
 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 1-844-282-3025. 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 [www.healthcare.gov/sbc-glossary](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> ?	\$3,600/individual or \$7,200/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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventative care services, primary care provider and specialist visits, and generic drugs 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 preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . 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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <a href="#">Prescription drugs</a> -- \$300/individual or \$600/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> ?	\$6,300/individual or \$12,600/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> , balance-billing charges, and health care this <a href="#">plan</a> 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 <a href="#">network provider</a> ?	Yes. See <a href="https://www.christushealthplan.org/provider-search">https://www.christushealthplan.org/provider-search</a> or call 1-844-282-3025 for a list of network providers.	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 out-of- <a href="#">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 out-of- <a href="#">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 in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 All [copayment](#) shown in this chart are **with** your [deductible](#), and all [coinsurance](#) cost 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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply	Not Covered	None.
	<a href="#">Specialist</a> visit	\$35 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply	Not Covered	None.
	<a href="#">Preventive care/Screening/Immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need 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)	\$30 <a href="#">Copay</a> per x-ray and diagnostic imaging visit; <a href="#">deductible</a> does not apply. 20% <a href="#">Coinsurance</a> after <a href="#">deductible</a> for laboratory tests.	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits MAY 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="http://www.christushealthplan.org">www.christushealthplan.org</a>	Generic drugs	\$5 <a href="#">Copay</a> /prescription; <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. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) Tier 1 drugs are not subject to <a href="#">deductible</a> .
	Preferred brand drugs	\$60 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	
	Non-preferred brand drugs	\$95 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	
	<a href="#">Specialty drugs</a>	45% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	

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 have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
	Physician/Surgeon fees	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
<b>If you need immediate medical attention</b>	<a href="#">Emergency Room Care</a>	\$950 <a href="#">Copay</a> with <a href="#">deductible</a>	\$950 <a href="#">Copay</a> with <a href="#">deductible</a>	Your <a href="#">copayment</a> is waived if you are admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	
	<a href="#">Urgent care</a>	\$35 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply	\$35 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1000 <a href="#">Copay</a> per Stay with <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
	Physician/Surgeon fees	No Charge after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	MH/SUD office visits are subject to the listed copay, while MH/SUD facility outpatient treatments are subject to the outpatient facility <a href="#">coinsurance</a> .
	Inpatient services	\$1000 <a href="#">Copay</a> per Stay with <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
<b>If you are pregnant</b>	Office visits	\$35 <a href="#">Copay</a> per visit; <a href="#">deductible</a> does not apply	Not Covered	None.
	Childbirth/delivery professional services	No Charge after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
	Childbirth/delivery facility services	\$1000 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	100 Days per Year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	<a href="#">Provider</a> must determine in advance that <a href="#">Rehabilitation services</a> can be expected to

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)	
				result in significant improvement in your condition. Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	<a href="#">Habilitation services</a>	\$30 <a href="#">Copay</a> with <a href="#">deductible</a>	Not Covered	Supplementing with the federal definition of habilitative services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	<a href="#">Skilled nursing care</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	60 Days per Year. Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	Only Durable Medical Equipment considered standard and/or basic as defined by nationally recognized guidelines are Covered. Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	<a href="#">Hospice services</a>	20% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY Be denied.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	1 exam per year.
	Children's glasses	No Charge	Not Covered	1 pair of glasses per year for children, with a limit of \$100 allowance for frames and lenses or \$150 for contact lenses.
	Children's dental check-up	No Charge	Not Covered	Limited services covered.* Additional coverage can be purchased as a stand-alone product from another health plan. CHRISTUS Health

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)	
				Plan does not provide any stand-alone dental products.

### 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</li> <li>• Cosmetic Surgery</li> <li>• Dental Services (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long-Term Care</li> <li>• Private-Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Exam (Adult)</li> <li>• Routine Foot Care</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>• Acupuncture (20 visit limit)</li> <li>• Chiropractic Care (20 visit limit)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (1 device per 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• Prosthetic Devices (1 per year)</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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>; New Mexico HICAP at 1-855-857-0972 or <http://www.nmhicap.org>; New Mexico Medicaid Program at 1-888-997-2583 or <http://www.hsd.state.nm.us>; or New Mexi-Kids at 1-888-997-2583 or <https://www.hsd.state.nm.us/mad>. 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 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 The Office of Superintendent of Insurance at 1-855-427-5674 or [mhcb.grievance@state.nm.us](mailto:mhcb.grievance@state.nm.us).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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:

CHPNM19SH7

OMB Control Numbers 1545-2229, 1210-014, and 0938-1146  
Released on April 6, 2016

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

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

Urdu: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں۔ 1-844-282-3025 (TTY: 1-800-735-2989) خبردار:

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, ໂດຍບໍ່ແຈ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-282-3025 (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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,600
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	20%

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>\$12,800</b>
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In this example, Peg would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,070
<a href="#">Coinsurance</a>	\$655
<i>What isn't covered</i>	
Limits or Exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,085</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,600
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	20%

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>\$7,400</b>
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In this example, Joe would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$3,102
<a href="#">Copayments</a>	\$1,085
<a href="#">Coinsurance</a>	\$372
<i>What isn't covered</i>	
Limits or Exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,614</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,600
■ <a href="#">Specialist</a> copay	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	20%

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>\$2,318</b>
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In this example, Mia would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,205
<a href="#">Coinsurance</a>	\$166
<i>What isn't covered</i>	
Limits or Exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,671</b>