




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/>. 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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$0 at IHCP or with IHCP <a href="#">referral</a> at non-IHCP; \$7,100/individual or \$14,200/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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> . No <a href="#">cost sharing</a> for the first two <a href="#">primary care physician</a> visits.	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="http://www.healthcare.gov/coverage/preventive-care-benefits/">http://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,150/individual or \$16,300/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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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="#">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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		Your Cost if You Use an Indian Health Care Provider IHCP	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	No Charge	\$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.	Not Covered	No <a href="#">cost sharing</a> for the first two <a href="#">primary care physician</a> visits.
	<a href="#">Specialist</a> visit	No Charge	\$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	No charge. <a href="#">Deductible</a> does not apply.	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)	No Charge	50% <a href="#">coinsurance</a>	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	No Charge	\$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 More information about <a href="#">Prescription drug coverage</a> is available at <a href="http://www.christushealthplan.org">www.christushealthplan.org</a>	Preferred generic drugs	No Charge	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. <a href="#">Cost sharing</a> for <a href="#">specialty drugs</a> is limited to \$150 per prescription 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	No Charge	\$25 <a href="#">copayment</a> /prescription. <a href="#">Deductible</a> does not apply.	Not Covered	
	Preferred brand drugs	No Charge	\$100 <a href="#">copayment</a>	Not Covered	
	Non-preferred brand drugs	No Charge	50% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	No Charge	50% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	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.

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.christushealthplan.org/>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You Use an Indian Health Care Provider IHCP	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	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 medical attention	<a href="#">Emergency room care</a>	No Charge	\$950 <a href="#">copayment</a>	\$950 <a href="#">copayment</a>	None.
	<a href="#">Emergency medical transportation</a>	No Charge	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	No Charge	\$60 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$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	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	No Charge	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.	Not Covered	MH/SUD office visits are subject to the listed cost sharing, while MH/SUD facility outpatient treatments are subject to the outpatient facility coinsurance. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be denied.
	Inpatient services	No Charge	\$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	No Charge	\$60 <a href="#">copayment</a> /visit; <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	No Charge	Not Covered	None.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You Use an Indian Health Care Provider IHCP	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No Charge	\$950 <a href="#">copayment</a>	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 special health needs	<a href="#">Home health care</a>	No Charge	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.
	<a href="#">Rehabilitation services</a>	No Charge	\$60 <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.
	<a href="#">Habilitation services</a>	No Charge	\$60 <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.
	<a href="#">Skilled nursing care</a>	No Charge	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.
	<a href="#">Durable medical equipment</a>	No Charge	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.
	<a href="#">Hospice services</a>	No Charge	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 your child needs dental or eye care	Children's eye exam	No Charge	No charge. <a href="#">Deductible</a> does not apply	Not Covered	Limited to one exam per year.
	Children's glasses	No Charge	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	No charge. <a href="#">Deductible</a> does not apply	Not Covered	Limited to one visit per 6 months.

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### 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</li><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li><li>• Dental Care – Basic and Major (Adults)</li><li>• Dental Care – Basic and Major (Children)</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 United States</li><li>• Orthodontia</li><li>• Routine dental services (Adults)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care for adults</li><li>• Routine foot care for diabetic members</li><li>• Treatment for temporomandibular joint disorders</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</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (1 hearing aid in each ear every 3 years)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</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>; Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 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: CHRISTUS Health Plan Customer Service at 1-844-282-3025 or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

### Does this [plan](#) provide [Minimum Essential Coverage](#)? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this [plan](#) meet the [Minimum Value Standards](#)? **Yes**

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 (TTY: 1-800-735-2989)。

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

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

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).

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: هاستند شما دسترس در كنند، می صحبت رایگان زبان، كمك خدمات فارسی، شما اگر 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: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ຄຸມ' ນມ' ອມໃຫ້ທ່ານ. 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](#) \$7,100
- [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>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$7,100
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or Exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,260</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$7,100
- [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>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or Exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$6,360</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$7,100
- [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>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or Exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>