



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. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$9,200/individual or \$18,400/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
		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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$5 copayment /visit	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$60 copayment /visit	Not covered	Including office services, other than those specifically shown below. Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening/immunization	No charge	No charge	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)	No charge	\$60 copayment /visit	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET scans, MRIs)	No charge	\$400 copayment /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 treat your illness or condition More information about prescription drug coverage is available at https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2025.pdf	Preferred generic drugs	No charge	No charge	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 . Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred generic drugs	No charge	No charge	Not covered	
	Preferred brand drugs	No charge	\$60 copayment /prescription	Not covered	
	Non-preferred brand drugs	No charge	\$80 copayment /prescription	Not covered	
	Specialty drugs	No charge	\$350 copayment /prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% 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 .
	Physician/surgeon fees	No charge	40% 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 .
If you need immediate medical attention	Emergency room care	No charge	\$950 copayment /visit	\$950 copayment /visit	No charge for virtual urgent care through CHRISTUS Health System. Cost sharing waived at non-IHCP with IHCP referral .
	Emergency medical transportation	No charge	40% coinsurance	40% coinsurance	
	Urgent care	No charge	\$60 copayment /visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$950 copayment /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 .
	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: \$60 copayment /visit Outpatient facility: 40% coinsurance	Not covered	Office visits are subject to the listed cost sharing , while facility outpatient treatments are subject to the outpatient facility coinsurance . Cost sharing waived at non-IHCP with IHCP referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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)	
	Inpatient services	No charge	\$950 copayment /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 .
If you are pregnant	Office visits	No charge	\$60 copayment /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). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	No charge	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery facility services	No charge	\$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. Cost sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No charge	40% 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 60 visits/calendar year.
	Rehabilitation services	No charge	\$60 copayment /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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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)	
	Habilitation services	No charge	\$60 copayment /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	40% 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.
	Durable medical equipment	No charge	40% coinsurance	Not covered	Preauthorization is required for some durable medical equipment . If you don't get preauthorization , benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	40% 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 .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Limited to one exam per year.
	Children's glasses	No charge	No charge	Not covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge	No charge	Not covered	Limited to one cleaning and exam per six months.

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, kwijigo 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: شما اگر خدمات فارسی، کمک رایگان زبان، می صحبت رایگان زبان، هستند شما دسترس در کنند، پاسخ 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: ຖ້າ ທ່ານ ກວາດພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

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

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

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

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

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.