

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,250/individual or \$2,500/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> .	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 deductibles 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> ?	\$6,950/individual or \$13,900/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	50% coinsurance	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	<u>Specialist</u> visit	50% coinsurance	Not covered	Including office services, other than those specifically shown below.
provider's office or clinic	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.
16	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	None.
If you have a test	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	Preferred generic drugs	50% <u>coinsurance</u>	Not covered	Cost sharing for a 90-day supply by mail order
condition More information about prescription drug	Non-preferred generic drugs	50% coinsurance	Not covered	<ul> <li>is triple the <u>cost sharing</u> for a standard 30-day supply. <u>Cost sharing</u> for <u>specialty drugs</u> is</li> <li>limited to \$150 per prescription for a standard</li> </ul>
coverage is available at	Preferred brand drugs	50% coinsurance	Not covered	30-day supply. Prescriptions for birth control
http://www.express- scripts.com/CHRISTUSH	Non-preferred brand drugs	50% <u>coinsurance</u>	Not covered	are not subject to <u>deductible</u> , and do not have a <u>copayment</u> .
ealthPlan	Specialty drugs	50% <u>coinsurance</u>	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
surgery	Physician/surgeon fees   50% coinsurance   Not cove		Not covered	Preauthorization is required. If you don't get preauthorization, 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/

		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 need immediate medical attention	Emergency room care Emergency medical transportation	50% <u>coinsurance</u> 50% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	None.
	Urgent care	50% coinsurance	Not covered	
lf you have a hospital	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
stay	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need mental health, behavioral health, or substance	Outpatient services	Office visit: 50% <u>coinsurance</u> Outpatient facility: 50% <u>coinsurance</u>	Not covered	Office visits are subject to the listed <u>cost</u> <u>sharing</u> , while facility outpatient treatments are subject to the outpatient facility <u>coinsurance</u> .
abuse services	Inpatient services	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Office visits	50% coinsurance	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% <u>coinsurance</u>	Not covered	None.
lf you are pregnant	Childbirth/delivery facility services	50% <u>coinsurance</u>	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.

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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	
	Home health care	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Rehabilitation services	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
lf you need help	Habilitation services	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
recovering or have other special health needs	Skilled nursing care	50% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Durable medical equipment	50% coinsurance	Not covered	Preauthorization is required for some <u>durable</u> 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.	
	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Not covered	Limited to one exam per year.	
If your child needs dental or eye care	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.	

# 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> <li>Abortion (Except in cases of rape, incest, or</li> </ul>	Dental Care – Basic and Major (Children, ex	xcept •	Orthodontia	
when the life of the mother is endangered)	dental checkup with <u>network providers</u> )	•	Routine eye care for adults	
Acupuncture	Infertility Treatment	•	Routine foot care for diabetic members	
Bariatric Surgery	Long-term Care	•	Treatment for temporomandibular joint disorders	
Cosmetic Surgery	Non-emergency care when traveling outside	e the •	Weight Loss Programs	
Dental Care (Adult)	United States			

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)					
Chiropractic care	•	Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device)	•	Private-duty nursing	

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 <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa">https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</a>; 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 <a href="https://www.HealthCare.gov">Health Insurance Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>. The contact information about the <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa">https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</a>; 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 <a href="https://www.HealthCare.gov">Health Insurance Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>. Area to the second to the 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; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>; 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.

. (1-200-735-2989) والبكم الصم هاتف رقم) 2025-282-1844 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا علحوظة : Arabic

. (TTY: 1-800-735-2989). اکبردار: 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).

Persian: پاسخ هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر (Persian: بال که ک خدمات فارسی، شما اگر (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: 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 plan's overall deductible	\$1,250
Specialist coinsurance	50%
Hospital (facility) <u>coinsurance</u>	50%
Other <u>coinsurance</u>	50%

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	\$1,250
<u>Copayments</u>	\$0
Coinsurance	\$5,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,010

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

The plan's overall deductible	\$1,250
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other <u>coinsurance</u>	50%
This FXAMPI F event includes servi	ces like:

 Inis EXAMPLE event includes services like:

 Primary care physician
 office visits (including disease education)

 Diagnostic tests (blood work)

 Prescription drugs

 Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$1,250
Copayments	\$0
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,270

# Mia's Simple Fracture

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

<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li>Specialist coinsurance</li> </ul>	\$1,250 50%
Hospital (facility) coinsurance	50%
Other <u>coinsurance</u>	50%

## This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,250
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,050

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