

CHRISTUS : CHRISTUS Gold + Dental & Vision + Fitness (\$0 Deductible, \$5 PCP, \$0 Generic Rx, \$0 Virtual Urgent Care) 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/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?	\$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 deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$9,200/individual or \$18,400/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.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** 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 <u>copayment</u> /visit	Not covered	None.
If you visit a health care provider's office or clinic	Specialist visit	\$60 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.
	Diagnostic test (x-ray, blood work)	\$60 copayment/visit	Not covered	None.
If you have a test	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	Preferred generic drugs	No charge	Not covered	Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard
condition More information about prescription drug	Non-preferred generic drugs	No charge	Not covered	30-day supply. Prescriptions for birth control are not subject to deductible, and do not
coverage is available at https://chppayment.chris	Preferred brand drugs	\$60 copayment/prescription	Not covered	have a <u>copayment</u> .
tushealth.org/document	Non-preferred brand drugs	\$80 copayment/prescription	Not covered	
s/hix/formulary/TXHIXFo rmulary2025.pdf	Specialty drugs	\$350 copayment/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fees	40% 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	
	Emergency room care	\$950 copayment/visit	\$950 copayment/visit		
If you need immediate medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	No charge for virtual urgent care through CHRISTUS Health System.	
	<u>Urgent care</u>	\$60 copayment/visit	Not covered		
If 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	<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: \$60 <u>copayment</u> /visit Outpatient facility: 40% <u>coinsurance</u>	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 <u>copayment</u> /stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Office visits	\$60 <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).	
If you are pregnant	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	

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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
				Cesarean section or (2) Post-Partum Care. If you don't get preauthorization, benefits will be denied.
	Home health care	40% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 60 visits/calendar year.
	Rehabilitation services	\$60 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.
If you need help recovering or have other	Habilitation services	\$60 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	40% 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	40% coinsurance	Not covered	<u>Preauthorization</u> is required for some <u>durable</u> <u>medical equipment</u> . If you don't get <u>preauthorization</u> , benefits will be denied.
	Hospice services	40% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Children's eye exam	No charge	Not covered	Limited to one exam per year.
If your child needs dental or eye care	Children's glasses	No charge	Not covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge	Not covered	Limited to one cleaning and exam per six months.

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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

- 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

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)
- Dental care (Adult item and visit limits apply.
 \$1,000 annual benefit maximum)
- 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 <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 http://www.tdi.texas.gov/index.html.

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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 (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 :ملحوظة :Arabic

.(735-2989-1-807: 1-802-3025). 844-282-3025 (TTY: 1-800-735-2989). المحتويات عند المحتويات المح

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 عدمات فارسی، شما اگر :Persian پاسخ هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما 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 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 <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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$950
■ Other coinsurance	40%

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 Evennela Cost

Total Example Cost	\$12,700		
In this example, Peg would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
Copayments	\$1,600		
Coinsurance	\$1,000		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$2,660		

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$950
■ Other <u>coinsurance</u>	40%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600		
In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
Copayments	\$1,100		
Coinsurance	\$300		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$1,420		

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$950
■ Other coinsurance	40%

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	\$500	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,400	

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