




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 <a href="#">deductible</a> ?                                | \$4,000/individual or \$8,000/family  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. <a href="#">Prescription drugs</a> -- \$850/individual or \$1,700/family. There are no other specific <a href="#">deductibles</a> .  | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$7,350/individual or \$14,700/family   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.christushealthplan.org/find-a-provider">https://www.christushealthplan.org/find-a-provider</a> or call 1-844-282-3025 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness       | \$5 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply         | Not covered  | None.   |
|   | <a href="#">Specialist</a> visit                       | \$60 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply        | Not covered  | Including office services, other than those specifically shown below.   |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply                                    | Not covered  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply        | Not covered  | None.   |
|   | Imaging (CT/PET scans, MRIs)                           | \$400 <a href="#">copayment</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2025.pdf">https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2025.pdf</a> | Preferred generic drugs                                | No charge; <a href="#">deductible</a> does not apply                                    | Not covered  | <a href="#">Cost sharing</a> for a 90-day supply by mail order is triple the <a href="#">cost sharing</a> for a standard 30-day supply. Prescriptions for birth control are not subject to <a href="#">deductible</a> , and do not have a <a href="#">copayment</a> . |
|   | Non-preferred generic drugs                            | \$20 <a href="#">copayment</a> /prescription; <a href="#">deductible</a> does not apply | Not covered  |   |
|   | Preferred brand drugs                                  | \$50 <a href="#">copayment</a> /prescription  | Not covered  |   |
|   | Non-preferred brand drugs                              | \$100 <a href="#">copayment</a> /prescription   | Not covered  |   |
|   | <a href="#">Specialty drugs</a>                        | \$500 <a href="#">copayment</a> /prescription   | Not covered  |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)         | 50% <a href="#">coinsurance</a>   | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.  |
|   | Physician/surgeon fees                                 | 50% <a href="#">coinsurance</a>   | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.  |
| If you need immediate   | <a href="#">Emergency room care</a>                    | \$950 <a href="#">copayment</a> /visit  | \$950  | No charge for virtual urgent care through   |

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| medical attention   |  |  | <a href="#">copayment</a> /visit                   | CHRISTUS Health System.  |
|   | <a href="#">Emergency medical transportation</a> | 50% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
|   | <a href="#">Urgent care</a>                      | \$60 <a href="#">copayment</a> /visit;<br><a href="#">deductible</a> does not apply  | Not covered  |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | \$950 <a href="#">copayment</a> /stay  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.   |
|   | Physician/surgeon fees                           | No charge  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office visit: \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply<br>Outpatient facility: 50% <a href="#">coinsurance</a> | Not covered  | Office visits are subject to the listed <a href="#">cost sharing</a> , while facility outpatient treatments are subject to the outpatient facility <a href="#">coinsurance</a> .       |
|   | Inpatient services                               | \$950 <a href="#">copayment</a> /stay  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.   |
| If you are pregnant   | Office visits                                    | \$60 <a href="#">copayment</a> /visit;<br><a href="#">deductible</a> does not apply  | Not covered  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services        | No charge  | Not covered  | None.  |
|   | Childbirth/delivery facility services            | \$950 <a href="#">copayment</a> /stay  | Not covered  | <a href="#">Preauthorization</a> is required for inpatient care, except for: (1) forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery                  |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most) |   |
|   |   |  |  | or ninety-six (96) hours of Inpatient care following an uncomplicated Cesarean section or (2) Post-Partum Care. If you don't get <a href="#">preauthorization</a> , benefits will be denied.    |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 50% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 60 visits/calendar year.                                  |
|   | <a href="#">Rehabilitation services</a>   | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 35 visits/calendar year, combined with chiropractic care. |
|   | <a href="#">Habilitation services</a>     | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.  |
|   | <a href="#">Skilled nursing care</a>      | 50% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Limited to 25 days/calendar year.                                    |
|   | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> is required for some <a href="#">durable medical equipment</a> . If you don't get <a href="#">preauthorization</a> , benefits will be denied.                  |
|   | <a href="#">Hospice services</a>          | 50% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply                             | Not covered  | Limited to one exam per year.   |
|   | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply                             | Not covered  | Limited to one pair of glasses per year.  |
|   | Children's dental check-up                | No charge; <a href="#">deductible</a> does not apply                             | Not covered  | Limited to one cleaning and exam per six months.  |

## Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                       |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>• Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing (Except medically necessary or authorized by the PCP)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>• Chiropractic care (35 visits per year, combined with <a href="#">rehabilitation services</a>)</li><li>• Dental care (Adult – item and visit limits apply. \$1,000 annual benefit maximum)</li></ul> | <ul style="list-style-type: none"><li>• Dental care – basic and major (Children)</li><li>• Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device)</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult – 1 item and 1 visit per year. Up to \$130 per person for glasses or contacts.)</li></ul> |

**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](http://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](#).



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](#) \$4,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$1,500        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,560</b> |

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,600        |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,520</b> |

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$60
- Hospital (facility) [copayment](#) \$950
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

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