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.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a 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 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	Not covered	Including office services, other than those specifically shown below.
	Specialist visit	No charge	Not covered	Including office services, other than those specifically shown below.
	Preventive care/screening/ immunization	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	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge	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/documents/hix/formulary/TXHIXFormulary2026.pdf**	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 30-day supply. Prescriptions for birth control are not subject to deductible, and do not have a copayment. Preauthorization is needed for certain prescription drugs and intravenous infusions.
	Non-preferred generic drugs	No charge	Not covered	
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	
	Specialty drugs	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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 immediate medical attention	Emergency room care	No charge	No charge	No charge for virtual urgent care through CHRISTUS Health System.
	Emergency medical transportation	No charge	No charge	
	Urgent care	No charge	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
	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: No charge Outpatient facility: No charge	Not covered	Office visits are subject to the listed cost sharing, while facility outpatient treatments are subject to the outpatient facility coinsurance.
	Inpatient services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you are pregnant	Office visits	No charge	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.
	Childbirth/delivery facility services	No charge	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	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 60 visits/calendar year.
	Rehabilitation services	No charge	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	No charge	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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
	Skilled nursing care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Limited to 25 days/calendar year.
	Durable medical equipment	No charge	Not covered	Preauthorization is required for some durable medical equipment. If you don't get preauthorization, benefits will be denied.
	Hospice services	No charge	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	Not covered	Limited to one exam per year.
	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.

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)	• 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 (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: ملحوظة: إذا كنت تتحدث اذكر، فإن اللغوية المساعدة خدمات تتوافر لك بالمجان. برقم اتصل 1-844-282-3025 (رقم هاتف الصم والبكم: 1-800-735-2989).

Urdu: خبردار: 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): 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 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: ຖ້າວ່າທ່ານເວົ້າພາສາ 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 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) coinsurance** **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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) coinsurance** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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) coinsurance** **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**

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**

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