

# 2021 Summary of Benefits

## CHRISTUS Health Plan Generations Plus (HMO) H1189, Plan 002

This is a summary of drug and health services covered by CHRISTUS Health Plan Generations Plus (HMO), January 1, 2021 – December 31, 2021.

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

The benefit information provided 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 Generations Plus (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, Rio Arriba, San Miguel and Santa Fe.

If you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800 MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, seven days a week.

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

For more information, please call us Toll-free 1-844-282-3026, ● TTY 711 or visit our website at [www.christushealthplan.org](http://www.christushealthplan.org).

### **Hours of Operation:**

October 1<sup>st</sup> – March 31<sup>st</sup>, 7 days a week from 8:00 a.m. to 8:00 p.m., local time.

April 1<sup>st</sup> – September 30<sup>th</sup>, Monday through Friday from 8:00 a.m. to 8:00 p.m., local time.

You can see our plan’s *Evidence of Coverage, Provider & Pharmacy Directory* and *Formulary* (list of Part D prescription drugs) at our website at [www.christushealthplan.org](http://www.christushealthplan.org).

Premiums and Benefits	CHRISTUS Health Plan Generations Plus (HMO)	What you should know
<b>Monthly Plan Premium</b>	\$20	You must continue to pay your Medicare Part B premium.
<b>Annual Prescription Deductible</b>	\$150	Applies to Tiers 4 & 5.
<b>Annual Maximum Out-of-Pocket</b> (does not include prescription drugs)	\$4,400	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient & Outpatient Services		
<b>Inpatient Hospital</b>		<i>Authorization rules may apply.</i>
<ul style="list-style-type: none"> <li>○ Acute hospital</li> <li>○ Mental health</li> </ul>	<p>You pay a \$275 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90.</p> <p>You pay a \$275 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90.</p>	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.
<b>Outpatient Hospital</b>		<i>Authorizations rules may apply.</i>
<ul style="list-style-type: none"> <li>○ Ambulatory surgical center</li> <li>○ Hospital facility</li> </ul>	<p>You pay a \$100 copay per visit.</p> <p>You pay a \$250 copay per visit.</p>	
<b>Doctor Visits</b>		
<ul style="list-style-type: none"> <li>○ Primary Care Physician</li> <li>○ Specialists</li> </ul>	<p>You pay nothing.</p> <p>You pay a \$25 copay per visit.</p>	
<b>Preventive Care</b> (e.g., flu, pneumonia and Hepatitis B vaccines; annual wellness visit, screenings for diabetes, depression, obesity; and breast, cervical, vaginal, prostate, colorectal and lung cancer.)	You pay nothing for Medicare-covered preventive care.	Other preventive services are available.

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<b>Emergency Care</b>	You pay a \$65 copay per visit.	Covered worldwide.  Copay is waived if admitted within 24 hours.
<b>Urgently Needed Services</b>	You pay a \$25 copay per visit. You pay a \$65 copay per visit (worldwide).	
<b>Diagnostic Services/Labs/Imaging</b> <ul style="list-style-type: none"> <li>○ Lab services</li> <li>○ Outpatient X-rays</li> <li>○ Diagnostic tests &amp; procedures (non-radiological)</li> <li>○ Diagnostic radiology services (MRI, CT, PET)</li> <li>○ Therapeutic radiology (e.g., radiation treatment of cancer)</li> </ul>	<p>You pay nothing. You pay nothing. You pay a \$150 copay per visit.</p> <p>You pay a \$150 copay per visit.</p> <p>You pay \$20 copay per visit.</p>	<p><i>Prior authorization is required for some services by your doctor or other network provider.</i></p> <p>Please contact the plan for more information.</p>
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>○ Routine hearing exam</li> <li>○ Hearing aid</li> <li>○ Medicare-covered exam to diagnose and treat hearing and balance issues</li> </ul>	<p>You pay a \$35 copay per exam.</p> <p>You pay a \$395, \$495 or \$695 copay from a network provider for hearing aids included in the 3 Tier Formulary.</p> <p>You pay a \$25 copay per service.</p>	<p>1 every year.</p> <p>Copay is based on manufacturer, product and style purchased from Amplifon 3 Tier Formulary. Hearing aids not listed in the 3 Tier Formulary are available at an additional cost. Member is responsible for full invoice amount if purchased outside of the 3 Tier Formulary. Copay does not apply. Out-of-network is not covered.</p>

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<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>○ Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</li> <li>○ Preventive dental services <ul style="list-style-type: none"> <li>● Oral exam</li> <li>● Dental X-rays</li> <li>● Cleaning</li> <li>● Fluoride treatment</li> </ul> </li> <li>○ Comprehensive dental services (diagnostic, restorative, extractions, endodontics, periodontics, dentures, prosthodontics, oral/maxillofacial surgery and other non-routine services.)</li> </ul>	<p>You pay a \$25 copay per service.</p> <p>You pay a \$5 copay per service.</p> <p>You pay a \$20 copay per service.</p>	<p>1 visit every year. 1 every 2 years. 1 every 6 months. 1 every 6 months.</p> <p>Maximum benefit limit is \$2,000. Benefit applies to non-Medicare-covered services.</p>
<p><b>Vision Services</b></p> <ul style="list-style-type: none"> <li>○ Medicare-covered eye to diagnose and treat diseases and conditions of the eye</li> <li>○ Glaucoma screening</li> <li>○ Routine eye exam</li> <li>○ Eyeglasses (frames/lenses) or contacts lenses</li> </ul>	<p>You pay a \$25 copay per exam.</p> <p>You pay a \$35 copay per screening.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>	<p>1 every year. \$100 allowance per year for 1 pair of eyeglasses (frames/lenses) or contacts.</p>
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>○ Outpatient individual or group therapy visit</li> </ul>	<p>You pay a \$10 copay per visit.</p>	
<p><b>Skilled Nursing Facility</b></p>	<p>You pay nothing per day for days 1 through 20. You pay a \$150 copay per day for days 21 through 100.</p>	<p><i>Authorization rules may apply.</i></p> <p>Plan covers up to 100 days per benefit period.</p>

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<b>Physical, Occupational and Speech Language Therapy Services</b>	You pay a \$35 copay per visit.	
<b>Ambulance</b>	You pay a \$110 copay per one-way trip.	<p><i>Authorization is required for non-emergency Medicare covered services.</i></p> <p>Waived if admitted to the hospital. Covered worldwide.</p>
<b>Transportation</b>	You pay nothing.	<p><i>Authorizations rules may apply.</i></p> <p>Limited to 12 one-way trips to plan-approved locations per year.</p>
<b>Medicare Part B Drugs</b> <ul style="list-style-type: none"> <li>○ Chemotherapy drugs</li> <li>○ Other Part B drugs</li> </ul>	<p>You pay 20% coinsurance.</p> <p>You pay 20% coinsurance.</p>	<p><i>Authorizations rules may apply.</i></p>

CHRISTUS Health Plan Generations (HMO) Outpatient Prescription Drugs		
<b>Phase 1: Annual Prescription Deductible</b>	You pay a \$150 deductible for Tier 4 and Tier 5.	
<b>Phase 2: Initial Coverage</b> (After you pay your deductible)	<b>Standard Retail (31-day supply)</b>	<b>Standard Mail-Order (90-day supply)</b>
	Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Brand Tier 5: Specialty Tier	You pay \$4. You pay \$10. You pay \$35. You pay 30%. You pay 29%.
<b>Phase 3: Coverage Gap</b>	<p>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 \$4,130.</p> <p>After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs, for any drug tier during the coverage gap.</p>	
<b>Phase 4: Catastrophic Coverage</b>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>○ 5% of the cost of the drug.</li> </ul> <p>–or– \$3.70 for a generic (including brand drugs treated as generic) and \$9.20 for all other drugs.</p>	
<p>Cost-Sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D Benefit.</p> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p>		

	CHRISTUS Health Plan Generations Plus (HMO)	What you should know
<b>Additional Benefits</b>		
<b>Home Health Care</b>	You pay nothing.	<p><i>Authorization rules may apply.</i></p> <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered home health agency care.</p>

	<b>CHRISTUS Health Plan Generations Plus (HMO)</b>	<b>What you should know</b>
<b>Outpatient Substance Abuse Services</b> (Individual and group therapy)	You pay a \$10 copay per visit.	<i>Authorization rules may apply.</i>
<b>Medical Equipment/Supplies</b> <ul style="list-style-type: none"> <li>○ Durable medical equipment (e.g., wheelchairs, oxygen)</li> <li>○ Prosthetics (e.g., braces, artificial limbs)</li> </ul>	You pay 20% coinsurance.  You pay 20% coinsurance.	<i>Authorizations rules may apply.</i>
<b>Diabetes Management</b> <ul style="list-style-type: none"> <li>○ Diabetes monitoring supplies</li> <li>○ Diabetes self-management training</li> <li>○ Therapeutic shoes or inserts</li> </ul>	You pay nothing.  You pay nothing.  You pay nothing.	<i>Authorization rules may apply.</i>
<b>Foot Care</b> <ul style="list-style-type: none"> <li>○ Medicare-covered foot exam and treatment if you have diabetes-related nerve damage and/or meet certain conditions</li> <li>○ Routine Foot care</li> </ul>	You pay a \$25 copay per visit.  You pay nothing.	
<b>Outpatient Rehabilitation Services</b> <ul style="list-style-type: none"> <li>○ Cardiac rehabilitation</li> <li>○ Pulmonary rehabilitation</li> </ul>	You pay a \$40 copay per visit. You pay a \$30 copay per visit.	<i>Authorization rules may apply.</i>
<b>Chiropractic Care</b> (manual manipulation of the spine to correct subluxation)	You pay a \$20 copay per visit.	<i>Authorization rules may apply.</i>  36 visits per year.
<b>Renal Dialysis</b>	You pay 20% coinsurance.	<i>Authorization rules apply.</i>
<b>Medicare-covered Acupuncture for Chronic Low Back Pain</b>	You pay a \$25 copay per visit.	<i>Authorizations rules may apply.</i>  Maximum of 20 visits per year.
<b>Routine Acupuncture and Other Alternative Therapies</b>	You pay nothing at CHRISTUS St. Vincent Holistic Health & Wellness Center.	<i>Authorizations rules may apply.</i>  4 treatments per year.

	<b>CHRISTUS Health Plan Generations Plus (HMO)</b>	<b>What you should know</b>
	You pay a \$45 copay per treatment at other facilities.	
<b>Over-The-Counter (OTC) Items</b>	You pay nothing. Up to \$100 allowance each quarter for the purchase of OTC products from Express Scripts Benefit Catalog.	\$100 limit every three months.  Nicotine Replacement Therapy (NRT) is not included in this benefit.
<b>Fitness</b>	Covered in full at Genoveva Chavez Community Center.  \$20 monthly allowance for other qualified fitness programs, reimbursed quarterly.	This benefit provides access to the fitness center in our markets. Our mission is to provide a health and fitness facility designed to educate our community on the importance of physical fitness. By providing a team of fitness and health professionals, as well as innovative programming, we aim to guide individuals toward a better quality of life.
<b>Home-delivered Meals</b>	You pay nothing for up to 14 home-delivered meals for up to 7 days.	You are eligible to receive home-delivered meals following a discharge from an inpatient hospital or skilled nursing facility stay.
<b>Telehealth</b>	You pay nothing.	Available only with in-network PCPs.