CHRISTUS Health Plan: Texas Individual Platinum - Two Free PCP Visits

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

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?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$1,700/individual or \$3,400/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 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 <u>network provider</u> ?	Yes. See https://www.christushealthplan.org/find-a-provider or call 1-844-282-3025 for a list of network providers .	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 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 specialist you choose without a referral.

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	\$5 copayment/visit	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 provider's office or clinic	Specialist visit	\$20 copayment/visit	Not covered	Including office services, other than those specifically shown below.
provider's office of clinic	Preventive care/screening/ immunization	No charge	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	Not covered	None.
If you have a test	Imaging (CT/PET scans, MRIs)	\$100 copayment/visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need drugs to	Preferred generic drugs	No charge	Not covered	
treat your illness or condition More information about prescription drug coverage is available at http://www.express-scripts.com/CHRISTUSH ealthPlan	Non-preferred generic drugs	\$3 copayment/prescription	Not covered	Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard
	Preferred brand drugs	\$20 copayment/prescription	Not covered	30-day supply. Prescriptions for birth control are not subject to deductible, and do not
	Non-preferred brand drugs	45% coinsurance	Not covered	have a <u>copayment</u> .
	Specialty drugs	45% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.

^{*} 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	Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Emergency room care	\$950 copayment/visit	\$950 copayment/visit	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	<u>Urgent care</u>	\$20 copayment/visit	Not covered	
If you have a hospital	Facility fee (e.g., hospital room)	\$950 copayment/stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
stay	Physician/surgeon fees	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need mental health, behavioral health, or substance	Outpatient services	Office visit: \$20 copayment/visit Outpatient facility: 20% coinsurance	Not covered	Office visits are subject to the listed cost sharing, while facility outpatient treatments are subject to the outpatient facility coinsurance.
abuse services	Inpatient services	\$950 copayment/stay	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	\$20 <u>copayment</u> /visit	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).
	Childbirth/delivery professional services	No charge	Not covered	None.

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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
	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 preauthorization, benefits will be denied.
	Home health care	20% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 60 visits/calendar year.
	Rehabilitation services	\$20 <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	\$20 copayment/visit	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
special health needs	Skilled nursing care	\$20 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 25 visits/calendar year.
	Durable medical equipment	20% coinsurance	Not covered	Preauthorization is required for durable medical equipment over \$500. If you don't get preauthorization, benefits will be denied.
	Hospice services	20% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one exam per year.

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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 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 (Check your policy or plan document for more information and a list of any other excluded services.)

Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
 Acupuncture
 Bariatric surgery
 Cosmetic surgery
 Dental Care (Adult)
 Infertility treatment
 Long-term care
 Non-emergency care when traveling outside the U.S.
 Private-duty nursing (Except medically necessary or authorized by the PCP)
 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.)

Chiropractic care (35 visits per year, combined with rehabilitation services)
 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 https://www.hhsc.state.tx.us/medicaid. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Lealth Lealth

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 http://www.tdi.texas.gov/index.html.

^{*} For more information about limitations and exceptions, see the <u>plan</u> 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 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 (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.

. (1-800-735-2989) والبكم الصم هاتف رقم) 282-3025 1-844 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا علموظة :Arabic

. (TTY: 1-800-735-2989) الجبردار: 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: ياسخ عسنند شما دسترس در كنند، مي صحبت رايگان زبان، كمك خدمات فارسي، شما اگر .Persian اگر

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.

Peg is Having a Baby

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$950
Other coinsurance	20%

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:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$900	
Coinsurance	\$800	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$1,760	

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	\$20
Hospital (facility) copayment	\$950
■ Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> 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>	\$0	
Copayments	\$400	
Coinsurance	\$200	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$620	

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
Hospital (facility) copayment	\$950
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (*x-ray*)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$900	
Coinsurance	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,200	

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