

 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:
<u>What is the overall deductible?</u>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<u>Are there services covered before you meet your deductible?</u>	Yes.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<u>What is not included in the out-of-pocket limit?</u>	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<u>Will you pay less if you use a network provider?</u>	Yes. See https://www.christushealthplan.org/find-a-provider 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 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.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 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	Not covered	Including office services, other than those specifically shown below.
	<u>Specialist</u> visit	No charge	Not covered	Including office services, other than those specifically shown below.
	<u>Preventive care/screening/immunization</u>	No charge	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	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<u>Preadmission</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
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/LAHIXFormulary2026.pdf	Preferred generic drugs	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. Prescriptions for birth control are not subject to <u>deductible</u> , and do not have a <u>copayment</u> .
	Non-preferred generic drugs	No charge	Not covered	
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	
	<u>Specialty drugs</u>	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Preadmission</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Physician/surgeon fees	No charge	Not covered	<u>Preadmission</u> is required. If you don't get <u>preauthorization</u> , 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/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 Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge for virtual urgent care through CHRISTUS Health System.
	Emergency medical transportation	No charge	No charge	
	Urgent care	No charge	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
	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	Office visit: No charge Outpatient facility: No charge	Not covered	Office visits are subject to the listed cost sharing , while facility outpatient treatments are subject to the outpatient facility coinsurance .
	Inpatient services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization , benefits will be denied.
If you are pregnant	Office visits	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).
	Childbirth/delivery professional services	No charge	Not covered	None.
	Childbirth/delivery facility services	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.

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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 Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Rehabilitation services</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Habilitation services</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	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>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per year.
	Children's glasses	No charge	Not covered	Limited to one pair of glasses per year.
	Children's dental check-up	No charge	Not covered	Limited to one cleaning and exam per six 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.)

- 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: 1-800-735-2989. إذاً كنت تتحدث كنت إذاً (ملحوظة: رقم هاتف الصم لكم) 3025-282-844-1.

Urdu: 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۔ کال کریں۔

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: 1-844-282-3025 (TTY: 1-800-735-2989). هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر:

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。

Laotian: ໂປ່ນຊັບ: ຖໍ່ ອົງ ' ອ ກ ' ກົມເວ ແກ້ວມາວົວ, ການບໍ່ ລໍາ ການຊ່ວຍເຫຼືອ ແລ້ວ ທົດ ກົມມາວົວ, ໂດຍບໍ່ ແຈ້ງ ປິດ ' ອ, ດ້ວຍ ນຸ້ມ ພ ທຳມີ້ຫ ກ ' ກົມ. 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 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) copayment	\$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) copayment	\$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) copayment	\$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**

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.