



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 deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$7,650/individual or \$15,300/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care service is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$7,650/individual or \$15,300/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 network provider?	Yes. See https://www.christushealthplan.org/find-a-provider or call 1-844-282-3025 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	on-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	Not covered	None. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Specialist</u> visit	No charge	No charge	Not covered	Including office services, other than those specifically shown below. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Preventive care/screening/immunization</u>	No charge	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://chppayment.christushealth.org/documents/hix/formulary/LAHIX/Formulary2026.pdf	Preferred generic drugs	No charge	No charge	Not covered	<u>Cost sharing</u> for a 90-day supply by mail order is triple the <u>cost sharing</u> for a standard 30-day supply. <u>Cost sharing</u> for <u>specialty drugs</u> is limited to \$150 per prescription for a standard 30-day supply. Prescriptions for birth control are not subject to <u>deductible</u> , and do not have a <u>copayment</u> . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Non-preferred generic drugs	No charge	No charge	Not covered	
	Preferred brand drugs	No charge	No charge	Not covered	
	Non-preferred brand drugs	No charge	No charge	Not covered	
	<u>Specialty drugs</u>	No charge	No charge	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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	on-IHCP Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Physician/surgeon fees	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If you need immediate medical attention	<u>Emergency room care</u>	No charge	No charge	No charge	No charge for virtual urgent care through CHRISTUS Health System. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	
	<u>Urgent care</u>	No charge	No charge	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Physician/surgeon fees	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office visit: No charge Outpatient facility: No charge	Not covered	Office visits are subject to the listed <u>cost sharing</u> , while facility outpatient treatments are subject to the outpatient facility <u>coinsurance</u> . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	on-IHCP Out-of-Network Provider (You will pay the most)	
	Inpatient services	No charge	No charge	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	No charge	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). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	No charge	Not covered	Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery facility services	No charge	No charge	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 preauthorization , benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	No charge	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied. Cost sharing waived at non-IHCP with IHCP referral .

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	on-IHCP Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	<u>Skilled nursing care</u>	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	<u>Durable medical equipment</u>	No charge	No charge	Not covered	<u>Preauthorization</u> is required for some <u>durable medical equipment</u> . If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	<u>Hospice services</u>	No charge	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No charge	No charge; <u>deductible</u> does not apply	Not covered	Limited to one exam per year.
	Children's glasses	No charge	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	No charge; <u>deductible</u> does not apply	Not covered	Limited to one cleaning and exam per six months.

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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.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Orthodontia
- Routine eye care (Adult)
- Routine foot care for diabetic members
- Treatment for temporomandibular joint disorders
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care – basic and major (Children)
- 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 <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 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; 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 (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: ملحوظة إذا كنت تتحدث فإن اللغة المساعدة المتوفرة لك بالمجان باتصال رقم 3025-282-844-1 (رقم هاتفكم) 2989-735-800-1.

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

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, kwijjigo 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: اگر شما خدمات فارسی، یا چیزی دیگری می‌خواهید که در اینجا درست نمایند، می‌توانید اینجا ۱-۸۰۰-۷۳۵-۲۹۸۹ (TTY: ۱-۸۰۰-۷۳۵-۲۹۸۹) یا ۱-۸۴۴-۲۸۲-۳۰۲۵ (TTY: ۱-۸۰۰-۷۳۵-۲۹۸۹) پاسخ بخواهید.

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 (телефон: 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。

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: જારાત: 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	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

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

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.