



Health Alliance Group Medicare Plans

2019 Benefit Highlights for HMO Basic Rx

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 \$32. 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 - 6: \$300 copay per day Days 7 +: \$0 copay per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1 - 6: \$250 copay per day Days 7 - 60: \$0 copay per day Days 61 - 90: \$100 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	\$25 copayment per visit
Specialist Office Visits	\$50 copayment per visit
Virtual Visits	\$25 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	20% coinsurance per visit
Outpatient Hospital Services	20% coinsurance 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	\$275 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

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)	\$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 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: 0% 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: \$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 \$200 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$200 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 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	<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.

grp-grpmabenshmobasicrxn19IL-0818