




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 deductible? | \$1,600/individual or \$3,200/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. Preventive care and primary care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. Prescription drugs -- \$0 There are no other specific deductibles . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | \$9,450/individual or \$18,900/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 network provider? | Yes. See https://www.christushealthplan.org/find-a-provider or call 1-844-282-3025 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$10 copayment /visit; deductible does not apply | Not covered | No cost sharing for the first two primary care physician visits. |
| | Specialist visit | \$35 copayment /visit; deductible does not apply | Not covered | Including office services, other than those specifically shown below. |
| | Preventive care/screening/immunization | No charge; deductible does not apply | Not covered | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-ray: \$20 copayment /visit; deductible does not apply Laboratory tests: 30% coinsurance | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$200 copayment /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 https://chppayment.christushealth.org/document/s/hix/formulary/TXHIXFormulary2024.pdf | Preferred generic drugs | No charge; deductible does not apply | Not covered | Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply. Prescriptions for birth control are not subject to deductible , and do not have a copayment . |
| | Non-preferred generic drugs | \$4 copayment /prescription; deductible does not apply | Not covered | |
| | Preferred brand drugs | \$35 copayment /prescription; deductible does not apply | Not covered | |
| | Non-preferred brand drugs | \$75 copayment /prescription; deductible does not apply | Not covered | |
| | Specialty drugs | 45% coinsurance ; deductible does not apply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | \$950 copayment /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. |
| If you need help recovering or have other special health needs | Home health care | 30% 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 copayment /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. |
| | Habilitation services | \$30 copayment /visit | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| | Skilled nursing care | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 25 days/calendar year. |
| | Durable medical equipment | 30% coinsurance | Not covered | Preauthorization is required for some durable medical equipment . If you don't get preauthorization , benefits will be denied. |
| | Hospice services | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , benefits will be denied. |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible does not apply | Not covered | Limited to one exam per year. |
| | Children's glasses | No charge; deductible does not apply | Not covered | Limited to one pair of glasses per year. |
| | Children's dental check-up | No charge; deductible does not apply | Not covered | Limited to one cleaning and exam per six months. |

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 .) | | |
|---|---|---|
| <ul style="list-style-type: none">• Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Bariatric surgery• Cosmetic surgery | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing (Except medically necessary or authorized by the PCP)• 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.) | | |
|---|---|---|
| <ul style="list-style-type: none">• Chiropractic care (35 visits per year, combined with rehabilitation services)• Dental care (Adult – item and visit limits apply. \$1,000 annual benefit maximum) | <ul style="list-style-type: none">• Dental care – basic and major (Children)• 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 <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://hhs.texas.gov/services/health/medicaid-chip>. 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: 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? Not Applicable.

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 (TTY: 1-800-735-2989)。

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: ملحوظة: بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا: 1-844-282-3025 برقم اتصل (TTY: 1-800-735-2989).

Urdu: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-844-282-3025 (TTY: 1-800-735-2989).

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): Dineek'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: هشتمند شما دسترس در كنند، مي صحبت را يگان زبان، كمك خدمات فارسي، 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: ໄປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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 કોલ કરો (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.

Peg is Having a Baby

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------|---------|
| Deductibles | \$1,600 |
| Copayments | \$1,000 |
| Coinsurance | \$600 |

| <i>What isn't covered</i> | |
|-----------------------------------|----------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,260 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 30%

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|-------|
| Deductibles | \$900 |
| Copayments | \$700 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|-----------------------------------|----------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

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) [copayment](#) \$950
- Other [coinsurance](#) 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:

| <i>Cost Sharing</i> | |
|-----------------------------|---------|
| Deductibles | \$1,600 |
| Copayments | \$300 |
| Coinsurance | \$90 |

| <i>What isn't covered</i> | |
|-----------------------------------|----------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,990 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.