



## Health Alliance Group Medicare Plans 2021 Benefit Highlights for **University of Iowa HMO Plus 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 \$60. If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2021 premium.	
	<b>In-Network Only</b>
Yearly Deductible	\$0
Yearly Out-of-Pocket Limit	\$4,000
<b>Services/Benefits</b>	<b>Member Pays In-Network</b>
Inpatient Hospital Care	Days 1 - 7: \$280 copayment per day Days 8 +: \$0 copayment per day
Inpatient Mental Health Care (in a psychiatric hospital)	Days 1 - 7: \$225 copayment per day Days 8 - 90: \$0 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 per visit
Hospice	\$0 copayment You must get care from a Medicare-certified hospice.
Primary Care Doctor Office Visits	\$10 copayment per visit
Specialist Office Visits	\$35 copayment per visit
Telehealth	Primary Care: \$10 copayment per visit Specialist: \$35 copayment per visit
Opioid Treatment Services	\$35 copayment
Virtual Visits	\$0 copayment per visit
Chiropractic Services	\$20 copayment for each Medicare-covered visit
Acupuncture	Medicare Covered: \$10 copayment per visit Non-Medicare Covered: \$10 copayment per visit up to 15 visits per year
Podiatry Services	\$35 copayment per visit
Partial Hospitalization	20% coinsurance
Outpatient Mental Health Care	\$40 copayment per visit
Outpatient Substance Abuse Care	\$65 copayment per visit
Ambulatory Surgery Center Services	\$275 copayment per visit
Outpatient Hospital Services	\$275 copayment per visit
Outpatient Hospital Observation	\$275 copayment 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.)	\$55 copayment per visit

<b>Services/Benefits</b>	<b>Member Pays In-Network</b>
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.)	\$55 copayment per visit
Outpatient Rehabilitation Services (occupational, physical, speech, respiratory therapy and more)	\$35 copayment per visit
Durable Medical Equipment (wheelchairs, oxygen, etc.)	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 Complex Diagnostic: 20% coinsurance General Diagnostic: 20% coinsurance Therapeutic: 20% coinsurance X-Rays: 20% coinsurance
Cardiac and Pulmonary Rehabilitation Services	Cardiac: \$0 copayment per service Intensive Cardiac: \$0 copayment per service Pulmonary: \$0 copayment per service Supervised Exercise Therapy: \$0 copayment per service
Help with Certain Chronic Conditions	Plan provides the meal benefit post discharge to any CHF member who has an inpatient stay for any reason. Plan provides up to 2 home delivered meals per day. Plan provides meals for up to 14 days. Up to 3 instances.
Welcome to Medicare and Annual Wellness Physical Exam/Visit	\$0 copayment
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 services
In-Home Safety Assessment (Non-Medicare Covered)	\$0 copayment per services
Smoking & Tobacco Cessation (Non-Medicare Covered)	\$0 copayment per services

Preventive and Screening Services (cardiovascular, abdominal aortic aneurysm, colorectal, paps smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma)	\$0 copayment per services
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<b>Services/Benefits</b>	<b>Member Pays In-Network</b>
Bone mass measurement (for at-risk people with Medicare)	\$0 copayment per services
Immunizations (flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine)	\$0 copayment per services
Kidney Disease Education Services	\$0 copayment
Kidney Disease and Conditions	Dialysis Services: 20% coinsurance 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: \$0 copayment Comprehensive Dental: \$0 copayment
Dental Service (Medicare Covered)	Comprehensive Dental: \$35 copayment
Hearing Exams (Medicare Covered)	\$45 copayment for each Medicare-covered exam
Routine Hear Test (Non-Medicare Covered)	\$45 copayment with a TruHearing provider
Hearing Aids (Non-Medicare Covered)	TruHearing Select Plan (adjudicated by TruHearing): \$699 for 700 level digital hearing aid or \$999 for 900 level digital hearing aid from TruHearing network audiologist
Vision Exams (Medicare Covered)	\$0 copayment
Routine Eye Exams (Non-Medicare Covered)	Not Covered
Eyewear: Glasses/Contacts	Medicare Covered: \$0 copayment Non-Medicare Covered: Not Covered

# Pharmacy Highlights

<b>Pharmacy Benefits</b>	<b>Member Pays In-Network</b>
Deductible	\$0
Does coverage continue through the Gap?	No
<b>Initial Coverage</b>	
Tier 1: Preferred Generic, 30-day supply	\$2 copayment per prescription
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 per prescription
Tier 5: Specialty Tier, 30-day supply	33% coinsurance per prescription
Mail-Order (90-day)	2.5 x 30-day copayment
Retail (90-day)	3 x 30-day copayment
<b>Coverage Gap</b>	
One-month (30-day) supply during the Coverage Gap (from \$4,130 until member's annual drug costs reach \$6,550)	25% 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	\$3.70 OR 5% (whichever is higher)
All other drugs	\$9.20 OR 5% (whichever is higher)

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 HMO with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal

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