Health Alliance™

Health Alliance Group Medicare Plans

2024 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 2024 premium.		
	In-Network	**Out-of-Network**
Yearly Deductible	$0	$0
Yearly Out-of-Pocket Maximum	$1,700	$2,000 Total IN and OON Combined
Services/Benefits	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital Care	10% coinsurance	40% coinsurance
Inpatient Services (in a Psychiatric Hospital)	10% coinsurance	40% coinsurance
Skilled Nursing Facility (SNF) Care (in a Medicare-certified skilled nursing facility)	10% coinsurance	40% coinsurance
Cardiac Rehabilitation Services and Pulmonary Rehabilitation Services	Cardiac: $0 copayment per visit Intensive Cardiac: $0 copayment per visit Pulmonary: $0 copayment per visit Supervised Exercise Therapy: $0 copayment per visit	Cardiac: 40% coinsurance per visit Intensive Cardiac: 40% coinsurance per visit Pulmonary: 40% coinsurance per visit Supervised Exercise Therapy: 40% coinsurance per visit
Emergency Care and World Wide Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	Emergency Care: $100 copayment per visit World Wide Emergency Care: $100 copayment per visit	Emergency Care: $100 copayment per visit World Wide Emergency Care: $100 copayment per visit
Urgently Needed Services (This is NOT emergency care, and in most cases, is out of the service area.)	Urgent Care: $65 copayment per visit World Wide Urgent Care: $65 copayment per visit	Urgent Care: $65 copayment per visit World Wide Urgent Care: $65 copayment per visit
Partial Hospitalization	10% coinsurance	40% coinsurance

Home Health Agency Care	10% coinsurance	40% coinsurance
Hospice Care	$0 copayment per visit. You must get care from a Medicare certified hospice program.	
Physician/Practitioner Services, including doctor's visits (Primary Care Provider)	$5 copayment per visit Telehealth: $5 copayment per visit	40% coinsurance Telehealth: 40% coinsurance
Chiropractic Services	Medicare Covered: $5 copayment per visit Non-Medicare Covered: Not Covered	Medicare Covered: 40% coinsurance Non-Medicare Covered: Not Covered
Physician/Practitioner Services, including doctor's office visits (Specialist Office Visits)	$5 copayment per visit Telehealth: $5 copayment per visit	40% coinsurance per visit Telehealth: 40% coinsurance
Outpatient Mental Health Care	0% coinsurance per visit; 10% coinsurance facility	40% coinsurance
Acupuncture	Medicare Covered: $5 copayment per visit Non-Medicare Covered: $5 copayment per visit, 15 visit max.	Medicare Covered: $5 copayment per visit Non-Medicare Covered: $5 copayment per visit, 15 visit max.
Podiatry Services	Diabetic Foot care: $5 copayment per visit Podiatry Services: $5 copayment per visit	Diabetic Foot care: 40% coinsurance per visit Podiatry Services: 40% coinsurance per visit
Outpatient Rehabilitation Services	Physical Therapy: 10% coinsurance Speech Therapy: 10% coinsurance Occupational Therapy: 10% coinsurance	Physical Therapy: 40% coinsurance Speech Therapy: 40% coinsurance Occupational Therapy: 40% coinsurance
Virtual Primary Care (Virtual Only)	$0 copayment per visit See EOC for complete details	Not Covered
Opioid Treatment Services	$5 copayment per visit	40% coinsurance
Outpatient Diagnostic Test and Therapeutic Services and Supplies (Labs & Radiological Services)	Labs: 10% coinsurance A1c: $0 copayment per test Complex Diagnostic: 10% coinsurance General Diagnostic: 10% coinsurance Therapeutic: 10% coinsurance X Rays: 10% coinsurance	Labs: 40% coinsurance A1c: 40% 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

Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	10% coinsurance	40% coinsurance
Outpatient Substance Abuse Services	0% coinsurance per visit; 10% coinsurance facility	40% coinsurance
Ambulance Services	Ground Ambulance: 10% coinsurance Air Ambulance: 10% coinsurance World Wide Ground Ambulance: 10% coinsurance World Wide Air Ambulance: 10% coinsurance	Ground Ambulance: 40% coinsurance Air Ambulance: 40% coinsurance World Wide Ground Ambulance: 40% coinsurance World Wide Air Ambulance: 40% coinsurance
Transportation (Non-medically necessary)	Not Covered	Not Covered
Durable Medical Equipment and Related Supplies (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance	Bed Rails: 20% coinsurance Other: 20% coinsurance
Durable Medical Equipment - Prosthetics and Related 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
Durable Medical Equipment – Diabetic Supplies	Preferred Test Strips covered at 0% coinsurance Non-Preferred Test Strips covered with approval at 0% All other diabetic supplies have a member coinsurance of 10% Diabetic Shoes or Inserts 10% coinsurance	Preferred Test Strips covered at 20% Non-Preferred Test Strips covered with approval at 20% All other diabetic supplies have a member coinsurance of 20% Diabetic Shoes or Inserts 20% coinsurance
Services to Treat Kidney Disease	Dialysis Services: $0 copayment per service Kidney Disease Education Services: $0 copayment per service	Dialysis Services: 40% coinsurance Kidney Disease Education Services: 40% coinsurance
Meals for Chronic Conditions	Plan provides the meal benefit post discharge to any CHF, Diabetes member, any member with 2 or more of the top 5 chronic conditions (Asthma, CHF, COPD, Diabetes, Vascular) who has an inpatient stay for any reason or is discharged from SNF. Additionally, members discharged from Inpatient Hospital with home care. Plan provides up to 2 home delivered meals per day. Plan provides meals for up to 14 days. Up to 3 instances.	
Over-the-Counter (OTC) products	Not Covered	Not Covered
Immunizations	$0 copayment per service	40% coinsurance

(Flu vaccine, pneumonia vaccine—for people with Medicare who are at risk, hepatitis B vaccine)		
Annual Wellness Visit, Physical Exam/Visit	Annual Wellness: $0 copayment per service Physical Exam: Not Covered	Annual Wellness: 40% coinsurance Physical Exam: Not Covered
Bone Mass Measurement (for at-risk people with Medicare)	$0 copayment per service	40% coinsurance
Welcome to Medicare Preventative Visit (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: $0 copayment Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: $0 copayment	Cardiovascular, abdominal aortic aneurysm, colorectal, pap smears/pelvic exams, prostate cancer, annual breast cancer: 40% coinsurance Glaucoma, barium enemas, digital rectal exam, EKG following Welcome Visit: 40% coinsurance
In-Home Support Companion Benefit	$0 for 30 annual hours of in home support through PAPA	$0 for 30 annual hours of in home support through PAPA
Nursing Advice Line (Non-Medicare Covered)	$0 copayment per service	$0 copayment per service
Fitness Benefit	Be Fit: Members will access up to $360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)	Be Fit: Members will access up to $360 per year towards fitness activities through the Medicare Flex Card. (Excluded: Fitness equipment)
Virtual Visits (Acute Care Services)	$0 copayment per visit	$0 copayment per visit
Medicare Part B Prescription Drugs	Insulin: 10% coinsurance, no more than $35 per month 10% coinsurance for Part B Drugs-Chemotherapy 10% coinsurance for Part B Drugs-Other (non-Chemotherapy)	Insulin: 20% coinsurance, no more than $35 per month 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	Your plan 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. Preventive – Annual Cleaning: $0 copayment Preventive – Supplemental Oral Exam: $0 copayment See EOC for Complete Details	

and repairs, crowns, bridge work, root canals and extractions.		
Dental Service (Medicare Covered)	Comprehensive Dental: $35 copayment	
Vision Exams	Medicare Covered: $0 Copayment Non-Medicare Covered: $5 Copayment, 1 exam per year	Medicare Covered: 40% coinsurance Non-Medicare Covered: 40% coinsurance
Eyewear: Glasses/Contacts	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered
Routine Hearing	Medicare Covered: 20% coinsurance Non-Medicare Covered: $45 copayment	Medicare Covered: 20% coinsurance Non-Medicare Covered: Not Covered
Hearing Aids	Plan covers up to two TruHearing-branded hearing aids every year (one per ear). TruHearing Advanced digital hearing aid is $699 and TruHearing Premium digital hearing aid is $999. Must use a TruHearing network provider. See EOC for complete details.	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 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 at Retail Pharmacies 90-day supply is 2 x 30-day copayment at Retail Pharmacies
Retail (90-day)	3 x 30-day copayment
Coverage Gap	
The Coverage Gap Phase begins when your total drug costs (your payments plus any Part D plan's payments) total $5,030 until your year-to-date out-of-pocket drug costs reach $8,000	Same copayments as Initial Coverage
Catastrophic Coverage (when out-of-pocket drug costs reach $8,000)	
Generics & all other drugs	$0 copayment
Out-of-Network Coverage	• Coverage for medications out-of-network may be available in special circumstances
Insulin	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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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