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/](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](http://www.healthcare.gov/sbc-glossary) or call 1-844-282-3025 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,325/individual or $2,650/family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductible for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$6,800/individual or $13,600/family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>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 network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

**CHPLA21SB7**

**Coverage Period:** 01/01/2021-12/31/2021

**Coverage for:** Individual, Individual + Family | **Plan Type:** HMO

**Key Points:**
- The SBC helps you understand your coverage.
- You must pay all costs up to the deductible before the plan begins to pay.
- Preventive care is covered before you meet your deductible.
- The plan covers certain preventive services with or without cost sharing.
- Out-of-pocket limits are the most you could pay in a year for covered services.
- Use a network provider for lower costs.
- You can see a specialist without a referral.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. Deductible does not apply.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic drugs</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the **plan** or policy document at [https://www.christushealthplan.org/](https://www.christushealthplan.org/).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Network Provider (You will pay the least) 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Emergency medical transportation</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Network Provider (You will pay the least) 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td></td>
<td>Preauthorization is required. If you don't get preauthorization, benefits will be denied.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Network Provider (You will pay the least) 50% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [https://www.christushealthplan.org/](https://www.christushealthplan.org/)
### 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.)**

<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Dental Care – Basic and Major (Children)</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Infertility Treatment</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Long-term Care</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Non-emergency care when traveling outside the United States</td>
</tr>
<tr>
<td>Dental Care (Adult)</td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Routine eye care for adults</td>
</tr>
<tr>
<td>Routine foot care for diabetic members</td>
<td>Treatment for temporomandibular joint disorders</td>
</tr>
<tr>
<td>Weight Loss Programs</td>
<td></td>
</tr>
</tbody>
</table>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids (1 hearing aid in each ear every 3 years)
- 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 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:
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)。

* For more information about limitations and exceptions, see the plan or policy document at https://www.christushealthplan.org/
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td><em>Specialist</em> office visits <em>(prenatal care)</em></td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
</tr>
<tr>
<td>Diagnostic tests <em>(ultrasounds and blood work)</em></td>
</tr>
<tr>
<td>Specialist visit <em>(anesthesia)</em></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>In this example, Peg would pay:</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managing Joe’s Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a year of routine in-network care of a well-controlled condition)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td><em>Primary care physician</em> office visits <em>(including disease education)</em></td>
</tr>
<tr>
<td>Diagnostic tests <em>(blood work)</em></td>
</tr>
<tr>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Durable medical equipment <em>(glucose meter)</em></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>In this example, Joe would pay:</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Emergency room care <em>(including medical supplies)</em></td>
</tr>
<tr>
<td>Diagnostic test <em>(x-ray)</em></td>
</tr>
<tr>
<td>Durable medical equipment <em>(crutches)</em></td>
</tr>
<tr>
<td>Rehabilitation services <em>(physical therapy)</em></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>In this example, Mia would pay:</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
</tr>
</tbody>
</table>

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