



2026 Summary of benefits

CHRISTUS Health Medicare Plus (HMO) H1189-004

Northeast Texas

Service Area: Anderson, Bowie, Camp, Cass, Cherokee, Franklin, Gregg, Harrison, Henderson, Hopkins, Marion, Morris, Panola, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, and Wood

This is a summary of drug and health services covered by CHRISTUS Health Medicare Plus (HMO) from January 1, 2026 through December 31, 2026. 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 visit our website at CHRISTUShealthplan.org to access the Evidence of Coverage (EOC). You may also call our member services department to request a copy.

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.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

If you have questions or need more information, please call us toll-free 1-844-282-3026, (TTY users should call 711) or visit our website at www.CHRISTUShealthplan.org. Our hours are 8 a.m. - 8 p.m.. local time, Monday through Friday. From October 1 - March 31, the hours are 8 a.m. - 8 p.m.. local time, seven days a week.

CHRISTUS Health Medicare Plus (HMO) is a Medicare Advantage HMO Plan with a Medicare contract. Enrollment in this plan depends on contract renewal.



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Premiums and benefits	Your costs in our plan
Monthly plan premium	\$20 You must continue to pay your Medicare Part B premium.
Plan deductible	\$0
Maximum out-of-pocket (MOOP) annual responsibility	\$4,200 Once you reach the maximum out-of-pocket, the plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.
Inpatient and outpatient hospital services	
Inpatient hospital (unlimited number of days)	\$0 per day
Outpatient hospital observation coverage	\$325 per stay
Outpatient hospital surgery	\$0-\$325
Ambulatory surgical center (ASC)	\$0-\$325
Doctor visits	
Primary care physician visits	\$0 office and/or telehealth visit
Specialist visits	\$30 office visit \$0 telehealth visit
Preventive, emergency and urgent care	
Preventive care	\$0 For a full list of preventive services, please see the EOC. Some covered services may have an associated cost.
Emergency and urgent care, including ambulance (inside the U.S.)	\$125 for emergency care \$30 for urgent care \$0 for telehealth urgent care \$300 for ambulance
Emergency and urgent care (outside the U.S.)	\$125 for emergency care \$125 for urgent care \$300 for ambulance



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Premiums and benefits	Your costs in our plan
Diagnostic tests and procedures	\$50
Lab services	\$0
Diagnostic radiology services (MRI, CT, etc.)	\$125
Outpatient x-rays	\$15
Therapeutic radiology (i.e. radiation treatment of cancer)	20% of total cost
Hearing services	
Medicare-covered exam	\$30
Routine hearing exam	\$0, one exam per year
Fitting/hearing evaluation for hearing aid	\$0, unlimited sessions
Prescription hearing aids	\$395-\$1,595 Cost per ear is determined by technology level of hearing aids, through Amplifon. Prescription and OTC hearing aids have a combined limit of two per year.
Over-the-counter (OTC) hearing aids	\$95-\$295 Cost per ear is determined by technology level of hearing aids, through Amplifon. Prescription and OTC hearing aids have a combined limit of two per year.
Dental services	
Medicare-covered dental exams	\$30
Preventive and diagnostic services	\$0 for preventive and diagnostic services, including oral exams twice a year, up to three cleanings per year and dental x-rays once a year
Comprehensive services	\$20 for comprehensive services, including fillings, extractions, crowns, root canals, dentures and oral surgery



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Premiums and benefits		Your costs in our plan	
Annual benefit amount		\$4,000	
		This is the total amount that will be paid for covered preventive and comprehensive services in the plan year. You are responsible for the cost of any comprehensive services over this amount.	
		The services covered by this benefit may be provided by a Delta Dental Medicare Advantage participating provider or a non-participating provider. To locate a participating provider, please visit www.deltadentalins.com/CHPMedicareAdvantage to search by location or specialty or call toll-free (888) 818-7929 to speak with a Delta Dental customer service representative.	
Vision services			
Medicare-covered medical eye exams (including diabetic eye exams)		\$30	
Routine eye exam		\$0 You have one exam per year when obtained from a Superior Vision in-network provider. If you choose a provider outside of the Superior Vision network, services will not be covered. Visit superiorvision.com/locator to find a provider.	
Contacts and eyeglasses (lenses/frames)		You get a vision eyewear benefit allowance up to \$300 per year for one pair of eyeglasses (lenses/frames) or contacts.	
Mental health services			
Inpatient psychiatric hospital stay		\$318 per day for days 1-5; \$0 per day for days 6-90	
Outpatient mental health therapy		\$30 per individual/group session \$0 telehealth visit	
Skilled nursing facility and therapy			
Skilled nursing facility (SNF)		\$0 per day for days 1-20; \$218 per day for days 21-100 This plan covers up to 100 days per benefit period.	
Physical, occupational and speech language therapy		\$30 per session \$0 per telehealth visit	
Transportation			
Ambulance (ground or air, one-way trip)		\$300	
Routine, non-emergency transportation		\$0 for 48 one-way trips, up to 100 miles per trip through SafeRide	



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Medicare Part B drugs

Medicare Part B only covers certain medications for certain conditions. These medicines are often given to you in your doctor's office. They can include things like vaccines, injections and nebulizers, among others. They can also include medicines you take at home using special medical equipment.

Part B drugs, including chemotherapy drugs

0% - 20%

Minimum cost share ensures member cost sharing does not exceed the adjusted Medicare coinsurance for Part B rebatable drugs.

CHRISTUS Health Medicare Plus (HMO) Prescription Prugs (Part D)

Medicare Part D covers a wide range of prescription drugs. They can include medications you take every day for conditions like high blood pressure or diabetes.

Deductible phase

\$250

You'll pay the plan's negotiated drug cost up to the deductible limit. The deductible applies to drugs on Tiers 3, 4, and 5.

Initial coverage phase – You begin this stage when you fill your first prescription of the year. You stay in the initial coverage phase until your total out-of-pocket drug costs for the year reaches \$2,100.

	Standard retail cost sharing (in-network) up to 30-day supply	Standard mail-order cost sharing (100-day supply)
Tier 1: Preferred generic	\$0	\$0
Tier 2: Generic	\$5	\$10
Tier 3: Preferred brand	25% of the cost No more than \$35 for covered insulin products	25% of the cost No more than \$105 for covered insulin products
Tier 4: Non-preferred brand drugs	30% of the cost No more than \$35 for covered insulin products	30% of the cost No more than \$105 for covered insulin products
Tier 5: Specialty	30% of the cost No more than \$35 for covered insulin products	Not covered
Tier 6: Select care drugs	\$0	\$0

Long-term supplies of your maintenance medications can be delivered to your door. Visit your member portal or caremark.com or call Member Services for more information.

Catastrophic phase - Once your out-of-pocket costs reach \$2,100, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. The plan pays the remaining cost for your covered Part D drugs. You pay nothing.



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Additional benefits		Your costs in our plan	
Chiropractic services			
Chiropractic care (Medicare-covered)	\$20	Medicare coverage is limited to fixing a subluxation. This is when one or more of the bones in your spine move out of place.	
Routine chiropractic services	\$20, up to 24 visits per year		
Durable Medical Equipment (DME)			
Continuous glucose monitors (CGM)	0% of the total cost		
Medicare-covered DME (including, but not limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, oxygen equipment, nebulizers and walkers)	15% of the total cost		
Nurse line			
24-hour nurse line	\$0		
Fitness benefit			
Physical fitness	\$0 Silver&Fit® Healthy Aging and Exercise program offers the flexibility of a fitness center membership, digital fitness tools and one home fitness kit from a variety of kit options, including a wearable fitness tracker. You can also take advantage of digital workout plans available on the program’s website, get one-on-one Health Aging Coaching by phone, video or chat and enjoy many other digital resources through the Well-Being Club.		
Home delivered meals			
Meal delivery	\$0 You are eligible to receive up to 14 home-delivered meals from GA Foods for up to seven days once discharged from inpatient hospital care.		
Home health agency care			
Part-time or intermittent skilled nursing and home health aide services, certified by your doctor (fewer than eight hours per day and 35 hours per week)	\$0		



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Additional benefits		Your costs in our plan	
		Kidney disease services	
Medicare-covered renal dialysis		20% of the total cost	
Medicare-covered kidney disease education services, including nutrition therapy for End-Stage Renal Disease (ESRD)		\$0	
		Outpatient substance use disorder services	
Partial hospitalization and intensive outpatient services (all day care for several days)		\$55 per day	
Substance abuse counseling		\$30 per individual/group session	
Over-the-counter (OTC) benefit			
You will receive a benefit allowance each quarter to purchase approved over-the-counter (OTC) health and wellness items like first aid supplies, cold and allergy medicine, pain relievers, COVID-19 tests and more. Your benefit amount is available the first day of each calendar quarter. Calendar quarters begin in January, April, July and October. Be sure to use the full benefit amount each calendar quarter, because any unused amount will not roll over into the next calendar quarter. This benefit is offered through Convey. You will use your CHRISTUS Health Plan member ID number to confirm benefit eligibility, confirm available benefit amount and make purchases. You can purchase approved products online, by phone or by app. Visit CHRISTUShealthplan.org for details, including a catalog.			
Over-the-counter		\$150 quarterly	



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Notice of availability

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-282-3026 (TTY: 711) or speak to your provider.

Español **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-282-3026 (TTY: 711) o hable con su proveedor.

Spanish

العربية **تنبيه:** إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-844-282-3026 (711) أو تحدث إلى مقدم الخدمة.

Arabic

中文 **注意:** 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-844-282-3026 (文本电话: 711) 或咨询您的服务提供商。

Chinese

Français **ATTENTION :** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-282-3026 (TTY:711) ou parlez à votre fournisseur.

French

Deutsch **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-844-282-3026 (TTY:711) an oder sprechen Sie mit Ihrem Provider.

German

ગુજરાતી **ધ્યાન આપો:** જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓકિઝવરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-282-3026 (TTY:711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Gujarati

हिंदी **ध्यान दें:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं 1-844-282-3026 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Hindi

日本語 **注:** 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰もが利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-282-3026 (TTY: 711)までお電話ください。または、ご利用の事業者にご相談ください。

Japanese



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한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-282-3026 (TTY:711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yánittigogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jük'eh ná hólé. Bee ahit bane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anida'wo'i áko bee baa hane'í bee badadilyaa bich'i' ahoot'i'ígíí éí t'áá jük'eb hóló. Kohji' 1-844-282-3026 (TTY:711) hodíilnih doodage nika'análwoi bich'i' hanidzih.
فارسی Farsi	توجه: اگر [وارد کردن زبان] صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-844-282-3026 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-282-3026 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-282-3026 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (1-844-282-3026 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Tiếng Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-844-282-3026 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.