Coverage for: Individual, Individual + Family | Plan Type: HMO

Texas Individual Silver Plus High-Deductible 73 - Two Free PCP Visits

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> ? | \$6,050/individual or \$12,100/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</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive 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-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$6,800/individual or \$13,600/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, balance-billing 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 provider</u> ? | Yes. See <u>https://www.christushealthplan.org/</u> <u>find-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 | 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 | \$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. |
| If you visit a health care | <u>Specialist</u> visit | \$35 <u>copayment</u> /visit; <u>deductible</u> does not apply. | Not covered | Including office services, other than those specifically shown below. |
| provider's office or clinic | Preventive care/screening/ immunization | 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) | X-ray: \$30 <u>copayment</u> /visit and <u>deductible</u> does not apply. 50% <u>coinsurance</u> for laboratory tests. | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$400 <u>copayment</u> /visit | 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. <u>Deductible</u> does not apply. | Not covered | |
| | Non-preferred generic drugs | \$5 <u>copayment</u> /prescription. <u>Deductible</u> does not apply. | Not covered | <u>Cost sharing</u> for a 90-day supply by mail order is triple the <u>cost sharing</u> for a standard |
| | Preferred brand drugs | \$60 copayment/prescription | Not covered | 30-day supply. Prescriptions for birth control are not subject to <u>deductible</u> , and do not |
| | Non-preferred brand drugs | \$95 copayment/prescription | Not covered | have a <u>copayment</u> . |
| | Specialty drugs | 45% <u>coinsurance</u> | Not covered | |

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

| | What You Will Pay | | Vill Pay | | |
|--|---|--|--|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. | |
| surgery | Physician/surgeon fees | 50% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. | |
| | Emergency room care | \$950 <u>copayment</u> /visit | \$950 <u>copayment</u> /visit | | |
| If you need immediate medical attention | Emergency medical transportation | 50% coinsurance | 50% coinsurance | None. | |
| | Urgent care | \$35 <u>copayment</u> /visit; <u>deductible</u> does not apply. | Not covered | | |
| lf you have a hospital | Facility fee (e.g., hospital room) | \$950 <u>copayment</u> /stay | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. | |
| stay | Physician/surgeon fees | No charge | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. | |
| lf you need mental health, behavioral health, or substance | Outpatient services | \$20 <u>copayment</u> /visit; <u>deductible</u> does not apply. | Not covered | Office visits are subject to the listed <u>cost</u> <u>sharing</u> , while facility outpatient treatments are subject to the outpatient facility <u>coinsurance</u> . | |
| abuse services | Inpatient services | \$950 <u>copayment</u> /stay | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. | |
| If you are pregnant | Office visits | \$35 <u>copayment</u> /visit; <u>deductible</u> 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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* 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 | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Childbirth/delivery professional services | No charge | Not covered | None. |
| | Childbirth/delivery facility services | \$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. |
| | Home health care | 50% 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 <u>copayment</u> /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. |
| If you need help recovering or have other | Habilitation services | \$30 <u>copayment</u> /visit | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| special health needs | Skilled nursing care | 50% 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 | 50% coinsurance | Not covered | Preauthorization is required for <u>durable</u> <u>medical equipment</u> over \$500. If you don't get <u>preauthorization</u> , benefits will be denied. |
| | Hospice services | 50% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |

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| | | What You Will Pay | | |
|--|----------------------------|--|--|---|
| Common Medical Event Services You May Need | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Children's eye exam | No charge. <u>Deductible</u> does not apply. | Not covered | Limited to one exam per year. |
| lf your child needs dental or eye care | Children's glasses | 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. <u>Deductible</u> does not apply. | Not covered | None. |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (C | Check your policy or <u>plan</u> document for more inform | nation and a list of any other <u>excluded services</u> .) |
|---|--|---|
| Abortion Acupuncture Bariatric surgery | Dental Care – Basic and Major (Children) Infertility treatment Long-term care | Private-duty nursingRoutine foot careWeight loss programs |
| Cosmetic surgery Other Covered Services (Limitations may apply to | Non-emergency care when traveling outside the U.S. o these services. This isn't a complete list. Please | |
| Chiropractic care (35 visits per year, combined with <u>rehabilitation services</u>) Dental Care (Adult – item and visit limits apply. \$1,000 annual benefit maximum) | Hearing aids (1 hearing aid in each ear every 3 years) | Routine eye care (Adult – 1 item and 1 visit per year. Up to \$130 per person for glasses or contacts.) |

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 <u>Health Insurance</u> Marketplace. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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>.

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

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: المعادة خدمات فإن اللغة، اذكر تتحدث كنت إذا علم المحان اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا ملحوظة : Arabic

. (TTY: 1-800-735-2989) کبردار: 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: જેરાત: 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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| The plan's overall deductible | \$6,050 |
|--------------------------------------|---------|
| Specialist copayment | \$35 |
| Hospital (facility) <u>copayment</u> | \$950 |
| Other coinsurance | 50% |

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 | \$6,050 | | |
| <u>Copayments</u> | \$800 | | |
| Coinsurance | \$0 | | |
| What isn't covered | | | |
| Limits or exclusions | \$60 | | |
| The total Peg would pay is | \$6,910 | | |

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

| The plan's overall deductible | \$6,050 |
|-----------------------------------|------------|
| Specialist copayment | \$35 |
| Hospital (facility) copayment | \$950 |
| Other <u>coinsurance</u> | 50% |
| This EXAMPLE overt includes servi | icae lika: |

 Inis 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: | |
| Cost Sharing | |
| <u>Deductibles</u> | \$1,200 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,220 |

Mia's Simple Fracture

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

| The <u>plan's</u> overall <u>deductible</u> | \$6,050 |
|---|---------|
| Specialist copayment | \$35 |
| Hospital (facility) copayment | \$950 |
| Other <u>coinsurance</u> | 50% |

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)

| Total Example Cost | \$2,800 |
|--------------------|---------|
|--------------------|---------|

| In this example, Mia would pay: | |
|---------------------------------|---------|
| Cost Sharing | |
| <u>Deductibles</u> | \$2,300 |
| <u>Copayments</u> | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,500 |

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.