



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> ?	\$8,200/individual or \$16,400/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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <a href="#">Prescription drugs</a> -- \$850/individual or \$1,700/family There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,200/individual or \$18,400/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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="#">network 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.
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> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$5 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None.
	<a href="#">Specialist</a> visit	\$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; <a href="#">deductible</a> does not apply	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)	\$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$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.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://chppayment.christushealth.org/documents/hix/formulary/LAHIXFormulary2025.pdf">https://chppayment.christushealth.org/documents/hix/formulary/LAHIXFormulary2025.pdf</a>	Preferred generic drugs	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. 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	\$20 <a href="#">copayment</a> /prescription; <a href="#">deductible</a> does not apply	Not covered	
	Preferred brand drugs	\$50 <a href="#">copayment</a> /prescription	Not covered	
	Non-preferred brand drugs	\$100 <a href="#">copayment</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	\$150 <a href="#">copayment</a> /prescription; <a href="#">deductible</a> does not apply	Not covered	

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.christushealthplan.org/member-resources/forms-documents/individual-and-family-plans/>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	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.
	Physician/surgeon fees	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>	\$950 <a href="#">copayment</a> /visit	\$950 <a href="#">copayment</a> /visit	No charge for virtual urgent care through CHRISTUS Health System.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$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)	\$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	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: \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply Outpatient facility: 50% <a href="#">coinsurance</a>	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	\$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	\$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	Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	\$950 <a href="#">copayment</a> /stay	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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>	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	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>	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	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>	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>	50% <a href="#">coinsurance</a>	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>	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.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to one exam per year.
	Children's glasses	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; <a href="#">deductible</a> does not apply	Not covered	Limited to one cleaning and exam per six months.

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.christushealthplan.org/member-resources/forms-documents/individual-and-family-plans/>

## 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 (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>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the United States</li></ul>	<ul style="list-style-type: none"><li>• Orthodontia</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><li>• Dental care (Adult – item and visit limits apply. \$1,000 annual benefit maximum)</li><li>• Dental care – basic and major (Children)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (1 hearing aid in each ear every 3 years limited to \$2,000 benefit maximum per device)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult - 1 item and 1 visit per year. Up to \$130 per person for glasses or contacts.)</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 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: 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); 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? 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 (TTY: 1-800-735-2989)。

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

Urdu: كمال کریں۔ کال کریں۔ (TTY: 1-800-735-2989) 1-844-282-3025 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).

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: شما اگر می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر پاسخ. هستند شما دسترس در کنند، 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: ຖ້າ ວ່າ ທ່ານ ແມ່ນ ພາສາ ລາວ, ການ ບໍລິການ ວ່າ ຍ່າ ອັດ ທ່ານ ພາສາ, ໂດຍ ບໍ່ ເສັ້ນ ຄ່າ, ແມ່ນ ມີ ອິບ ທ່ານ. 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](#) \$8,200
- [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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$8,200
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$9,260</b>
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**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$8,200
- [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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$2,520</b>
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**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$8,200
- [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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,500</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.