

**CHRISTUS** : CHRISTUS Gold Plus HD Limited-2 Free PCP;\$10 PCP;\$35 SPE; \$0 Rx Ded:Adult vision.dental.fitness

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/member-resources/forms-documents/individual-and-family-plans/. 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; \$1,600/individual or \$3,200/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> – \$0. 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> ?	\$9,100/individual or \$18,200/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 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</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	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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 <u>referral</u> .
	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 usu have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	X-ray: \$20 <u>copayment</u> /visit; <u>deductible</u> does not apply Laboratory tests: 30% <u>coinsurance</u>	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
lf you have a test	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	Preferred generic drugs	No charge	No charge; <u>deductible</u> does not apply	Not covered	
treat your illness or condition More information about	Non-preferred generic drugs	No charge	\$4 <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 30-day
prescription drug coverage is available at	Preferred brand drugs	No charge	\$35 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	supply. Prescriptions for birth control are not subject to <u>deductible</u> , and do not have a
https://chppayment.chri stushealth.org/docume nts/hix/formulary/TXHIX	Non-preferred brand drugs	No charge	\$75 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	copayment. Cost sharing waived at non-IHCP with IHCP referral.
Formulary2023.pdf	Specialty drugs	No charge	45% <u>coinsurance;</u> <u>deductible</u> does not apply	Not covered	

		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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)	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% <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.
	Emergency room care	No charge	\$950 <u>copayment</u> /visit	\$950 copayment/visit	
If you need immediate medical attention	Emergency medical transportation	No charge	30% coinsurance	30% coinsurance	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	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.
stay	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	Office visit: \$20 <u>copayment</u> /visit; <u>deductible</u> does not apply Outpatient facility: 30% <u>coinsurance</u>	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> . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .

	What You Will Pay				
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out- of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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.
	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> .
	Childbirth/delivery professional services	No charge	No charge	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
lf 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	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 referral. Limited to 60 visits/calendar year.
recovering or have other special health needs	Rehabilitation 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. Limited to 35 visits/calendar year, combined with chiropractic care.

			What You Will Pay		
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out- of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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.
	Skilled nursing care	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. Limited to 25 days/calendar year.
	<u>Durable medical</u> equipment	No charge	30% <u>coinsurance</u>	Not covered	Preauthorization is required for some <u>durable</u> medical equipment. If you don't get preauthorization, benefits will be denied. <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP referral.
	Hospice services	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.
	Children's eye exam	No charge	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	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:** 

Se	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	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 foot care Weight loss programs		
Ot	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)					
•	<ul> <li>Chiropractic care (35 visits per year, combined with <u>rehabilitation services</u>)</li> <li>Dental care (Adult – item and visit limits apply. \$1,000 annual benefit maximum)</li> </ul>	Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device)		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 <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa">https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</a>; Texas Health and Human Services Commission at 1-800-252-8263 or <a href="https://hts.texas.gov/services/health/medicaid-chip">https://hts.texas.gov/services/health/medicaid-chip</a>. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="https://www.HealthCare.gov">Health Insurance Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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: 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? Not Applicable.

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: المحم الصم هاتف رقم) 3025-282-3025 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا علحوظة : 1-800-735-2989). Urdu: الردو بولتے ہيں، تو آپ كو زبان كى مدد كى خدمات مفت ميں دستياب ہيں - كال كريں :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).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne '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 .Persian

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	d a
hospital delivery)	

The plan's overall deductible	\$1,600
Specialist copayment	\$35
Hospital (facility) <u>copayment</u>	\$950
Other <u>coinsurance</u>	30%

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 wellcontrolled condition)

The plan's overall deductible	\$1,600
Specialist copayment	\$35
Hospital (facility) copayment	\$950
Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:Primary care physicianoffice visits (including<br/>disease education)Diagnostic tests(blood work)Prescription drugsDurable medical equipment (glucose meter)

In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$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	\$1,600
Specialist copayment	\$35
Hospital (facility) <u>copayment</u>	\$950
Other <u>coinsurance</u>	30%

### 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:

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.