Health Alliance Group Medicare Plans

2021 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 2021 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	$0 copayment You must get care from a Medicare-certified hospice.	$0 copayment You must get care from a Medicare-certified hospice.
Primary Care Doctor Office Visits	$5 copayment per visit	40% coinsurance per visit
Specialist Office Visits	$5 copayment per visit	40% coinsurance per visit
Telehealth	Primary Care: $5 copayment Specialist: $5 copayment	Primary Care: 40% coinsurance Specialist: 40% coinsurance
Opioid Treatment Services	$5 copayment	40% coinsurance
Virtual Visits	$0 copayment per visit	$0 copayment per visit
Chiropractic Services	$5 copayment for each Medicare-covered visit	40% coinsurance for each Medicare-covered visit
Acupuncture	Medicare Covered: $5 copayment Non-Medicare Covered: $5 copayment up to 15 visits	Medicare Covered: $5 copayment Non-Medicare Covered: $5 copayment up to 15 visits
Podiatry Services	$5 copayment 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
Outpatient Hospital Observation	10% coinsurance	40% coinsurance

Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$50 copayment per visit, then 10% coinsurance	$50 copayment 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 copayment 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 copayment per visit, then 10% coinsurance	$50 copayment 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 copayment 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
Medical Nutrition Therapy	$0 copayment	40% coinsurance
Durable Medical Equipment (wheelchairs, oxygen, etc.)	20% coinsurance	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	Self-Management Training: 40% coinsurance Test Strips: 20% coinsurance Other Supplies: 20% coinsurance Diabetic Shoes or Inserts: 20% 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 copayment	Cardiac: 40% coinsurance Intensive Cardiac: 40% coinsurance Pulmonary: 40% coinsurance Supervised Exercise Therapy: 40% coinsurance
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. .	Not Covered
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)	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	Not Covered
Vision Exams (Medicare Covered)	$0 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	copayment$0 copayment per prescription
Tier 2: Generic, 30-day supply	20% 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 copayments apply for mail-order as retail. (see above for more details)
Retail (90-day)	3 x 30-day copayment
Coverage Gap	
One-month (30-day) supply during the Coverage Gap (from $4,130 until member's annual drug costs reach $6,550)	Same copayment as Initial Coverage
Catastrophic Coverage (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)
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.

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