**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 deductible?** | $75/individual or $150/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 and primary care services are covered before you meet your deductible. No cost sharing for the first two primary care physician visits. | 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?** | Yes. Prescription drugs -- $50/individual or $100/family. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $700/individual or $1,400/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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | 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 | $5 copayment/visit; deductible does not apply. | Not covered | No cost sharing for the first two primary care physician visits. |
| | Specialist visit | $35 copayment/visit; deductible does not apply. | Not covered | Including office services, other than those specifically shown below. |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: $30 copayment/visit and deductible does not apply. 30% coinsurance for laboratory tests. | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | $400 copayment/visit; deductible does not apply. | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.christushealthplan.org** | Preferred generic drugs | No charge. Deductible does not apply. | Not covered | Cost sharing for a 90-day supply by mail order is triple the cost sharing for a standard 30-day supply. Cost sharing for specialty drugs is limited to $150 per prescription for a standard 30-day supply. Prescriptions for birth control are not subject to deductible, and do not have a copayment. |
| | Non-preferred generic drugs | $5 copayment/prescription. Deductible does not apply. | Not covered | |
| | Preferred brand drugs | $60 copayment/prescription | Not covered | |
| | Non-preferred brand drugs | $95 copayment/prescription | Not covered | |
| | Specialty drugs | 45% coinsurance | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |

| 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 need immediate medical attention** | Emergency room care | $700 copayment/visit | $700 copayment/visit | None. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | |
| | Urgent care | $35 copayment/visit; deductible does not apply. | Not covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $700 copayment/stay | 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 | $20 copayment/visit; deductible 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 | $700 copayment/stay | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| **If you are pregnant** | Office visits | $35 copayment/visit; deductible does not apply. | 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. |

| 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 | $700 copayment/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 preauthorization, benefits will be denied. |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| | Rehabilitation services | $30 copayment/visit | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be denied. |
| | Habilitation services | $30 copayment/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% coinsurance | 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. Deductible does not apply. | Not covered | Limited to one exam per year. |
| | Children's glasses | No charge. Deductible does not apply. | Not covered | Limited to one pair of glasses per year. |
| | Children's dental check-up | No charge. Deductible 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.) | | |
|---|---|---|
| • Abortion<br>• Acupuncture<br>• Bariatric Surgery<br>• Cosmetic Surgery<br>• Dental Care – Basic and Major (Children) | • Infertility Treatment<br>• Long-term Care<br>• Non-emergency care when traveling outside the United States<br>• Orthodontia | • Routine foot care for diabetic members<br>• Treatment for temporomandibular joint disorders<br>• 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<br>• Dental Care (Adult – item and visit limits apply. $1,000 annual benefit maximum) | • Hearing aids (1 hearing aid in each ear every 3 years)<br>• Private-duty nursing | • Routine eye care for adults (1 item and 1 visit per year. Up to $130 per person for glasses or contacts.) |

**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 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: 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 اذكر، فإن اللغوية المساعدة خدمات لك تتوافر بالمجان. برقم اتصل** 1-844-282-3025 (**رقم هاتف الصم والبكم**: 1-800-735-2989).
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* For more information about limitations and exceptions, see the plan or policy document at https://www.christushealthplan.org/

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں1-844-282-3025 (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).
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 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: 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 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 | $75 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $700 |
| Other coinsurance | 30% |

**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 | $75 |
| Copayments | $0 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$735** |

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

| | |
|---|---|
| The plan's overall deductible | $75 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $700 |
| 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* | |
| Deductibles | $100 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$720** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $75 |
| Specialist copayment | $35 |
| Hospital (facility) copayment | $700 |
| 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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $75 |
| Copayments | $400 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$775** |

The plan would be responsible for the other costs of these EXAMPLE covered services.