

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:
What is the overall <u>deductible</u> ?	\$125/individual or \$250/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> . No <u>cost</u> <u>sharing</u> for the first two <u>primary</u> <u>care physician</u> visits.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$600/individual or \$1,200/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>https://www.christushealthplan.org/</u> <u>find-a-provider</u> or call 1-844-282- 3025 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance</u> <u>billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$5 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	No <u>cost sharing</u> for the first two <u>primary care</u> <u>physician</u> visits.
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	Including office services, other than those specifically shown below.
	Preventive care/screening/ immunization	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
lf you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$30 <u>copayment</u> /visit and <u>deductible</u> does not apply. 30% <u>coinsurance</u> for laboratory tests.	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$400 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need drugs to	Preferred generic drugs	No charge. <u>Deductible</u> does not apply.	Not covered	Cost sharing for a 90-day supply by mail
treat your illness or condition More information about <u>prescription drug</u> <u>coverage</u> is available at <u>www.christushealthplan.</u> org	Non-preferred generic drugs	\$5 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	Not covered	order is triple the <u>cost sharing</u> for a standard 30-day supply. <u>Cost sharing</u> for <u>specialty</u>
	Preferred brand drugs	\$60 copayment/prescription	Not covered	drugs is limited to \$150 per prescription for a standard 30-day supply. Prescriptions for
	Non-preferred brand drugs	\$95 copayment/prescription	Not covered	birth control are not subject to <u>deductible</u> , and do not have a copayment.
	Specialty drugs	45% coinsurance	Not covered	

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		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
surgery	Physician/surgeon fees	30% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Emergency room care	\$600 <u>copayment</u> /visit	\$600 <u>copayment</u> /visit	
If you need immediate medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	None.
medical attention	Urgent care	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	
If you have a hospital	Facility fee (e.g., hospital room)	\$600 <u>copayment</u> /stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
stay	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	\$30 <u>copayment</u> /visit; <u>deductible</u> 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. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Inpatient services	\$600 <u>copayment</u> /stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
lf you are pregnant	Office visits	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply.	Not covered	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None.

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		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	\$600 <u>copayment</u> /stay	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 <u>preauthorization</u> , benefits will be denied.
	Home health care	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need help recovering or have other special health needs	Rehabilitation services	\$30 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Habilitation services	\$30 <u>copayment</u> /visit	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Skilled nursing care	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Hospice services	30% <u>coinsurance</u>	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. <u>Deductible</u> does not apply.	Not covered	Limited to one exam per year.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one visit per 6 months.

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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	Dental Care – Basic and Major (Children) Orthodontia		
Acupuncture	Infertility Treatment Routine eye care for adults		
Bariatric Surgery	Long-term Care Routine foot care for diabetic members		
Cosmetic Surgery	Non-emergency care when traveling outside the Treatment for temporomandibular joint disorders		
Dental Care (Adult)	United States		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
Chiropractic care	 Hearing aids (1 hearing aid in each ear every 3 Private-duty nursing 		
	years)		

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. For more information about the Marketplace. For more information about the Marketplace. Poc. Box of the second second

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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.

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? 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: CHÚÝ: 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: والبكم الصم هاتف رقم) 2025-282-3021 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا ملحوظة : 1-800-735-2989). CHPLA21SL9

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

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).

. (TTY: 1-800-735-2989) پاسخ هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر Persian:

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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$125
Specialist copayment	\$35
Hospital (facility) copayment	\$600
Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$100	
Copayments	\$0	
<u>Coinsurance</u>	\$500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$660	

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

The plan's overall deductible	\$125
Specialist copayment	\$35
Hospital (facility) copayment	\$600
Other coinsurance	30%

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		
<u>Deductibles</u>	\$100	
Copayments	\$400	
Coinsurance	\$100	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$620	

Mia's Simple Fracture

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

The plan's overall deductible	\$125
Specialist copayment	\$35
Hospital (facility) copayment	\$600
Other coinsurance	30%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$500

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.