

2019 Summary of Benefits

CHRISTUS Health Plan Generations (HMO) H1189, Plan 003

This is a summary of drug and health services covered by CHRISTUS Health Plan Generations (HMO), January 1, 2019 – December 31, 2019.

CHRISTUS Health Plan Generations 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 (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 Texas: Camp, Cherokee, Franklin, Gregg, Harrison, Hopkins, Marion, Morris, Panola, Smith, Titus, Upshur and Wood.

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 or get a copy by calling 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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.

Hours of Operation:

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

April 1st – September 30th, 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.

Premiums and Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
Monthly Plan Premium	\$0	You must continue to pay your Medicare Part B premium.
Annual Prescription Deductible	\$150	Applies to Tiers 4 & 5.
Annual Maximum Out-of-Pocket (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		
Inpatient Hospital		<i>Authorization rules may apply.</i>
<ul style="list-style-type: none"> ○ Acute hospital 	<p>You pay a \$320 copay per day for days 1 through 5.</p> <p>You pay nothing per day for days 6 through 90.</p>	<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.</p>
<ul style="list-style-type: none"> ○ Mental health 	<p>You pay a \$318 copay per day for days 1 through 5.</p> <p>You pay nothing per day for days 6 through 90.</p>	
Outpatient Hospital		<i>Authorizations rules may apply.</i>
<ul style="list-style-type: none"> ○ Ambulatory surgical center ○ Hospital facility 	<p>You pay a \$255 copay per visit.</p> <p>You pay a \$325 copay per visit.</p>	
Doctor Visits		
<ul style="list-style-type: none"> ○ Primary Care Physician ○ Specialists 	<p>You pay nothing.</p> <p>You pay a \$25 copay per visit.</p>	
Preventive Care (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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<p>Dental Services</p> <ul style="list-style-type: none"> ○ Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth) ○ Preventive dental services <ul style="list-style-type: none"> ● Oral exam ● Dental X-rays ● Cleaning ● Fluoride treatment 	<p>You pay a \$25 copay per service.</p> <p>You pay a \$5 copay per service.</p>	<p>1 visit every year. 1 every 2 years. 1 every 6 months. 1 every 6 months.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> ○ Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye ○ Glaucoma screening ○ Routine eye exam ○ Eyeglasses (frames/lenses) or contacts lenses 	<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>Mental Health Services</p> <ul style="list-style-type: none"> ○ Outpatient individual or group therapy visit 	<p>You pay a \$40 copay per visit.</p>	
<p>Skilled Nursing Facility</p>	<p>You pay nothing per day for days 1 through 20. You pay a \$164.50 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>
<p>Physical, Occupational and Speech Language Therapy Services</p>	<p>You pay a \$25 copay per visit.</p>	
<p>Ambulance</p>	<p>You pay a \$265 copay per one-way trip.</p>	<p><i>Not waived if admitted to the hospital</i></p> <p>Covered worldwide.</p> <p><i>Authorization is required for non-emergency</i></p>

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			<i>Medicare covered services.</i>
Transportation	You pay nothing.		Limited to 12 one-way trips to plan-approved locations per year. <i>Authorization rules may apply.</i>
Medicare Part B Drugs ○ Chemotherapy drugs ○ Other Part B drugs	You pay 20% coinsurance. You pay 20% coinsurance.		<i>Authorization rules may apply.</i>
CHRISTUS Health Plan Generations (HMO) Outpatient Prescription Drugs			
Phase 1: Annual Prescription Deductible	You pay a \$150 deductible for Tier 4 and Tier 5.		
Phase 2: Initial Coverage (After you pay your deductible) Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Brand Tier 5: Specialty Tier	Standard Retail (31-day supply)	Standard Mail-Order (90-day supply)	
	You pay \$4. You pay \$10. You pay \$35. You pay \$90. You pay 29%.	You pay \$0. You pay \$0. You pay \$70. You pay \$180. You pay 29%.	
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 \$3,820. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 37% 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 \$5,100, you pay the greater of: ○ 5% of the cost of the drug. –or– \$3.40 for a generic (including brand drugs treated as generic) and \$8.50 for all other drugs.		
Cost-Sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D Benefit.			

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

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Additional Benefits		
Home Health Care	You pay nothing.	<i>Authorization rules may apply.</i> There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered home health agency care.
Outpatient Substance Abuse Services (Individual and group therapy)	You pay a \$40 copay per visit.	<i>Authorization rules may apply.</i>
Medical Equipment/Supplies <ul style="list-style-type: none"> ○ Durable medical equipment (e.g., wheelchairs, oxygen) ○ Prosthetics (e.g., braces, artificial limbs) 	You pay 20% coinsurance. You pay 20% coinsurance.	<i>Authorization rules may apply.</i>
Diabetes Management <ul style="list-style-type: none"> ○ Diabetes monitoring supplies ○ Diabetes self-management training ○ Therapeutic shoes or inserts 	You pay nothing. You pay nothing. You pay a \$10 copay per item.	<i>Authorization rules may apply.</i>
Foot Care <ul style="list-style-type: none"> ○ Medicare-covered foot exam and treatment if you have diabetes-related nerve damage and/or meet certain conditions ○ Routine Foot care 	You pay a \$25 copay per visit. You pay nothing.	
Outpatient Rehabilitation Services <ul style="list-style-type: none"> ○ Cardiac rehabilitation ○ Pulmonary rehabilitation 	You pay a \$40 copay per visit. You pay a \$30 copay per visit.	<i>Authorization rules may apply.</i>
Chiropractic Care	You pay a \$20 copay per visit.	36 visits per year.

Premiums and Benefits	CHRISTUS Health Plan Generations (HMO)	What you should know
(manual manipulation of the spine to correct subluxation)		
Renal Dialysis	You pay nothing.	<i>Authorization rules apply.</i>
Fitness	<p>Covered in full at participating CHRISTUS Trinity Mother Frances Fitness Clinics.</p> <p>\$20 monthly allowance for another qualified fitness program, reimbursed quarterly.</p>	<p>This benefit provides access to the CHRISTUS Trinity Mother Frances Fitness Clinics 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. For more information, see our website http://www.tmfhc.org/illness-resources/fitness-centers.</p>