



Health Alliance Group Medicare Plans 2019 Benefit Highlights for **HMO Option 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 \$220. 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	\$6,700
Services/Benefits	Member Pays In-Network
Inpatient Hospital Care	Days 1-8: \$247 copayment per day Days 9-60: \$0 copayment per day Days 61-90: \$100 copayment per day Days 91+: \$0 copayment per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1-7: \$225 copayment per day Days 8-60: \$0 copayment per day Days 61-90: \$100 copayment per day
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	Days 1 – 20: \$0 copayment per day Days 21 – 100: \$160 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: \$10 copayment per visit Non-Medicare Covered: Not Covered
Podiatry Services	\$50 copayment per visit
Partial Hospitalization	20% coinsurance
Outpatient Mental Health Care	\$40 copayment per visit
Outpatient Substance Abuse Care	20% coinsurance
Ambulatory Surgery Center Services	20% coinsurance
Outpatient Hospital Services	20% coinsurance
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	\$90 copayment per visit
Medically Necessary Ambulance	\$275 copayment per trip
Transportation (routine)	Not Covered

Services/Benefits	Member Pays In-Network
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	\$65 copayment per visit
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)	\$275 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 copay 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: 0% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$0 copayment
Diagnostic Tests, X-rays, Lab Services and Radiology Services	Procedures/Test/Lab: 20% coinsurance per test Complex Diagnostic: \$150 copayment per test General Diagnostic: \$150 copayment 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: \$25 copayment
Hearing Exams (Medicare Covered)	\$25 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)	\$25 copayment
Routine Eye Exams (Non-Medicare Covered)	\$0 copayment
Eyewear: Glasses/Contacts	Medicare Covered: \$25 copayment Non-Medicare Covered: Not

Pharmacy Highlights

Pharmacy Benefits	Member Pays In-Network
Deductible	\$0
Does coverage continue through the Gap?	Yes
Initial Coverage	
Tier 1: Preferred Generic, 30-day supply	*\$0 copayment per prescription at Walgreens \$15 copayment per prescription at other network pharmacies
Tier 2: Generic, 30-day supply	\$30 copayment per prescription
Tier 3: Preferred Brand, 30-day supply	\$30 copayment per prescription
Tier 4: Non-Preferred Drug, 30-day supply	\$100 copayment per prescription
Tier 5: Specialty Tier, 30-day supply	25% 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)	Same copayments as Initial Coverage
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	<ul style="list-style-type: none"> • 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.

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