




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](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> ?	\$3,000/Individual or \$6,000/Family	Generally, you must pay all of the costs from providers 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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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 <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	No	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,500/Individual or \$9,000/Family	The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
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 <a href="#">network providers</a> .	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).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	\$35 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copayment</a> /test for x-rays and diagnostic imaging and No charge for blood work; <a href="#">deductible</a> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">copayment</a> /test	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.christushealthplan.org">www.christushealthplan.org</a>	Generic drugs	\$12 <a href="#">copayment</a> /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 <a href="#">deductible</a> , and do not have a <a href="#">copayment</a> .
	Preferred brand drugs	\$60 <a href="#">copayment</a> /prescription (Retail and mail order)	Not covered	
	Non-preferred brand drugs	\$95 <a href="#">copayment</a> /prescription (Retail and mail order)	Not covered	
	<a href="#">Specialty drugs</a>	25% <a href="#">coinsurance</a> /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</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>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.

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\* For more information about limitations and exceptions, see the plan or policy document at [www.christushealthplan.org](http://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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copayment</a> /visit	\$250 <a href="#">copayment</a> /visit	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>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$35 <a href="#">copayment</a> /visit	\$35 <a href="#">copayment</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <a href="#">copayment</a> /admission	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
	Physician/surgeon fees	\$1,000 <a href="#">copayment</a> /admission	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	Inpatient services	\$1,000 <a href="#">copayment</a> /admission	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
If you are pregnant	Office visits	\$35 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	Childbirth/delivery professional services	\$1,000 <a href="#">copayment</a> /admission; <a href="#">deductible</a> does not apply	Not covered	None
	Childbirth/delivery facility services	\$1,000 <a href="#">copayment</a> /admission	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits MAY be denied.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Habilitation services</a>	\$30 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	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](#).)

- |                                                                                                                          |                                                                                                                                           |                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Cosmetic Surgery</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the United States</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (Covered for Members with diabetes)</li> <li>• Fertility Services</li> </ul> |
|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|

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

- |                                                                                              |                                                                                                            |                                                                               |
|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids for children</li> </ul> | <ul style="list-style-type: none"> <li>• Some weight loss programs</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:

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 jiiik'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: وبالكلمة الصم هاتف رقم 1-844-282-3025 برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة: 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: هسـتند شما دسترس در ،کنند یم صحبت گان یرا ،زبان کمک خدمات ،یـفارس شما اگر 1-844-282-3025 (TTY: 1-800-659-8331) پاسخ.

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

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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>	\$3,000
■ <a href="#">Specialist copayment</a>	\$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:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</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>	\$3,000
■ <a href="#">Specialist copayment</a>	\$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:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$1,200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,555</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>	\$3,000
■ <a href="#">Specialist copayment</a>	\$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>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$300
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>