



Health Alliance Group Medicare Plans 2019 Benefit Highlights for **Simplete 3 (HMO-POS)**

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 \$48.
If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2019 premium.

	In-Network		Out-of-Network
	Tier 1	Tier 2	
Yearly Deductible	\$0	\$0	\$0
Yearly Out-of-Pocket Limit	\$4,500 Combined Tier 1 & Tier 2		\$6,700
Services/Benefits	Member Pays Tier 1 In-Network	Member Pays Tier 2 In-Network	Member Pays Out-of-Network
Inpatient Hospital Care	Days 1-8: \$200 copay per day Days 9-60: \$0 copay per day Days 61 –90: \$100 copay per day Days 91+: \$0 copay per day	Days 1-4: \$450 copay per day Days 5+: \$0 copay per day	Days 1-4: \$600 copay per day Days 5-90: \$0 copay per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1-6: \$200 copay per day Days 7-60: \$0 copay per day Days 61 –90: \$100 copay per day	Days 1-4: \$395 copay per day Days 5-90: \$0 copay per day	Days 1-4: \$470 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 copay per day Days 21-100: \$170 copay per day	Days 1–20: \$0 copay per day Days 21-100: \$170 copay per day	Days 1–20: \$100 copay per day Days 21-100: \$200 copay per day
Home Health	\$0 copay	\$0 copay	\$50 copay
Hospice	You must get care from a Medicare-certified hospice.		
Primary Care Doctor Office Visits	\$5 copay per visit	\$20 copay per visit	\$50 copay per visit
Specialist Office Visits	\$10 copay per visit	\$40 copay per visit	\$50 copay per visit
Virtual Visits	\$5 copay per visit	\$20 copay per visit	\$20 copay per visit
Chiropractic Services	Medicare Covered: \$15 copay per visit Non-Medicare Covered: Not Covered	Medicare Covered: \$20 copay per visit Non-Medicare Covered: Not Covered	Medicare Covered: \$50 copay per visit Non-Medicare Covered: Not Covered
Podiatry Services	\$50 copay per visit	\$50 copay per visit	\$50 copay per visit

Services/Benefits	Member Pays Tier 1 In-Network	Member Pays Tier 2 In-Network	Member Pays Out-of-Network
Partial Hospitalization	\$55 copay per visit	\$55 copay per visit	\$55 copay per visit
Outpatient Mental Health Care	\$40 copay per visit	\$40 copay per visit	\$50 copay per visit
Outpatient Substance Abuse Care	20% coinsurance per visit	\$50 copay per visit	\$50 copay per visit
Ambulatory Surgery Center Services	20% coinsurance per visit	25% coinsurance per visit	25% coinsurance per visit
Outpatient Hospital Services	\$100 copay per visit	25% coinsurance per visit	25% coinsurance 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	\$90 copay per visit
Medically Necessary Ambulance	\$220 copay per trip	\$300 copay per trip	\$300 copay per trip
Transportation (routine)	Not Covered	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	\$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	\$90 copay per visit
Worldwide Transportation (Medically Necessary Ambulance)	\$220 copay per trip	\$220 copay per trip	\$220 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	\$40 copay per visit
Outpatient Rehabilitation Services (occupational, physical, speech, respiratory therapy and more)	\$40 copay per visit	\$40 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	Bed Rails: 0% coinsurance Other: 20% coinsurance
Prosthetic Devices (braces, artificial limbs and eyes, etc.)	20% coinsurance	20% coinsurance	20% coinsurance

Services/Benefits	Member Pays Tier 1 In-Network	Member Pays Tier 2 In-Network	Member Pays Out-of-Network
Diabetes Screening, Self-Monitoring Training, Nutrition Therapy and Supplies	Self-Management Training: \$0 copay Test Strips: 0% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$0 copay per visit	Self-Management Training: \$0 copay Test Strips: 0% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$0 copay per visit	Self-Management Training: \$50 copay Test Strips: 20% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: \$50 copay per visit
Diagnostic Tests, X-rays, Lab Services and Radiology Services	Procedures/Test/Lab: \$10 copay per test Complex Diagnostic: \$50 copay per test General Diagnostic: \$50 copay per test Therapeutic: \$10 copay per test X-Rays: \$10 copay per test	Procedures/Test: \$10 copay per test Lab: \$30 copay per test Complex Diagnostic: \$30 copay per test General Diagnostic: \$30 copay per test Therapeutic: \$30 copay per test X-Rays: \$30 copay per test	Procedures/Test/Lab: \$50 copay per test Complex Diagnostic: \$50 copay per test General Diagnostic: \$50 copay per test Therapeutic: \$50 copay per test X-Rays: \$50 copay per test
Cardiac and Pulmonary Rehabilitation Services	Cardiac: \$0 copay per visit Intensive Cardiac: \$0 copay per visit Pulmonary: \$0 copay per visit Supervised Exercise Therapy: \$0 copay per visit	Cardiac: \$0 copay per visit Intensive Cardiac: \$0 copay per visit Pulmonary: \$0 copay per visit Supervised Exercise Therapy: \$0 copay per visit	Cardiac: \$50 copay per visit Intensive Cardiac: \$50 copay per visit Pulmonary: \$50 copay per visit Supervised Exercise Therapy: \$50 copay 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 copay per visit	\$0 copay per visit	\$50 copay 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 copay per service	\$0 copay per service	\$0 copay per service
In-Home Safety Assessment (Non-Medicare Covered)	\$0 copay per service	\$0 copay per service	\$0 copay per service
Smoking & Tobacco Cessation (Non-Medicare Covered)	\$0 copay per service	\$0 copay per service	\$0 copay per service

Services/Benefits	Member Pays Tier 1 In-Network	Member Pays Tier 2 In-Network	Member Pays Out-of-Network
Preventive and Screening Services (cardiovascular, abdominal aortic aneurysm, colorectal, paps smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma)	\$0 copay per service	\$0 copay per service	\$50 copay per visit
Bone mass measurement (for at-risk people with Medicare)	\$0 copay per service	\$0 copay per service	\$50 copay per visit
Immunizations (flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine)	\$0 copay per service	\$0 copay per service	\$50 copay per visit
Kidney Disease Education Services	\$0 copay per service	\$0 copay per service	\$50 copay per visit
Kidney Disease and Conditions	Dialysis Services: \$0 copay for renal dialysis	Dialysis Services: \$0 copay for renal dialysis	Dialysis Services: \$0 copay for renal dialysis
Medicare Part B Drugs	20% coinsurance	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	Comprehensive Dental: \$20 copay
Hearing Exams (Medicare Covered)	\$25 copay	\$25 copay	\$40 copay
Routine Hearing Test (Non-Medicare Covered)	\$45 copay with a TruHearing provider	\$45 copay 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		Not Covered
Vision Exams (Medicare Covered)	\$10 copay	\$20 copay	\$40 copay
Routine Eye Exams (Non-Medicare Covered)	\$0 copay	\$40 copay	Not Covered
Eyewear: Glasses/Contacts	Medicare Covered: \$25 copay Non-Medicare Covered: Not Covered	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
Initial Coverage	
Tier 1: Preferred Generic, 30-day supply	*\$0 copayment per prescription at Walgreens \$5 copayment per prescription at other network pharmacies
Tier 2: Generic, 30-day supply	\$15 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)
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)
Out-of-Network Coverage	<ul style="list-style-type: none"> Coverage for medications out-of-network may be available in special circumstances
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-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.

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