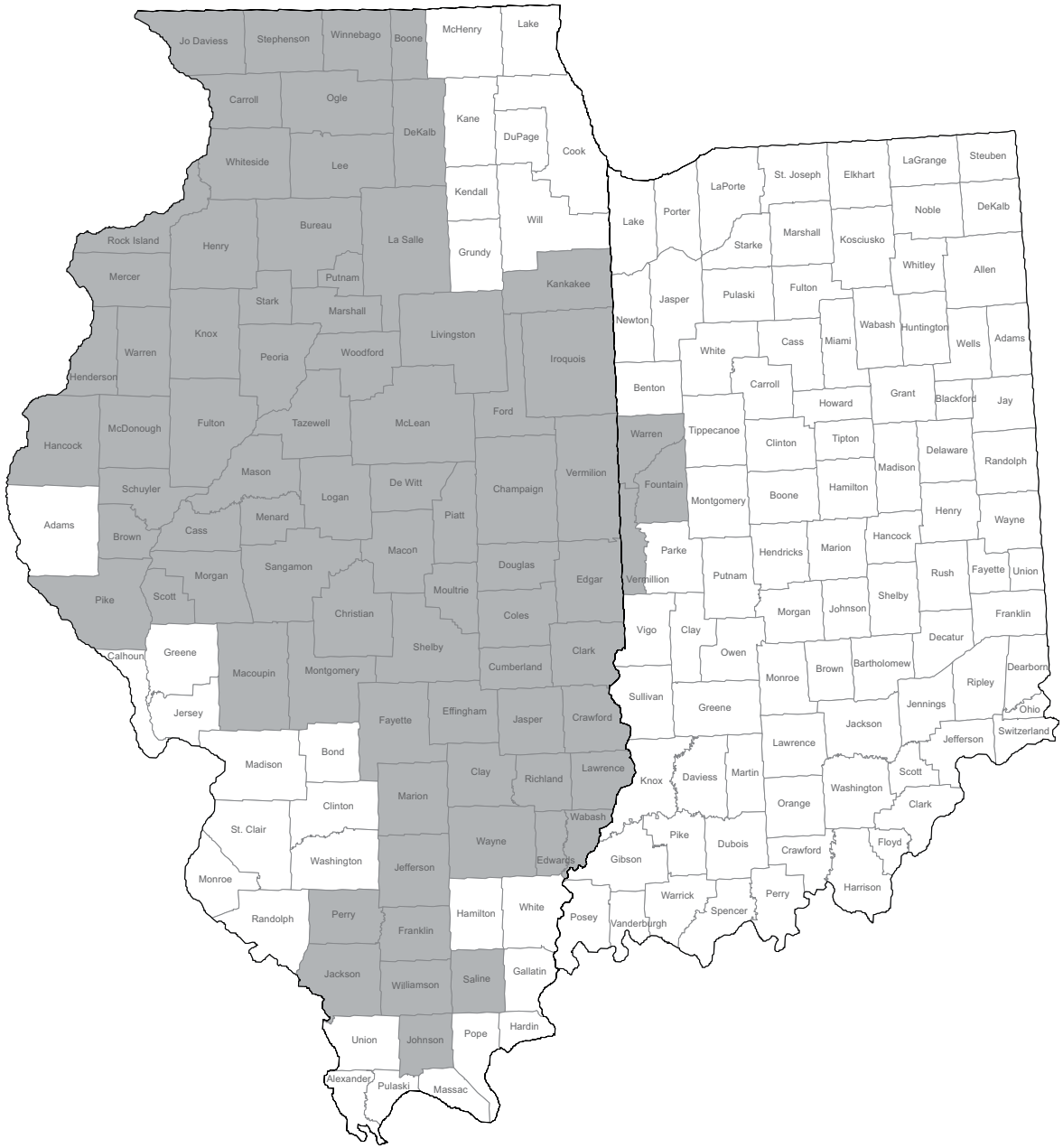
2020 Illinois and Western Indiana Health Alliance Group Medicare



Health Alliance Group Medicare Advantage HMO and POS service area

Health Alliance Group Medicare Advantage HMO and POS Plans are available to groups domiciled in all shaded counties in Illinois and the three shaded counties in Indiana.

Health Alliance Group Medicare Supplement Plans and Group Stand-Alone Prescription Drug Plans are available in all counties in Illinois. These plans are not available in Indiana.

Health Alliance™

Group Medicare–IL/IN	HMO Option 1 (available for groups only)	HMO Option 2 (available for groups only)
Monthly Premium	$257	$234
Member Benefits	**In-Network Only**	**In-Network Only**
Plan Year Deductible	$0	$0
Plan Year Out-of-Pocket Maximum	$3,500	$6,700
Be Healthy Annual Physical and Preventive Services*	$0 copayment	$0 copayment
Primary Care Office Visit	$20 copayment	$10 copayment
Specialist Office Visit	$40 copayment	$50 copayment
Virtual Visit	$0 copayment	$0 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	$0 copayment	20% coinsurance
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	$5 copayment	$150 copayment
Outpatient Radiological Services- X-rays	$0 copayment	20% coinsurance
Outpatient Hospital Services- Surgery	$150 copayment	20% coinsurance
Inpatient Hospital Care *Unlimited days each benefit period*	$150 each day for days 1–7, $0 each day for days 8–60, $50 each day for days 61–90, $0 each day for days 91 and beyond	$247 each day for days 1–8, $0 each day for days 9–60, $100 each day for days 61–90, $0 each day for days 91 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	$0 each day for days 1–20, $125 each day for days 21–100	$0 each day for days 1–20, $160 each day for days 21–100
Emergency Care/Post Stabilization Care	$90 copayment	$90 copayment
Urgently Needed Care	$25 copayment	$65 copayment
Durable Medical Equipment and Prosthetic Devices	0% - 20% of the cost, depending on the supply	0% - 20% of the cost, depending on the supply
Diabetic Supplies - Test Strips	0% coinsurance	0% coinsurance
Diabetic Supplies - Other	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	$0 deductible	$0 deductible
Tier 1 Preferred Generic at Walgreens	$0 copayment	$0 copayment
Tier 1 Preferred Generic Elsewhere	$12 copayment	$15 copayment
Tier 2 Generic	$20 copayment	$20 copayment
Tier 3 Preferred Brand	$47 copayment	$30 copayment
Tier 4 Non-Preferred Drug	50% coinsurance	$100 copayment
Tier 5 Specialty Tier	33% coinsurance	25% coinsurance
Coverage Gap Stage One-month (30-day) supply	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.	
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach $6,350, member pays the greater of: $3.60 or 5% for generics (whichever is higher) $8.95 or 5% for all other drugs (whichever is higher)	

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.
**Plans include 2.5x copay for 90-day scripts filled at Preferred pharmacies including Walgreens and other select pharmacies and mail order pharmacies (3x30 day copays for 90 day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	HMO Basic (available for groups and individuals)	HMO Basic Rx (available for groups and individuals)	HMO 40 Rx (available for groups and individuals)	HMO 20 Rx (available for groups and individuals)
Monthly Premium	$0	$32	$71	$120
Member Benefits	**In-Network Only**	**In-Network Only**	**In-Network Only**	**In-Network Only**
Plan Year Deductible	$0	$0	$0	$0
Plan Year Out-of-Pocket Maximum	$6,700	$6,700	$4,700	$4,000
Be Healthy Annual Physical and Preventive Services*	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Primary Care Office Visit	$25 copayment	$15 copayment	$10 copayment	$20 copayment
Specialist Office Visit	$50 copayment	$50 copayment	$45 copayment	$40 copayment
Virtual Visit	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Outpatient Diagnostic Procedures/Tests/Lab	20% coinsurance	20% coinsurance	$10 copayment	$10 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	$150 copayment	$150 copayment	$150 copayment	$5 copayment
Outpatient Radiological Services- X-rays	20% coinsurance	20% coinsurance	$10 copayment	$0 copayment
Outpatient Hospital Services- Surgery	20% coinsurance	20% coinsurance	$275 copayment	$275 copayment
Inpatient Hospital Care *Unlimited days each benefit period*	$300 each day for days 1-6, $0 each day for days 7 and beyond	$300 each day for days 1-6, $0 each day for days 7 and beyond	$275 each day for days 1-7, $0 each day for days 8 and beyond	$250 each day for days 1-7, $0 each day for days 8 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	$0 each day for days 1–20, $178 each day for days 21–100	$0 each day for days 1–20, $178 each day for days 21–100	$0 each day for days 1–20, $178 each day for days 21–100	$0 each day for days 1–20, $178 each day for days 21–100
Emergency Care/Post Stabilization Care	$90 copayment	$90 copayment	$90 copayment	$90 copayment
Urgently Needed Care	$65 copayment	$65 copayment	$40 copayment	$25 copayment
Durable Medical Equipment and Prosthetic Devices	0% - 20% of the cost, depending on the supply	0% - 20% of the cost, depending on the supply	0% - 20% of the cost, depending on the supply	0% - 20% of the cost, depending on the supply
Diabetic Supplies - Test Strips	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance
Diabetic Supplies - Other	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	N/A	$0 deductible	$0 deductible	$0 deductible
Tier 1 Preferred Generic at Walgreens	N/A	$0 copayment	$0 copayment	$0 copayment
Tier 1 Preferred Generic Elsewhere	N/A	$12 copayment	$12 copayment	$12 copayment
Tier 2 Generic	N/A	$20 copayment	$20 copayment	$20 copayment
Tier 3 Preferred Brand	N/A	$47 copayment	$47 copayment	$47 copayment
Tier 4 Non-Preferred Drug	N/A	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 Specialty Tier	N/A	33% coinsurance	33% coinsurance	33% coinsurance
Coverage Gap Stage One-month (30-day) supply	N/A	One-month (30-day) supply during the Coverage Gap (from $4,020 until member's annual drug costs reach $6,350) 25% for all generic drugs and 25% for all brand-name drugs		
Catastrophic Coverage One-month (30-day) supply	N/A	Catastrophic Coverage (when out-of-pocket drug costs reach $6,350) Generics $3.60 OR 5% (whichever is higher)All other drugs $8.95 OR 5% (whichever is higher)		

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.
**Plans include 2.5x copay for 90-day scripts filled at Preferred pharmacies including Walgreens and other select pharmacies and mail order pharmacies (3x30 day copays for 90 day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	POS Option 1 (available for groups only)		POS Option 2 (available for groups only)		POS Option 3 (available for groups only)	
Monthly Premium	$278		$357		$420	
Member Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Year Deductible	$0		$0		$0	
Plan Year Out-of-Pocket Maximum	$4,000	$5,100 (in- and out-of-network combined)	$4,000	$5,100 (in- and out-of-network combined)	$4,000	$5,100 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	$0 copayment	$30 copayment	$0 copayment	$30 copayment	$0 copayment	$30 copayment
Primary Care Office Visit	$20 copayment	$40 copayment	$20 copayment	$40 copayment	$20 copayment	$40 copayment
Specialist Office Visit	$30 copayment	$40 copayment	$30 copayment	$40 copayment	$30 copayment	$40 copayment
Virtual Visit	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	$0 copayment	$30 copayment	$0 copayment	$30 copayment	$0 copayment	$30 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	$0 copayment	$30 copayment	$0 copayment	$30 copayment	$0 copayment	$30 copayment
Outpatient Radiological Services- X-rays	$0 copayment	$30 copayment	$0 copayment	$30 copayment	$0 copayment	$30 copayment
Outpatient Hospital Services- Surgery	$175 copayment	$250 copayment	$175 copayment	$250 copayment	$175 copayment	$250 copayment
Inpatient Hospital Care *Unlimited days each benefit period in-network*	$195 each day for days 1–10, $0 each day for days 11 and beyond	25% coinsurance	$195 each day for days 1–10, $0 each day for days 11 and beyond	25% coinsurance	$195 each day for days 1–10, $0 each day for days 11 and beyond	25% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	$20 each day for days 1–20, $75 each day for days 21–100	$25 each day for days 1–20, $125 each day for days 21–100	$20 each day for days 1–20, $75 each day for days 21–100	$25 each day for days 1–20, $125 each day for days 21–100	$20 each day for days 1–20, $75 each day for days 21–100	$25 each day for days 1–20, $125 each day for days 21–100
Emergency Care/Post Stabilization Care	$90 copayment	$90 copayment	$90 copayment	$90 copayment	$90 copayment	$90 copayment
Urgently Needed Care	$30 copayment	$30 copayment	$30 copayment	$30 copayment	$30 copayment	$30 copayment
Durable Medical Equipment and Prosthetic Devices	0% - 20% of the cost, depending on the supply	20% coinsurance	0% - 20% of the cost, depending on the supply	20% coinsurance	0% - 20% of the cost, depending on the supply	20% coinsurance
Diabetic Supplies - Test Strips	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Diabetic Supplies - Other	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	$0 deductible		$0 deductible		$0 deductible	
Tier 1 Preferred Generic at Walgreens	$0 copayment		$0 copayment		$0 copayment	
Tier 1 Preferred Generic Elsewhere	$20 copayment		$15 copayment		$10 copayment	
Tier 2 Generic	$20 copayment		$20 copayment		$20 copayment	
Tier 3 Preferred Brand	$40 copayment		$30 copayment		$20 copayment	
Tier 4 Non-Preferred Drug	$100 copayment		$100 copayment		$100 copayment	
Tier 5 Specialty Tier	25% coinsurance		25% coinsurance		25% coinsurance	
Coverage Gap Stage One-month (30-day) supply	One-month (30-day) supply during the Coverage Gap (from $4,020 until member's annual drug costs reach $6,350) 25% for all generic drugs and 25% for all brand-name drugs					
Catastrophic Coverage One-month (30-day) supply	Catastrophic Coverage (when out-of-pocket drug costs reach $6,350) Generics $3.60 OR 5% (whichever is higher) All other drugs $8.95 OR 5% (whichever is higher)					

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.
**Plans include 2.5x copay for 90-day scripts filled at Preferred pharmacies including Walgreens and other select pharmacies and mail order pharmacies (3x30 day copays for 90 day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	POS Basic Rx (available for groups and individuals)		POS 30 Rx (available for groups and individuals)		POS 10 Rx (available for groups and individuals)	
Monthly Premium	$51		$100		$160	
Member Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Year Deductible	$0		$0		$0	
Plan Year Out-of-Pocket Maximum	$6,700	$10,000 (in- and out-of-network combined)	$5,500	$10,000 (in- and out-of-network combined)	$4,500	$5,750 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$30 copayment
Primary Care Office Visit	$15 copayment	$50 copayment	$15 copayment	$50 copayment	$20 copayment	$40 copayment
Specialist Office Visit	$50 copayment	$65 copayment	$45 copayment	$50 copayment	$30 copayment	$40 copayment
Virtual Visit	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	$40 copayment	$50 copayment	$40 copayment	$50 copayment	$0 copayment	$30 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	$40 copayment	$50 copayment	$40 copayment	$50 copayment	$0 copayment	$30 copayment
Outpatient Radiological Services- X-rays	$40 copayment	$50 copayment	$40 copayment	$50 copayment	$0 copayment	$30 copayment
Outpatient Hospital Services- Surgery	25% coinsurance	25% coinsurance	$325 copayment	$375 copayment	$275 copayment	$325 copayment
Inpatient Hospital Care *Unlimited days each benefit period in-network*	$450 each day for days 1–4, $0 each day for days 5 and beyond	$600 each day for days 1–6, $0 each day for days 7–90	$350 each day for days 1–5, $0 each day for days 6 and beyond	$375 each day for days 1–8, $0 each day for days 9–60, $200 each day for days 61–90	$250 each day for days 1-8, $0 each day for days 9 and beyond	25% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	$0 each day for days 1–20, $178 each day for days 21–100	$100 each day for days 1–20, $200 each day for days 21–100	$0 each day for days 1–20, $178 each day for days 21–100	$200 each day for days 1–20, $400 each day for days 21–100	$0 each day for days 1–20, $178 each day for days 21–100	$85 each day for days 1–20, $225 each day for days 21–100
Emergency Care/Post Stabilization Care	$90 copayment	$90 copayment	$90 copayment	$90 copayment	$90 copayment	$90 copayment
Urgently Needed Care	$65 copayment	$65 copayment	$40 copayment	$40 copayment	$30 copayment	$30 copayment
Durable Medical Equipment and Prosthetic Devices	0% - 20% of the cost, depending on the supply	20% coinsurance	0% - 20% of the cost, depending on the supply	20% coinsurance	0% - 20% of the cost, depending on the supply	20% coinsurance
Diabetic Supplies - Test Strips	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Diabetic Supplies - Other	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance	0% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	$0 deductible	$0 deductible	$0 deductible	$0 deductible	$0 deductible	$0 deductible
Tier 1 Preferred Generic at Walgreens	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 1 Preferred Generic Elsewhere	$12 copayment	$12 copayment	$12 copayment	$12 copayment	$12 copayment	$12 copayment
Tier 2 Generic	$20 copayment	$20 copayment	$20 copayment	$20 copayment	$20 copayment	$20 copayment
Tier 3 Preferred Brand	$47 copayment	$47 copayment	$47 copayment	$47 copayment	$47 copayment	$47 copayment
Tier 4 Non-Preferred Drug	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 Specialty Tier	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Coverage Gap Stage One-month (30-day) supply	From $4,020 until member's yearly out-of-pocket drug costs reach $6,350, member pays 25% of generic drugs and 25%					
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach $6,350, member pays the greater of: $3.60 or 5% for generics (whichever is higher) $8.95 or 5% for all other drugs (whichever is higher)					

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.
**Plans include 2.5x copay for 90-day scripts filled at Preferred pharmacies including Walgreens and other select pharmacies and mail order pharmacies (3x30 day copays for 90 day scripts at all other contracted pharmacies).

Group Medicare–IL/IN	**POS Basic (available for groups and individuals)**	
Monthly Premium	$23	
Member Benefits	**In-Network**	**Out-of-Network**
Plan Year Deductible	$0	
Plan Year Out-of-Pocket Maximum	$6,700	$10,000 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	$0 copayment	$0 copayment
Primary Care Office Visit	$35 copayment	$50 copayment
Specialist Office Visit	$50 copayment	$65 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	$40 copayment	$50 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	$40 copayment	$50 copayment
Outpatient Radiological Services- X-rays	$40 copayment	$50 copayment
Outpatient Hospital Services- Surgery	25% coinsurance	25% coinsurance
Inpatient Hospital Care *Unlimited days each benefit period in-network*	$450 each day for days 1–4, $0 each day for days 5 and beyond	$600 each day for days 1–6, $0 each day for days 7–90
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	$0 each day for days 1–20, $178 each day for days 21–100	$100 each day for days 1–20, $200 each day for days 21–100
Emergency Care/Post Stabilization Care	$90 copayment	$90 copayment
Urgently Needed Care	$65 copayment	$65 copayment
Durable Medical Equipment and Prosthetic Devices	0% - 20% of the cost, depending on the supply	20% coinsurance
Diabetic Supplies - Test Strips	0% coinsurance	20% coinsurance
Diabetic Supplies - Other	0% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)	N/A	N/A
Tier 1 Preferred Generic at Walgreens	N/A	N/A
Tier 1 Preferred Generic Elsewhere	N/A	N/A
Tier 2 Generic	N/A	N/A
Tier 3 Preferred Brand	N/A	N/A
Tier 4 Non-Preferred Drug	N/A	N/A
Tier 5 Specialty Tier	N/A	N/A
Coverage Gap Stage One-month (30-day) supply	N/A	N/A
Catastrophic Coverage One-month (30-day) supply	N/A	N/A

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

Group Medicare – PDP	PDP Option 1 (available for groups only)	PDP Option 2 (available for groups only)
Monthly Premium	$69	$166
Member Benefits		
Plan Year Deductible	N/A	N/A
Plan Year Out-of-Pocket Maximum	N/A	N/A
Be Healthy Annual Physical and Preventive Services	N/A	N/A
Primary Care Office Visit	N/A	N/A
Specialist Office Visit	N/A	N/A
Outpatient Diagnostic Procedures/Tests/ Lab	N/A	N/A
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	N/A	N/A
Outpatient Radiological Services- X-rays	N/A	N/A
Outpatient Hospital Services- Surgery	N/A	N/A
Inpatient Hospital Care *Unlimited days each benefit period*	N/A	N/A
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	N/A	N/A
Emergency Care/Post Stabilization Care	N/A	N/A
Urgently Needed Care	N/A	N/A
Durable Medical Equipment and Prosthetic Devices	N/A	N/A
Diabetic Supplies - Test Strips	N/A	N/A
Diabetic Supplies - Other	N/A	N/A
Prescription Drugs (30-day supply)* (deductibles exclude Tiers 1 and 2)	$0 deductible	$150 deductible
Tier 1 Preferred Generic at Walgreens	$0 copayment	$0 copayment
Tier 1 Preferred Generic Elsewhere	$20 copayment	$20 copayment
Tier 2 Generic	$20 copayment	$20 copayment
Tier 3 Preferred Brand	$47 copayment	$47 copayment
Tier 4 Non-Preferred Drug	$100 copayment	$100 copayment
Tier 5 Specialty Tier	25% coinsurance	25% coinsurance
Coverage Gap Stage One-month (30-day) supply	From $4,020 until member's yearly out-of-pocket drug costs reach $6,350, member pays 25% of generic drugs and 25%	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach $6,350, member pays the greater of: $3.60 or 5% for generics (whichever is higher) $8.95 or 5% for all other drugs (whichever is higher)	

**Plans include 2.5x copay for 90-day scripts filled at Preferred pharmacies including Walgreens and other select pharmacies and mail order pharmacies (3x30 day copays for 90 day scripts at all other contracted pharmacies).

Health Alliance Medicare is a Medicare Advantage Organization with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal. Other pharmacies/physicians/providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Health Alliance Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

GMAK-b&wbk20ILN-0719