



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 ?	\$7,500/individual or \$15,000/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 is 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

 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	\$50 copayment /visit; deductible does not apply	Not covered	Telemedicine and telehealth services have the same cost sharing .
	Specialist visit	\$100 copayment /visit; deductible does not apply	Not covered	Including office services, other than those specifically shown below. Telemedicine and telehealth services have the same cost sharing .
	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)	50% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	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/TXHIXFormulary2027.pdf	Preferred generic drugs	\$25 copayment /prescription; 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 . Preauthorization is needed for certain prescription drugs and intravenous infusions.
	Non-preferred generic drugs	\$25 copayment /prescription; deductible does not apply	Not covered	

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 have outpatient surgery	Physician/surgeon fees	50% 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	50% coinsurance	50% coinsurance	No charge for virtual urgent care through CHRISTUS Health System.
	Emergency medical transportation	50% coinsurance	50% coinsurance	
	Urgent care	\$75 copayment /visit; deductible does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Physician/surgeon fees	50% coinsurance	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: \$50 copayment /visit; deductible does not apply Outpatient facility: 50% 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	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
If you are pregnant	Office visits	\$100 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	50% coinsurance	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	50% coinsurance	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	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied. Limited to 60 visits/calendar year.
	Rehabilitation services	\$50 copayment /visit; deductible does not apply	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	\$50 copayment /visit; deductible does not apply	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	Skilled nursing care	50% 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	50% coinsurance	Not covered	Preauthorization is required for some durable medical equipment . If you don't get preauthorization , benefits will be denied.
	Hospice services	50% 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)	
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](#).)

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| • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult) | • Private-duty nursing (Except medically necessary or authorized by the PCP) |
| • Acupuncture | • Infertility treatment | • Routine eye care (Adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| • Chiropractic care (35 visits per year, combined with rehabilitation services) | • Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device) |
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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>.

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	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$7,500
Copayments	\$10
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$10,070

Managing Joe's Type 2 Diabetes