CHRISTUS Health Plan
Generations (HMO)

Summary of Benefits

Finally, access to the doctor and hospital you know and trust.

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CHRISTUS Health Plan®

Summary of Benefits

CHRISTUS Health Plan Generations (HMO)
H1189

This is a summary of drug and health services covered by CHRISTUS Health Plan (HMO) January 1, 2017 – December 31, 2017.

CHRISTUS Health Plan is Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join CHRISTUS Health Plan (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New Mexico: Los Alamos, San Miguel, and Santa Fe.

CHRISTUS Health Plan (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

For more information, please call us at the phone number below or visit our website at www.christushealthplan.org.

Toll-free 1-844-282-3026, ● TTY 1-800-659-8331

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain Time.

You can see our plan's provider directory at our website at www.christushealthplan.org.

You can see our plan's pharmacy directory at our website at www.christushealthplan.org.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.christushealthplan.org.

Premiums and Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
Monthly Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium
Deductible	You pay $150	Prescription Drugs coverage
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,500 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage	$275 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90.	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Authorization rules may apply.
Doctor Visits ○ Primary ○ Specialists	 You pay $0 copay per visit You pay $40 copay per visit	
Preventive Care	You pay nothing	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost.

Premiums and Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
Emergency Care	You pay $65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.	
Urgently Needed Services	You pay $25 copay per visit	Urgently needed care is covered worldwide.
Diagnostic Services/Labs/ Imaging ○ Diagnostic radiology service (e.g., MRI). *Cost for these services may be different if received in an outpatient surgery setting.* ○ Lab services ○ Diagnostic tests and procedures ○ Outpatient x-rays	You pay $150 copay per visit You pay $0 copay per visit You pay $300 copay per visit You pay $0 copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
Hearing Services ○ Routine Hearing exam ○ Hearing aid	You pay $35 copay per visit Not covered	

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Dental Services		
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	You pay $35 copay	
Preventive Dental Services ○ Cleaning (for up to 1 every six months)	You pay $30 copay per visit	
○ Dental x-ray(s) (for up to 1 every two years)	You pay $30 copay per visit	
○ Fluoride treatment (for up to 1 every six months)	You pay $30 copay per visit	
Oral exam (for up to 1 every year)	You pay $30 copay per visit	
Vision Services		Plan pays up to $100 every year for eyewear.
○ Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	You pay $35 copay per visit	
○ Routine eye exam (for up to 1 every year)	You pay nothing	
○ Contact lenses (for up to 1 every year)	You pay nothing	
○ Eyeglasses (frames and lenses) for up to 1 every year)	You pay nothing	
○ Eyeglass frames (for up to 1 every year)	You pay nothing	
○ Eyeglasses or contact lenses after cataract surgery	You pay nothing	

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Mental Health Services ○ Inpatient visit ○ Outpatient group therapy visit ○ Outpatient individual therapy visit	$275 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90. 190 day lifetime limit, excludes Hospital setting. You pay $10 copay per visit You pay $10 copay per visit	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Authorization rules may apply.
Skilled Nursing Facility	You pay nothing per day for days 1 through 20. $150 copay per day for days 21 through 100.	Authorization rules may apply.
Rehabilitation Services (outpatient) ○ Occupational therapy visit ○ Physical therapy and speech and language therapy visit	 You pay $40 copay per visit You pay $40 copay per visit	Authorization rules may apply.
Ambulance	You pay $110 copay	Waived if admitted to the hospital.
Transportation	You pay nothing Limited to 12 one-way trips per year	
Foot Care (podiatry services) ○ Foot exam and treatment if you have diabetes-related nerve damage and/or meet certain conditions ○ Routine Foot care	 You pay $40 copay per visit You pay nothing	

Premiums and Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
Medical Equipment/Supplies ○ Durable Medical Equipment (e.g., wheelchairs, oxygen) ○ Prosthetics (e.g., braces, artificial limbs) ○ Diabetes supplies and Services (monitoring supplies; self- management training; Therapeutic shoes or inserts)	You pay 20% of the cost You pay 20% of the cost You pay nothing	
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs ○ Chemotherapy drugs ○ Other Part B drugs	 20% of the cost 20% of the cost	

Outpatient Prescription Drugs		
Phase 1: Annual Prescription Deductible	You pay $150	
Phase 2: Initial Coverage (After you pay your deductible)	Standard Retail Rx (30-day supply)	Standard Mail Order (90 day supply)
Tier 1: Preferred Generic	You pay $4	You pay $8
Tier 2: Generic	You pay $10	You pay $20
Tier 3: Preferred Brand	You pay $35	You pay $70
Tier 4: Non-Preferred Brand	You pay $90	You pay $180
Tier 5: Specialty Tier	You pay 29%	You pay 29%

Outpatient Prescription Drugs	
Phase 3: **Coverage Gap**	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs, for any drug tier during the coverage gap.
Phase 4: **Catastrophic Coverage**	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: 5% of cost, or $3.30 copay for generic (including brand drugs treated as generic) and $8.25 copayment for all other drugs.
You may get drugs from an out-of-network pharmacy at the same cost as in-network pharmacy.	
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.	

Additional Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
Therapeutic radiology services (such as radiation treatment for cancer)	You pay $20 copay per visit	
Home Health Care	You pay nothing	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered home health agency care. Authorization rules may apply.
Outpatient Surgery ○ Ambulatory Surgical Center ○ Hospital Facility	 You pay $100 copay per visit You pay $150 copay per visit	Authorizations rules may apply.
Outpatient Substance Abuse	Group therapy visit: $10 copay Individual therapy visit: $10 copay	Authorization rules may apply.
Rehabilitation Services (outpatient) ○ Cardiac rehabilitation ○ Pulmonary rehabilitation	 You pay $40 copay per visit You pay $30 copay per visit	Authorization rules may apply. Maximum of 2 one-hour sessions per day for up to 36 sessions for up to 36 weeks (Cardiac and Pulmonary rehabilitation).
Acupuncture	You pay $45 copay per visit	4 Annual visits
Chiropractic Care	You pay $20 copay Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Routine chiropractic visit up to 36 every year	
Over-the-counter items	Not covered	

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800 MEDICARE (1800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

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