



# Health Alliance Group Medicare Plans

## 2022 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 2022 premium.

	<b>In-Network</b>	<b>Out-of-Network</b>
Yearly Deductible	\$0	\$0
Yearly Out-of-Pocket Limit	\$1700	\$2000 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	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
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
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	Emergency Care: \$50 copayment, then 10% coinsurance World Wide Emergency Care: \$50 copayment, then 10% coinsurance	Emergency Care: \$50 copayment, then 10% coinsurance World Wide Emergency Care: \$50 copayment, then 10% coinsurance
Urgent Care (This is NOT emergency care, and in most cases, is out of the service area.)	Urgent Care: \$5 copayment per visit; 10% coinsurance for other services World Wide Urgent Care: \$5 copayment per visit; 10% coinsurance for other services	40% coinsurance
Partial Hospitalization	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	40% coinsurance
Chiropractic Services	Medicare Covered: \$5 copayment Non-Medicare Covered: Not Covered	Medicare Covered: 40% coinsurance Non-Medicare Covered: Not Covered

Occupational Therapy	10% coinsurance	40% coinsurance
Specialist Office Visits	\$5 copayment	40% coinsurance
Outpatient Mental Health Care	0% coinsurance per visit 10% coinsurance facility	40% coinsurance
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	Diabetic Foot care: \$5 copayment Podiatry Services: \$5 copayment	Diabetic Foot care: 40% coinsurance Podiatry Services: 40% coinsurance
Outpatient Rehabilitation Services	Physical Therapy: 10% coinsurance Speech Therapy: 10% coinsurance	Physical Therapy: 40% coinsurance Speech Therapy: 40% coinsurance
Telehealth	\$5 copayment PCP; \$5 copayment Specialist	40% coinsurance PCP; 40% coinsurance Specialist
Opioid Treatment Services	\$5 copayment	40% coinsurance
Labs	Labs: 10% coinsurance A1c: \$0	Labs: 40% coinsurance A1c: 40% coinsurance
Radiological Services	Complex Diagnostic: 10% coinsurance General Diagnostic: 10% coinsurance Therapeutic: 10% coinsurance X-Rays: 10% coinsurance	Complex Diagnostic: 40% coinsurance General Diagnostic: 40% coinsurance Therapeutic: 40% coinsurance X-Rays: 40% coinsurance
Outpatient Hospital Services	Surgery: 10% coinsurance Observation Services: 10% coinsurance	Surgery: 40% coinsurance Observation Services: 40% coinsurance
Ambulatory Surgery Center Services	10% coinsurance	40% coinsurance
Outpatient Substance Abuse Care	0% coinsurance per visit 10% coinsurance facility	40% coinsurance
Ambulance	Ground Ambulance: 10% coinsurance Air Ambulance: 10% coinsurance World Wide Ambulance: 10% coinsurance	Ground Ambulance: 40% coinsurance Air Ambulance: 40% coinsurance World Wide Ambulance: 40% coinsurance
Transportation (Non-medically necessary)	Not Covered	Not Covered
Durable Medical Equipment (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance	Bed Rails: 20% coinsurance Other: 20% coinsurance
Medical Supplies	Prosthetic Devices (braces, artificial limbs and eyes, etc.): 20% coinsurance Other: 20% coinsurance	Prosthetic Devices (braces, artificial limbs and eyes, etc.): 20% coinsurance Other: 20% coinsurance

Diabetic Supplies	Preferred Test Strips covered at 0% Non-Preferred Test Strips covered with approval at 0% All other diabetic supplies 10% coinsurance	Preferred Test Strips covered at 20% Non-Preferred Test Strips covered with approval at 20% All other diabetic supplies 20% coinsurance
Renal Dialysis	Dialysis Services: \$0 copayment Kidney Disease Education Services: \$0 copayment	Dialysis Services: 40% coinsurance Kidney Disease Education Services: 40% coinsurance
Meals for Chronic Conditions	Plan provides the meal benefit post discharge to any member with Congestive Heart Failure and Diabetes 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 for a maximum of 3 instances per year.	
Immunizations (Flu vaccine, pneumonia vaccine— for people with Medicare who are at risk, hepatitis B vaccine)	\$0 copayment	40% coinsurance
Welcome to Medicare and Annual Wellness Physical Exam/Visit	\$0 copayment	40% coinsurance
Bone mass measurement (for at-risk people with Medicare)	\$0 copayment	40% coinsurance
Preventive and Screening Services Please see preventative Flier for list of services.	Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer, glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: \$0 copayment	40% coinsurance
In-Home Safety Assessment (Non-Medicare Covered)	\$0 copayment	40% coinsurance
Nursing Hotline (Non-Medicare Covered)	\$0 copayment	
Fitness Benefit	BeFit: Members will be reimbursed up to \$360 per year towards fitness activities. (Excluded: Fitness equipment and personal training sessions)	
Smoking & Tobacco Cessation (Non-Medicare Covered)	\$0 copayment	40% coinsurance
Virtual Visits	\$0 copayment	\$0 copayment
Medicare Part B Drugs	10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)	20% coinsurance for Part B Drugs-Chemotherapy 20% coinsurance for Part B Drugs-Other (non-Chemotherapy)
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	
Vision Exams	Medicare Covered: \$0 copayment Non-Medicare Covered:\$5 copayment	Medicare Covered: 40% coinsurance Non-Medicare Covered: 40% coinsurance
Eyewear: Glasses/Contacts	Medicare Covered: \$0 copayment Non-Medicare Covered: Not Covered	
Routine Hearing	Medicare Covered: 20% coinsurance Non-Medicare Covered: \$45 copayment with a TruHearing provider	Medicare Covered: 20% coinsurance Non-Medicare Covered: Not Covered
Hearing Aids	TruHearing Select Plan (adjudicated by TruHearing): \$699 for Advanced digital hearing aid or \$999 for Premium digital hearing aid from TruHearing network audiologist	

# Pharmacy Highlights

<b>Pharmacy Benefits</b>	<b>Member Pays In-Network</b>
Deductible	\$0 (Out-of-Pocket Limit: \$1,100)
Does coverage continue through the Gap?	Yes
<b>Initial Coverage</b>	
Tier 1: Preferred Generic, 30-day supply	\$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	30-day supply same as 30-day copayment  90-day supply is 2 x 30-day copayment
Retail (90-day)	3 x 30-day copayment
<b>Coverage Gap</b>	
The Coverage Gap Phase begins when your total drug costs (your payments plus any Part D plan's payments) total \$4,430 until your year-to-date out-of-pocket drug costs reach \$7,050)	Same copayments as Initial Coverage
<b>Catastrophic Coverage</b> (when out-of-pocket drug costs reach \$7,050)	
Generics	\$3.95 OR 5% (whichever is higher)
All other drugs	\$9.85 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 PPO plan with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

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