Health Alliance™

Health Alliance Group Medicare Plans

2020 Benefit Highlights for **University of Iowa PPO 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 $320. If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2020 premium.		
	In-Network	**Out-of-Network**
Yearly Deductible	$0	$0
Yearly Out-of-Pocket Limit	$1,700	$2,000 total in and out-of-network
Services/Benefits	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital Care	10% coinsurance	40% coinsurance
Inpatient Mental Health Care (in a psychiatric hospital)	10% coinsurance	40% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	10% coinsurance	40% coinsurance
Home Health	10% coinsurance	40% coinsurance
Hospice	10% coinsurance You must get care from a Medicare-certified hospice.	40% coinsurance You must get care from a Medicare-certified hospice.
Primary Care Doctor Office Visits	$5 copay per visit	40% coinsurance per visit
Specialist Office Visits	$5 copay per visit	40% coinsurance per visit
Virtual Visits	$0 copay per visit	$0 copay per visit
Chiropractic Services	$5 copay for each Medicare-covered visit	40% coinsurance for each Medicare-covered visit
Podiatry Services	$5 copay for each Medicare-covered visit	40% coinsurance for each Medicare-covered visit
Partial Hospitalization	10% coinsurance	40% coinsurance per visit
Outpatient Mental Health Care	0% coinsurance per visit 10% coinsurance facility	40% coinsurance per visit
Outpatient Substance Abuse Care	0% coinsurance per visit 10% coinsurance facility	40% coinsurance per visit
Ambulatory Surgery Center Services	10% coinsurance per visit	40% coinsurance per visit
Outpatient Hospital Services	10% coinsurance per visit	40% coinsurance per visit
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$50 copay per visit, then 10% coinsurance	$50 copay per visit, then 10% coinsurance
Medically Necessary Ambulance	10% coinsurance per trip	40% coinsurance per visit
Transportation (routine)	Not Covered	Not Covered
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	$5 copay per visit 10% coinsurance for other services	40% coinsurance per visit

Services/Benefits	Member Pays In-Network	Member Pays Out-of-Network
Worldwide Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$50 copay per visit, then 10% coinsurance	$50 copay per visit, then 10% coinsurance
Worldwide Transportation (Medically Necessary Ambulance)	10% coinsurance per trip	40% coinsurance per visit
Worldwide Urgent Care (This is NOT emergency care, and in most cases, is out of the service area.)	$5 copay per visit 10% coinsurance for other services	40% coinsurance per visit
Outpatient Rehabilitation Services (occupational, physical, speech, respiratory therapy and more)	10% coinsurance per visit	40% coinsurance per visit
Durable Medical Equipment (wheelchairs, oxygen, etc.)	Other: 20% 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 copayment Test Strips: 0% coinsurance Other Supplies: 10% coinsurance Diabetic Shoes or Inserts: 10% coinsurance Medical Nutrition Therapy: $0 copay	Self-Management Training: 40% coinsurance Test Strips: 20% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% coinsurance Medical Nutrition Therapy: 40% coinsurance
Diagnostic Tests, X-rays, Lab Services and Radiology Services	Procedures/Test/Lab: 10% coinsurance Complex Diagnostic: 10% coinsurance General Diagnostic: 10% coinsurance Therapeutic: 10% coinsurance X-Rays: 10% coinsurance	Procedures/Test/Lab: 40% coinsurance Complex Diagnostic: 40% coinsurance General Diagnostic: 40% coinsurance Therapeutic: 40% coinsurance X-Rays: 40% coinsurance
Cardiac and Pulmonary Rehabilitation Services	Cardiac: $0 copayment Intensive Cardiac: $0 copayment Pulmonary: $0 copayment Supervised Exercise Therapy: $0 copay	Cardiac: 40% coinsurance Intensive Cardiac: 40% coinsurance Pulmonary: 40% coinsurance Supervised Exercise Therapy: 40% coinsurance
Welcome to Medicare and Annual Wellness Physical Exam/Visit	$0 copayment per service	40% coinsurance 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.	
Nursing Hotline (Non-Medicare Covered)	$0 copayment per service	$0 copayment per service
In-Home Safety Assessment (Non-Medicare Covered)	$0 copayment per service	40% coinsurance per service

Services/Benefits	Member Pays In-Network	Member Pays Out-of-Network
Smoking & Tobacco Cessation (Non-Medicare Covered)	$0 copayment per service	40% coinsurance per service
Preventive and Screening Services (cardiovascular, abdominal aortic aneurysm, colorectal, paps smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma)	$0 copayment per service	40% coinsurance per service
Immunizations (flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine	$0 copayment per service	40% coinsurance per service
Bone mass measurement (for at-risk people with Medicare)	$0 copayment per service	40% coinsurance per service
Kidney Disease Education Services	$0 copayment per service	40% coinsurance per service
Kidney Disease and Conditions	Dialysis Services: $0 copayment for renal dialysis	Dialysis Services: 40% coinsurance for renal dialysis
Medicare Part B Drugs	10% 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 copayment Preventative-Supplemental Oral Exam: $0 copayment Comprehensive Dental: $0 copayment	
Dental Service (Medicare Covered)	Comprehensive Dental: $35 copayment	
Hearing Exams (Medicare Covered)	20% coinsurance for each Medicare-covered exam	20% coinsurance for each Medicare-covered exam
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 700 level digital hearing aid or $999 for 900 level digital hearing aid from TruHearing network audiologist	Not Covered
Vision Exams (Medicare Covered)	$5 copayment	40% coinsurance
Routine Eye Exams (Non-Medicare Covered)	$5 copayment	40% coinsurance
Eyewear: Glasses/Contacts	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered	

Pharmacy Highlights

Pharmacy Benefits	Member Pays In-Network
Deductible	$0 (Out-of-Pocket Limit: $1,100)
Does coverage continue through the Gap?	Yes
Initial Coverage	
Tier 1: Preferred Generic, 30-day supply	*$0 copay per prescription at Walgreens $0 copay per prescription at other network pharmacies
Tier 2: Generic, 30-day supply	30% coinsurance per prescription
Tier 3: Preferred Brand, 30-day supply	50% coinsurance per prescription
Tier 4: Non-Preferred Drug, 30-day supply	50% coinsurance per prescription
Tier 5: Specialty Tier, 30-day supply	50% coinsurance per prescription
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 $4,020 until member's annual drug costs reach $6,350)	Same copayments as Initial Coverage
Catastrophic Coverage (when out-of-pocket drug costs reach $5,100)	
Generics	$3.60 OR 5% (whichever is higher)
All other drugs	$8.95 OR 5% (whichever is higher)
Out-of-Network Coverage	• Coverage for medications out-of-network may be available in special circumstances
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 PPO 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.

GMAC20-bhsppoUIA-0819