



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> ?                                | \$0             | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                               |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.            | 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. |
| Are there other <a href="#">deductibles</a> for specific services?              | No.             | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                             |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Not Applicable. | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                      |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not Applicable. | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                      |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Not Applicable. | This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .                                                      |
| 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> .                                                                                                            |

| Common Medical Event                                                                                                                                                                                                                                                                                                                     | Services You May Need                                  | What You Will Pay                                              |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                          |                                                        | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                                                                                                                            | Primary care visit to treat an injury or illness       | No charge                                                      | Not covered                                  | Including office services, other than those specifically shown below.<br><br>Telemedicine and telehealth services have the same <a href="#">cost sharing</a> .                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                       | No charge                                                      | Not covered                                  | Including office services, other than those specifically shown below.<br><br>Telemedicine and telehealth services have the same <a href="#">cost sharing</a> .                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                          | <a href="#">Preventive care/screening/immunization</a> | No charge                                                      | 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.                                                                                                                                                                                                  |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                                                | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                      | Not covered                                  | None.                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                           | No charge                                                      | Not covered                                  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2027.pdf">https://chppayment.christushealth.org/documents/hix/formulary/TXHIXFormulary2027.pdf</a> | Preferred generic drugs                                | No charge                                                      | 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> . <a href="#">Preauthorization</a> is needed for certain <a href="#">prescription drugs</a> 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                                  |                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                        | No charge                                                      | Not covered                                  |                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center)         | No charge                                                      | 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                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                              |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           |                                                  |                                                                |                                              | <a href="#">preauthorization</a> , benefits will be denied.                                                                                                                                                                                                                                                                                                        |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                      | No charge                                    | No charge for virtual urgent care through CHRISTUS Health System.                                                                                                                                                                                                                                                                                                  |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                      | Not covered                                  |                                                                                                                                                                                                                                                                                                                                                                    |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                      | 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: No charge<br>Outpatient facility: No charge      | 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                               | 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 are pregnant                                                       | Office visits                                    | No charge                                                      | 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            | No charge                                                      | 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 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. |
| If you need help recovering or have other                                 | <a href="#">Home health care</a>                 | No charge                                                      | Not covered                                  | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                 |
| <b>special health needs</b>                   |                                           |                                                                |                                              | Limited to 60 visits/calendar year.                                                                                                                                                             |
|                                               | <a href="#">Rehabilitation services</a>   | No charge                                                      | 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>     | No charge                                                      | 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>      | No charge                                                      | 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> | No charge                                                      | 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>          | No charge                                                      | 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                                                      | 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](#).)

- |                                                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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>• Dental care (Adult)</li> <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 eye care (Adult)</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 [plan](#) document.)

- 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)

**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](#).

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

Urdu: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں: (TTY: 1-800-735-2989) 1-844-282-3025 خبردار:

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: 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: ໄປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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)

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

In this example, Peg would pay:

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

### Managing Joe's Type 2 Diabetes

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

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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)

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

In this example, Joe would pay:

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

### Mia's Simple Fracture

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

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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)

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

In this example, Mia would pay:

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

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