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. 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?	$2,600/Individual or $5,200/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.	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 don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$4,150/Individual or $8,300/Family	The out-of-pocket limit is the most you could pay in a year for covered services.
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 and 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).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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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	None
	Specialist visit	$20 copayment/visit; deductible does not apply	Not covered	
	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)	$20 copayment/test for x-rays and diagnostic imaging and No charge for blood work; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copayment/test	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	$4 copayment/prescription (Retail and mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) Tier 5 drugs, such as immunizations and prescriptions for birth control, are not subject to deductible, and do not have a copayment.
	Preferred brand drugs	$35 copayment/prescription (Retail and mail order)	Not covered	
	Non-preferred brand drugs	$75 copayment/prescription (Retail and mail order)	Not covered	
	Specialty drugs	15% coinsurance/prescription (Retail and Mail Order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	Physician/surgeon fees	15% coinsurance	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)	
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Your copayment is waived if you are admitted to the hospital.
	Emergency medical transportation	15% coinsurance	15% coinsurance	
	Urgent care	$20 copayment/visit	$20 copayment/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copayment/admission	Not covered	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
	Physician/surgeon fees	$150 copayment/admission	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	$15 copayment/visit; deductible does not apply	Not covered	None
	Inpatient services	$150 copayment/admission	Not covered	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
If you are pregnant	Office visits	$20 copayment/visit; deductible does not apply	Not covered	None
	Childbirth/delivery professional services	$150 copayment/admission; deductible does not apply	Not covered	None
	Childbirth/delivery facility services	$150 copayment/admission	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	15% coinsurance	Not covered	None
	Rehabilitation services	$20 copayment/visit	Not covered	None
	Habilitation services	$20 copayment/visit	Not covered	None
	Skilled nursing care	15% coinsurance	Not covered	None
	Durable medical equipment	15% coinsurance	Not covered	None
	Hospice services	15% coinsurance	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)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	None
	Children's glasses	No Charge	Not covered	None
	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
- Private-duty nursing
- Long-term care
- Non-emergency care when traveling outside the United States
- Routine foot care (Covered for Members with diabetes)
- Fertility Services

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids for children
- Some weight loss programs

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

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: 1-800-659-8331).

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-844-282-3025 (TTY: 1-800-659-8331).

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: 1-800-659-8331).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-282-3025 (TTY: 1-800-659-8331).

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: 1-800-659-8331)。

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-282-3025 (رقم هاتف الصم والبكم: 1-800-659-8331).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-282-3025 (TTY: 1-800-659-8331)번으로 전화해 주십시오.

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: 1-800-659-8331).

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: 1-800-659-8331）まで、お電話にてご連絡ください。

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-282-3025 (ATS : 1-800-659-8331).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-282-3025 (TTY: 1-800-659-8331).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-282-3025 (телетайп: 1-800-659-8331).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-282-3025 (TTY: 1-800-659-8331) पर कॉल करें।

Persian: اگر شما فارسی، زبان کمک خدمات، با شما در تماس هستند. پاسخ 1-844-282-3025 (TTY: 1-800-659-8331).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-282-3025 (TTY: 1-800-659-8331).

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	$2,600
Specialist copayment	$20
Hospital (facility) copayment	$150
Other coinsurance	15%

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	$2,600
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

The plan's overall deductible	$2,600
Specialist copayment	$20
Hospital (facility) copayment	$150
Other coinsurance	15%

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	$2,600
Copayments	$700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,655**

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

The plan's overall deductible	$2,600
Specialist copayment	$20
Hospital (facility) copayment	$150
Other coinsurance	15%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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