# 2020 Summary of Benefits

## CHRISTUS Health Plan Generations (HMO)
## H1189, Plan 001

This is a summary of drug and health services covered by CHRISTUS Health Plan Generations (HMO), January 1, 2020 – December 31, 2020.

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 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 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.

**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)* | $4,900 | The most you pay for copays, coinsurance and other costs for medical services for the year. |
| **Inpatient & Outpatient Services** | | |
| **Inpatient Hospital**<br><br>o Acute hospital<br><br>o Mental health | <br><br>You pay a $295 copay per day for days 1 through 6.<br>You pay nothing per day for days 7 through 90.<br><br>You pay a $275 copay per day for days 1 through 5.<br>You pay nothing per day for days 6 through 90. | *Authorization rules may apply.*<br><br>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. |
| **Outpatient Hospital**<br>o Ambulatory surgical center<br>o Hospital facility | You pay a $175 copay per visit.<br><br>You pay a $325 copay per visit. | *Authorizations rules may apply.* |
| **Doctor Visits**<br>o Primary Care Physician<br>o Specialists | You pay nothing.<br>You pay a $25 copay per visit. | |
| **Preventive Care**<br>(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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| **Emergency Care** | You pay a $65 copay per visit. | Covered worldwide.<br><br>Copay is waived if admitted within 24 hours. |
| **Urgently Needed Services** | You pay a $55 copay per visit.<br>You pay a $65 copay per visit (worldwide). | |
| **Diagnostic Services/Labs/Imaging**<br>o Routine blood tests<br>o Other lab services<br>o Outpatient X-rays<br>o Diagnostic tests & procedures (non-radiological)<br>o Diagnostic radiology services (MRI, CT, PET)<br>o Therapeutic radiology (e.g., radiation treatment of cancer) | <br><br>You pay 0% coinsurance per visit.<br>You pay 20% coinsurance per visit.<br>You pay 20% coinsurance per visit.<br>You pay a $150 copay per visit.<br><br>You pay a $150 copay per visit.<br><br>You pay 20% coinsurance per visit. | *Prior authorization is required for some services by your doctor or other network provider.*<br><br>Please contact the plan for more information. |
| **Hearing Services**<br>o Routine hearing exam<br><br>o Hearing aid<br><br><br><br><br><br><br><br><br><br><br><br>o Medicare-covered exam to diagnose and treat hearing and balance issues | <br>You pay a $35 copay per exam.<br><br>You pay a $395, $495 or $695 copay from a network provider for hearing aids included in the 3 Tier Formulary.<br><br><br><br><br><br><br><br><br><br><br><br>You pay a $25 copay per service. | <br>1 every year.<br><br>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. |

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| **Dental Services**<br>o Medicare-covered dental services (this does not include services in connection with care, treatment, filing, removal, or replacement of teeth) | You pay a $25 copay per service. | |
| o Preventive dental services<br>• Oral exam<br>• Dental X-rays<br>• Cleaning<br>• Fluoride treatment | You pay a $5 copay per service. | 1 visit every year.<br>1 every 2 years.<br>1 every 6 months.<br>1 every 6 months. |
| **Vision Services**<br>o Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye<br>o Glaucoma screening<br>o Routine eye exam<br>o Eyeglasses (frames/lenses) or contacts lenses | You pay a $25 copay per exam.<br>You pay a $35 copay per screening.<br>You pay nothing.<br>You pay nothing. | 1 every year.<br>$100 allowance per year for 1 pair of eyeglasses (frames/lenses) or contacts. |
| **Mental Health Services**<br>o Outpatient individual or group therapy visit | You pay a $10 copay per visit. | |
| **Skilled Nursing Facility** | You pay nothing per day for days 1 through 20.<br>You pay a $167.50 copay per day for days 21 through 100. | *Authorization rules may apply.*<br><br>Plan covers up to 100 days per benefit period. |
| **Physical, Occupational and Speech Language Therapy Services** | You pay a $40 copay per visit. | |
| **Ambulance** | You pay a $200 copay per one-way trip. | *Authorization is required for non-emergency Medicare covered services.*<br><br>Waived if admitted to the hospital.<br>Covered worldwide. |

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| **Transportation** | You pay nothing. | *Authorization rules may apply.*<br><br>Limited to 12 one-way trips to plan-approved locations per year. |
| **Medicare Part B Drugs**<br>o Chemotherapy drugs<br>o Other Part B drugs | <br>You pay 20% coinsurance.<br>You pay 20% coinsurance. | *Authorization rules may apply.* |

| CHRISTUS Health Plan Generations (HMO)<br>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) | **Standard Retail (31-day supply)** | **Standard Mail-Order (90-day supply)** |
| Tier 1: Preferred Generic | You pay $4. | You pay $0. |
| Tier 2: Generic | You pay $10. | You pay $0. |
| 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%. |
| **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 $4,020.<br><br>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. | |
| **Phase 4: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of:<br>o 5% of the cost of the drug.<br>–or – $3.60 for a generic (including brand drugs treated as generic) and $8.95 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.<br><br>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. | *Authorization rules may apply.*<br><br>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered home health agency care. |
| **Outpatient Substance Abuse Services**<br>(Individual and group therapy) | You pay a $10 copay per visit. | *Authorization rules may apply.* |
| **Medical Equipment/Supplies**<br>o Durable medical equipment (e.g., wheelchairs, oxygen)<br>o Prosthetics (e.g., braces, artificial limbs) | You pay 20% coinsurance.<br><br>You pay 20% coinsurance. | *Authorization rules may apply.* |
| **Diabetes Management**<br>o Diabetes monitoring supplies<br>o Diabetes self-management training<br>o Therapeutic shoes or inserts | You pay nothing.<br><br>You pay nothing.<br><br>You pay nothing. | *Authorization rules may apply.* |
| **Foot Care**<br>o Medicare-covered foot exam and treatment if you have diabetes-related nerve damage and/or meet certain conditions<br>o Routine Foot care | You pay a $25 copay per visit.<br><br>You pay nothing. | |
| **Outpatient Rehabilitation Services**<br>o Cardiac rehabilitation<br>o Pulmonary rehabilitation | You pay a $40 copay per visit.<br>You pay a $30 copay per visit. | *Authorization rules may apply.* |
| **Chiropractic Care**<br>(manual manipulation of the spine to correct subluxation) | You pay a $20 copay per visit. | *Authorization rules may apply.*<br><br>36 visits per year. |
| **Renal Dialysis** | You pay nothing. | *Authorization rules apply.* |

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| **Acupuncture and Other Alternative Therapies** | You pay a $45 copay per treatment. | *Authorization rules may apply.*<br><br>4 treatments per year available through the CHRISTUS St. Vincent Holistic Health & Wellness Center. |
| **Fitness** | Covered in full at Genoveva Chavez Community Center.<br><br>$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. |