

 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 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 policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventative care services, primary care provider and specialist visits, and generic drugs are 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? | 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/provider-search 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 in-network specialist you choose without a referral . |



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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$10 Copay per visit; deductible does not apply | Not Covered | None. |
| | Specialist visit | \$35 Copay per visit; deductible does not apply | Not Covered | None. |
| | Preventive care/Screening/Immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$30 Copay per x-ray and diagnostic imaging visit; deductible does not apply. 20% Coinsurance after deductible for laboratory tests. | Not Covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$250 Copay with deductible | Not Covered | Preauthorization is required. If you don't get preauthorization, benefits MAY be denied. |
| If you need drugs to treat your illness or condition More information about Prescription drug coverage is available at www.christushealthplan.org | Generic drugs | \$5 Copay /prescription; 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. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) Tier 1 drugs are not subject to deductible . |
| | Preferred brand drugs | \$60 Copay with deductible | Not Covered | |
| | Non-preferred brand drugs | \$95 Copay with deductible | Not Covered | |
| | Specialty drugs | 45% Coinsurance after deductible | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY 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) | |
| | Physician/Surgeon fees | 20% Coinsurance after deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| If you need immediate medical attention | Emergency Room Care | \$700 Copay with deductible | \$700 Copay with deductible | Your copayment is waived if you are admitted to the hospital. |
| | Emergency medical transportation | 20% Coinsurance after deductible | 20% Coinsurance after deductible | |
| | Urgent care | \$35 Copay per visit; deductible does not apply | \$35 Copay per visit; deductible does not apply | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$700 Copay per Stay with deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| | Physician/Surgeon fees | No Charge after deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 Copay per visit; deductible 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 coinsurance . |
| | Inpatient services | \$700 Copay per Stay with deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| If you are pregnant | Office visits | \$35 Copay per visit; deductible does not apply | Not Covered | None. |
| | Childbirth/delivery professional services | No Charge after deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| | Childbirth/delivery facility services | \$700 Copay with deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance after deductible | Not Covered | 100 Days per Year. Preauthorization is required. If you don't get preauthorization , benefits MAY be denied. |
| | Rehabilitation services | \$30 Copay with deductible | Not Covered | Provider must determine in advance that Rehabilitation services can be expected to result in significant improvement in your condition. Preauthorization is required. If you |

| 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) | |
| | | | | don't get preauthorization, benefits MAY be denied. |
| | Habilitation services | \$30 Copay with deductible | 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. |
| | Skilled nursing care | 20% Coinsurance after deductible | Not Covered | 60 Days per Year. Preauthorization is required. If you don't get preauthorization, benefits MAY be denied. |
| | Durable medical equipment | 20% Coinsurance after deductible | 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. |
| | Hospice services | 20% Coinsurance after deductible | Not Covered | Preauthorization is required. If you don't get preauthorization , benefits MAY Be denied. |
| If your child needs dental or eye care | 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 Plan does not provide any stand-alone dental products. |

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
- Cosmetic Surgery
- Dental Services (Adult)
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Exam (Adult)
- Routine Foot Care

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

- Acupuncture (20 visit limit)
- Chiropractic Care (20 visit limit)
- Hearing Aids (1 device per 3 years)
- Prosthetic Devices (1 per year)

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 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.

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:

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

Urdu: 1-800-735-2989 (TTY: 1-800-735-2989) 1-844-282-3025 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).

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) پاسخ. 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 (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: ໂປດລາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, 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 [plan's](#) overall [deductible](#) \$75
- [Specialist](#) copay \$35
- Hospital (facility) [copayment](#) \$700
- Other [coinsurance](#) 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost sharing | |
|-----------------------------------|--------------|
| Deductibles | \$50 |
| Copayments | \$7 |
| Coinsurance | \$643 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$60 |
| The total Peg would pay is | \$760 |

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](#) copay \$35
- Hospital (facility) [copayment](#) \$700
- Other [coinsurance](#) 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost sharing | |
|-----------------------------------|--------------|
| Deductibles | \$125 |
| Copayments | \$426 |
| Coinsurance | \$149 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$55 |
| The total Joe would pay is | \$755 |

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

- The [plan's](#) overall [deductible](#) \$75
- [Specialist](#) copay \$35
- Hospital (facility) [copayment](#) \$700
- Other [coinsurance](#) 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,185 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost sharing | |
|-----------------------------------|--------------|
| Deductibles | \$50 |
| Copayments | \$531 |
| Coinsurance | \$119 |
| <i>What isn't covered</i> | |
| Limits or Exclusions | \$0 |
| The total Mia would pay is | \$700 |