Health Alliance℠

Health Alliance Group Medicare Plans

2019 Benefit Highlights for **Guide HMO Rx 2**

Please use this Benefit Highlight in conjunction with your Evidence of Coverage (EOC) to understand all of your benefits.

If you receive a bill directly from Health Alliance, your premium is $0. If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2019 premium.	
	In-Network Only
Yearly Deductible	$0
Yearly Out-of-Pocket Limit	$5,900
Services/Benefits	**Member Pays In-Network**
Inpatient Hospital Care	Days 1 - 5: $350 copay per day Days 6 -90: $0 copay per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1 - 4: $395 copay per day Days 5 - 90: $0 copay per day
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	Days 1 – 20: $0 copayment per day Days 21 – 100: $168 copayment per day
Home Health	$0 copayment
Hospice	You must get care from a Medicare-certified hospice.
Primary Care Doctor Office Visits	$10 copayment per visit
Specialist Office Visits	$50 copayment per visit
Virtual Visits	$10 copayment per visit
Chiropractic Services	Medicare Covered: $20 copayment per visit Non-Medicare Covered: Not Covered
Podiatry Services	$50 copayment per visit
Partial Hospitalization	$55 copayment per visit
Outpatient Mental Health Care	$40 copayment per visit
Outpatient Substance Abuse Care	20% coinsurance per visit
Ambulatory Surgery Center Services	$425 copayment per visit
Outpatient Hospital Services	$425 copayment per visit
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$90 copayment per visit
Medically Necessary Ambulance	$265 copayment per trip
Transportation (routine)	Not Covered
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	$65 copayment per visit

33,185-2019

Services/Benefits	Member Pays In-Network
Worldwide Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$90 copayment per visit
Worldwide Transportation (Medically Necessary Ambulance)	$265 copayment per trip
Worldwide Urgent Care (This is NOT emergency care, and in most cases, is out of the service area.)	$65 copayment per visit
Outpatient Rehabilitation Services (occupational, physical, speech, respiratory therapy and more)	$40 copayment per visit
Durable Medical Equipment (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance
Prosthetic Devices (braces, artificial limbs and eyes, etc.)	20% coinsurance
Diabetes Screening, Self-Monitoring Training, Nutrition Therapy and Supplies	Self-Management Training: $0 copayment Test Strips: 20% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: $0 copayment per visit
Diagnostic Tests, X-rays, Lab Services and Radiology Services	Procedures/Test/Lab: 20% coinsurance per test Complex Diagnostic: 20% coinsurance per test General Diagnostic: 20% coinsurance per test Therapeutic: 20% coinsurance per test X-Rays: 20% coinsurance per test
Cardiac and Pulmonary Rehabilitation Services	Cardiac: $0 copayment per visit Intensive Cardiac: $0 copayment per visit Pulmonary: $0 copayment per visit Supervised Exercise Therapy: $0 copayment per visit
Help with Certain Chronic Conditions	Meals are for Congestive Heart Failure Discharges. $0 copayment. Plan provides up to 2 meals per day for up to 28 days.
Welcome to Medicare and Annual Wellness Physical Exam/Visit	$0 copayment per visit
Health/Wellness Education: BeFit	Members may submit receipts for eligible fitness classes and facilities for reimbursement up to $360 per year. Any submission for non-eligible classes or facilities or for amounts in excess of the $360 per year allowance will result in a denial of reimbursement.
Nursing Hotline (Non-Medicare Covered)	$0 copayment per service
In-Home Safety Assessment (Non-Medicare Covered)	$0 copayment per service
Smoking & Tobacco Cessation (Non-Medicare Covered)	$0 copayment per service

Services/Benefits	Member Pays In-Network
Preventive and Screening Services (cardiovascular, abdominal aortic aneurysm, colorectal, paps smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma)	$0 copayment per service
Bone mass measurement (for at-risk people with Medicare)	$0 copayment per service
Immunizations (flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine)	$0 copayment per service
Kidney Disease Education Services	$0 copayment per service
Kidney Disease and Conditions	Dialysis Services: $0 copayment for renal dialysis
Medicare Part B Drugs	20% coinsurance
Dental Services (Non-Medicare Covered): Including but not limited to oral exam, cleaning, x-rays, fluoride treatment, fillings, dentures, denture adjustments and repairs, crowns, bridge work, root canals and extractions	Health Alliance will pay a maximum of $325 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the $325 maximum. Preventative-Annual Cleaning: $0 copayment Preventative-Supplemental Oral Exam: $20 copayment Comprehensive Dental: $0 copayment
Dental Service (Medicare Covered)	Comprehensive Dental: $50 copayment
Hearing Exams (Medicare Covered)	$45 copayment
Routine Hearing Test (Non-Medicare Covered)	$45 copayment with a TruHearing provider
Hearing Aids (Non-Medicare Covered)	TruHearing Select Plan (adjudicated by TruHearing): $699 for Flyte 700 level digital hearing aid or $999 for Flyte 900 level digital hearing aid from TruHearing network audiologist
Vision Exams (Medicare Covered)	$40 copayment
Routine Eye Exams (Non-Medicare Covered)	$0 copayment
Eyewear: Glasses/Contacts	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered

Pharmacy Highlights

Pharmacy Benefits	**Member Pays In-Network**
Deductible	$0
Does coverage continue through the Gap?	No
Initial Coverage	
Tier 1: Preferred Generic, 30-day supply	*$0 copayment per prescription at Walgreens $9 copayment per prescription at other network pharmacies
Tier 2: Generic, 30-day supply	$20 copayment per prescription
Tier 3: Preferred Brand, 30-day supply	$47 copayment per prescription
Tier 4: Non-Preferred Drug, 30-day supply	50% coinsurance
Tier 5: Specialty Tier, 30-day supply	33% coinsurance
Mail-Order	Same copayments apply for mail-order as retail. (see above for more details)
Coverage Gap	
One-month (30-day) supply during the Coverage Gap (from $3,820 until member's annual drug costs reach $5,100)	37% for all generic drugs and 25% for all brand-name drugs
Catastrophic Coverage (when out-of-pocket drug costs reach $5,100)	
Generics	$3.40 OR 5% (whichever is higher)
All other drugs	$8.50 OR 5% (whichever is higher)

Limitations	• Certain prescription drugs have quantity limits • Your doctor must get preauthorization from Health Alliance Medicare for certain prescription medications
Formulary	The Health Alliance Medicare Part D Formulary is a list of drugs covered by Health Alliance. Generally, we only cover drugs listed in the formulary.

This is a summary of benefits. Please refer to your Evidence of Coverage for additional information. Health Alliance Medicare is a HMO with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal

*Other preferred pharmacies may be available in your area. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call Customer Service at 1-800-965-4022 TTY 711 or consult the online pharmacy directory at HealthAlliance.org.

grp-grpmabensguidehmorx219IL-0818