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?	$125/individual or $250/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. 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?	No.	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?	$600/individual or $1,200/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. 35% 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)	35% Coinsurance after deductible	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits MAY Be denied.

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

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	35% 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	$600 Copay with deductible	$600 Copay with deductible	Your copayment is waived if you are admitted to the hospital.
	Emergency medical transportation	35% Coinsurance after deductible	35% 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)	$600 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	$30 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	$600 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	$600 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	35% 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	35% 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	35% 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	35% 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 (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 اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-282-3025 (رقم هاتف الصم والبكم: 1-800-735-2989).

Urdu: **خبردار: 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).

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: اگر شما فارسی، خدمات کمک زبان، رایگان می صحبت کنند، در دسترس شما هستند. پاسخ 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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.

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

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	$125
Specialist copay	$35
Hospital (facility) copayment	$600
Other coinsurance	35%

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	$116
Copayments	$0
Coinsurance	$484
What isn't covered	
Limits or Exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	$125
Specialist copay	$35
Hospital (facility) copayment	$600
Other coinsurance	35%

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	$250
Copayments	$233
Coinsurance	$117
What isn't covered	
Limits or Exclusions	$55
The total Joe would pay is	**$655**

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

The plan's overall deductible	$125
Specialist copay	$35
Hospital (facility) copayment	$600
Other coinsurance	35%

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	**$1,925**

In this example, Mia would pay:

Cost sharing	
Deductibles	$125
Copayments	$268
Coinsurance	$207
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$600**