charge	X-ray: \$20 <u>copayment</u> /visit and <u>deductible</u> does not apply. 30% <u>coinsurance</u> for laboratory tests.	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	\$200 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.
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	No charge. <u>Deductible</u> does not apply.	Not covered	Cost sharing for a 90-day supply by mail order is
	Non-preferred generic drugs	No charge	\$4 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	Not covered	triple the <u>cost sharing</u> for a standard 30-day supply. Prescriptions for birth control are not
	Preferred brand drugs	No charge	\$35 copayment/prescription	Not covered	subject to <u>deductible</u> , and do not have a <u>copayment</u> . <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	Non-preferred brand drugs	No charge	\$75 copayment/prescription	Not covered	

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* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://www.christushealthplan.org/</u>

			What You Will Pay			
Common Medical Event	Services You May Need	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)	Limitations, Exceptions, & Other Important Information	
	Specialty drugs	No charge	45% <u>coinsurance</u>	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.	
surgery	Physician/surgeon fees	No charge	30% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
1	Emergency room care	No charge	\$950 <u>copayment</u> /visit	\$950 <u>copayment</u> /vis it		
If you need immediate medical attention	Emergency medical transportation	No charge	30% coinsurance	30% <u>coinsurance</u>	Cost sharing waived at non-IHCP with IHCP referral.	
	Urgent care	No charge	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered		
lf you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$950 <u>copayment</u> /stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.	
	Physician/surgeon fees	No charge	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$20 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	Office visits are subject to the listed <u>cost sharing</u> , while facility outpatient treatments are subject to the outpatient facility <u>coinsurance</u> . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
	Inpatient services	No charge	\$950 <u>copayment</u> /stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP referral.	

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		What You Will Pay			
Common Medical Event	Services You May Need	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)	Limitations, Exceptions, & Other Important Information
	Office visits	No charge	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If you are program	Childbirth/delivery professional services	No charge	No charge	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Childbirth/delivery facility services	No charge	\$950 <u>copayment</u> /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 <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If you need help recovering or have other special health needs	Home health care	No charge	30% <u>coinsurance</u>	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> . Limited to 60 visits/calendar year.
	Rehabilitation services	No charge	\$30 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> . Limited to 35 visits/calendar year, combined with chiropractic care.
	Habilitation services	No charge	\$30 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.

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		What You Will Pay				
Common Medical Event	Services You May Need	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)	Limitations, Exceptions, & Other Important Information	
	Skilled nursing care	No charge	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> . Limited to 25 visits/calendar year.	
	<u>Durable medical</u> equipment	No charge	30% coinsurance	Not covered	Preauthorization is required for <u>durable medical</u> equipment over \$500. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
	Hospice services	No charge	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral.	
If your child needs dental or eye care	Children's eye exam	No charge	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one exam per year.	
	Children's glasses	No charge	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one pair of glasses per year.	
	Children's dental check-up	No charge	No charge. <u>Deductible</u> 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.)						
Abortion	Dental Care – Basic and Major (Children)	Private-duty nursing				
Acupuncture	Infertility treatment	 Routine eye care (Adult) 				
Bariatric surgery	Long-term care	Routine foot care				
Cosmetic surgery	Non-emergency care when traveling outside the	Weight loss programs				
Dental Care (Adult)	U.S.					
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)						
 Chiropractic care (35 visits per year, combined with <u>rehabilitation services</u>) 	Hearing aids (1 hearing aid in each ear every 3 years)					

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* For more information about limitations and exceptions, see the plan or policy document at https://www.christushealthplan.org/

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 https://www.hhsc.state.tx.us/medicaid. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>http://www.tdi.texas.gov/index.html</u>.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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)。

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: المعاند المعاقف رقم) 3025-282-282-1 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا المحوظة .

. (TTY: 1-800-735-2989) کجبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں :Urdu

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: پاسخ .هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر .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: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-282-3025 (TTY: 1-800-735-2989).

Hindi: हंद: सावधानी: यदि आप हिंदी बोलते हैं, तो आप मुफ्त भाषा सहायता सेवाओं से लाभ उठा सकते हैं। 1-844-282-3025 पर कॉल करें (टीटीवी: 1-800-735-2989)

Gujarati: જરાત: સાવધાન: જો તમે ગુજરાતી બોલતા હોવ તો, તમે મફત ભાષા સહાય સેવાઓમાંથી લાભ મેળવી શકો છો. 1-844-282-3025 પર કૉલ કરો (TTY: 1-800-735-2989)

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

\$0 \$0

\$0 0%

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

\$0

\$0 \$0

0%

hospital delivery)

The plan's overall deductible
Specialist copayment
Hospital (facility) copayment
Other coinsurance

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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

The plan's overall deductible
Specialist copayment
Hospital (facility) copayment
Other coinsurance
This EXAMPLE event includes convised like

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

Mia's Simple Fracture

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

The plan's overall deductible	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other coinsurance	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

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