



## Health Alliance Group Medicare Plans 2019 Benefit Highlights for POS 30 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 \$95. If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2019 premium.		
	<b>In-Network</b>	<b>Out-of-Network</b>
Yearly Deductible	\$0	\$0
Yearly Out-of-Pocket Limit	\$5,500	\$10,000 Total In and OON combined
<b>Services/Benefits</b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Inpatient Hospital Care	Days 1-5: \$350 copay per day Days 6+: \$0 copay per day	Days 1-8: \$375 copay per day Days 9-60: \$0 copay per day Days 61-90: \$200 copay per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1-6: \$245 copay per day Days 7-90: \$0 copay per day	Days 1-8: \$275 copay per day Days 9-60: \$0 copay per day Days 61-90: \$150 copay per day
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	Days 1–20: \$0 copay per day Days 21–100: \$168 copay per day	Days 1–20: \$200 copay per day Days 21–100: \$400 copay per day
Home Health	\$0 copay	\$50 copay
Hospice	You must get care from a Medicare-certified hospice.	You must get care from a Medicare-certified hospice.
Primary Care Doctor Office Visits	\$15 copay per visit	\$50 copay per visit
Specialist Office Visits	\$45 copay per visit	\$50 copay per visit
Virtual Visits	\$15 copay per visit	\$15 copay per visit
Chiropractic Services	Medicare Covered: \$20 copay per visit Non-Medicare Covered: Not Covered	Medicare Covered: \$50 copay per visit Non-Medicare Covered: Not Covered
Podiatry Services	\$45 copay per visit	\$50 copay per visit
Partial Hospitalization	\$40 copay per visit	\$50 copay per visit
Outpatient Mental Health Care	\$40 copay per visit	\$50 copay per visit
Outpatient Substance Abuse Care	\$40 copay per visit	\$50 copay per visit
Ambulatory Surgery Center Services	\$325 copay per visit	\$375 copay per visit
Outpatient Hospital Services	\$325 copay per visit	\$375 copay per visit
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	\$90 copay per visit	\$90 copay per visit
Medically Necessary Ambulance	\$275 copay per trip	\$275 copay per trip

<b>Services/Benefits</b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Transportation (routine)	Not Covered	Not Covered
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	\$40 copay per visit	\$40 copay per visit
Worldwide Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	\$90 copay per visit	\$90 copay per visit
Worldwide Transportation (Medically Necessary Ambulance)	\$275 copay per trip	\$275 copay per trip
Worldwide Urgent Care (This is NOT emergency care, and in most cases, is out of the service area.)	\$40 copay per visit	\$40 copay per visit
Outpatient Rehabilitation Services (occupational, physical, speech, respiratory therapy and more)	\$20 copay per visit	\$50 copay per visit
Durable Medical Equipment (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance	Bed Rails: 0% coinsurance Other: 20% coinsurance
Prosthetic Devices (braces, artificial limbs and eyes, etc.)	20% coinsurance	20% coinsurance
Diabetes Screening, Self-Monitoring Training, Nutrition Therapy and Supplies	Self-Management Training: \$0 copay Test Strips: 0% coinsurance Other Supplies: \$0 copay Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$0 copay	Self-Management Training: \$50 copay Test Strips: 0% coinsurance Other Supplies: \$20 copay Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$50 copay
Diagnostic Tests, X-rays, Lab Services and Radiology Services	Procedures/Test/Lab: \$40 copay Complex Diagnostic: \$40 copay General Diagnostic: \$40 copay Therapeutic: \$40 copay X-Rays: \$40 copay	Procedures/Test/Lab: \$50 copay Complex Diagnostic: \$50 copay General Diagnostic: \$50 copay Therapeutic: \$50 copay X-Rays: \$50 copay
Cardiac and Pulmonary Rehabilitation Services	Cardiac: \$0 copay Intensive Cardiac: \$0 copay Pulmonary: \$0 copay Supervised Exercise Therapy: \$0 copay	Cardiac: \$50 copay Intensive Cardiac: \$50 copay Pulmonary: \$50 copay Supervised Exercise Therapy: \$50 copay
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 copay per service	\$50 copay per service
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.	

<b>Services/Benefits</b>	<b>Member Pays In-Network</b>	<b>Member Pays Out-of-Network</b>
Nursing Hotline (Non-Medicare Covered)	\$0 copay per service	\$0 copay per service
In-Home Safety Assessment (Non-Medicare Covered)	\$0 copay per service	\$0 copay per service
Smoking & Tobacco Cessation (Non-Medicare Covered)	\$0 copay per service	\$0 copay per service
Preventive and Screening Services (cardiovascular, abdominal aortic aneurysm, colorectal, paps smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma)	\$0 copay per service	\$50 copay per service
Bone mass measurement (for at-risk people with Medicare)	\$0 copay per service	\$0 copay per service
Immunizations (flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine)	\$0 copay per service	\$50 copay per service
Kidney Disease Education Services	\$0 copay per service	\$50 copay per service
Kidney Disease and Conditions	Dialysis Services: \$0 copay for renal dialysis	Dialysis Services: \$0 copay for renal dialysis
Medicare Part B Drugs	20% coinsurance	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 copay Preventative-Supplemental Oral Exam: \$20 copay Comprehensive Dental: \$0 copay	
Dental Service (Medicare Covered)	Comprehensive Dental: \$20 copay	Comprehensive Dental: \$20 copay
Hearing Exams (Medicare Covered)	\$25 copay	\$40 copay
Routine Hearing Test (Non-Medicare Covered)	\$45 copayment with a TruHearing provider	Not Covered
Hearing Aids (Non-Medicare Covered)	TrueHearing 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 copay	\$40 copay
Routine Eye Exams (Non-Medicare Covered)	\$0 copay	Not Covered
Eyewear: Glasses/Contacts	Medicare Covered: \$25 copay Non-Medicare Covered: Not Covered	Medicare Covered: \$40 copay Non-Medicare Covered: Not Covered

# Pharmacy Highlights

Pharmacy Benefits	Member Pays In-Network
Deductible	\$0
Does coverage continue through the Gap?	No
<b>Initial Coverage</b>	
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 copays apply for mail-order as retail. (see above for more details)
<b>Coverage Gap</b>	
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
<b>Catastrophic Coverage</b> (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)
Out-of-Network Coverage	<ul style="list-style-type: none"> <li>Coverage for medications out-of-network may be available in special circumstances</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>Certain prescription drugs have quantity limits</li> <li>Your doctor must get preauthorization from Health Alliance Medicare for certain prescription medications</li> </ul>
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-POS 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](http://HealthAlliance.org).

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