Health Alliance™

Health Alliance Group Medicare Plans

2024 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 2024 premium.	
	In-Network Only
Yearly Deductible	$0
Yearly Out-of-Pocket Maximum	$4,000
Services/Benefits	**Member Pays In-Network**
Inpatient Hospital Care	Days 1-7: $280 copayment per day Days 8+: $0 copayment per day
Inpatient Services in a Psychiatric Hospital	Days 1-7: $225 copayment per day Days 8-90: $0 copayment per day
Skilled Nursing Facility (SNF) Care (in a Medicare-certified skilled nursing facility)	Days 1-20: $0 copayment per day Days 21-100: $160 copayment per day
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
Emergency Care and World Wide Emergency Care(You may go to any emergency room if you reasonably believe you need emergency care.)	Emergency Care: $90 copayment per visit World Wide Emergency Care: $90 copayment per visit
Urgently Needed Services (This is NOT emergency care, and in most cases, is out of the service area.)	Urgent Care: $55 copayment per visit World Wide Urgent Care: $55 copayment per visit
Partial Hospitalization	20% coinsurance
Home Health Agency Care	$0 copayment per visit
Hospice Care	$0 copayment. You must get care from a Medicare certified hospice program
Physician/Practitioner Services, including doctor's visits (Primary Care Provider)	Primary Care: $10 copayment per visit Telehealth: $10 copayment per visit
Chiropractic Services	Medicare Covered: $20 copayment per visit Non-Medicare Covered: Not Covered
Physician/Practitioner Services, including doctor's office visits (Specialist Office Visits)	Specialist $35 copayment per visit Telehealth: $35 copayment per visit
Outpatient Mental Health Care	$40 copayment per visit

Acupuncture	Medicare Covered: $10 copayment per visit Non-Medicare Covered: $10 copayment per visit, 15 visit max.
Podiatry Services	Diabetic Footcare: $35 copayment per visit Podiatry Services: $35 copayment per visit
Outpatient Rehabilitation Services	Physical Therapy: $35 copayment per visit Speech Therapy: $35 copayment per visit Occupational Therapy $35 copayment per visit
Virtual Primary Care (Virtual Only)	$0 copayment See EOC for complete details
Opioid Treatment Services	$35 copayment per visit
Outpatient Diagnostic Tests and Therapeutic Services and Supplies (Labs & Radiological Services)	Labs: 20% coinsurance per test A1c: $0 copayment per test Complex Diagnostic: 20% coinsurance per test General Diagnostic: 20% coinsurance per test Therapeutic: 20% coinsurance per test X Rays: 20% coinsurance per test
Outpatient Hospital Services	Surgery: $275 copayment per visit Observation Services: $275 copayment per visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	$275 copayment per visit
Outpatient Substance Abuse Services	$65 copayment per visit
Ambulance Services	Ground Ambulance: $275 copayment per trip Air Ambulance: $275 copayment per trip World Wide Ground Ambulance: $275 copayment per trip World Wide Air Ambulance: $275 copayment per trip
Transportation (Non-medically necessary)	Not Covered
Durable Medical Equipment and Related Supplies (wheelchairs, oxygen, etc.)	Bed Rails: 0% coinsurance Other: 20% coinsurance
Durable Medical Equipment-Prosthetics and related supplies	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% coinsurance All other diabetic monitoring supplies have a member coinsurance of 20% coinsurance Diabetic Shoes or Inserts 20% coinsurance
Services to Treat Kidney Disease	Dialysis Services: 20% coinsurance Kidney Disease Education Services: $0 copayment per service
Help with Certain Chronic Conditions (Meals for Chronic Conditions)	Plan provides the meal benefit post discharge to any CHF, Diabetes member, or 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
Immunizations (Flu vaccine, pneumonia vaccine—for people with Medicare who are at risk, hepatitis B vaccine)	$0 copayment per service
Annual Wellness Visit, Physical Exam/Visit	Annual Wellness: $0 copayment per service Physical Exam: Not Covered
Bone Mass Measurement (for at-risk people with Medicare)	$0 copayment per service
Welcome to Medicare Preventive Visit (Preventive and Screening Services Please see preventive 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
In-Home Support– Companion Benefit	$0 copayment for 30 annual hours of in home support through PAPA
Nursing Advice Line (Non-Medicare Covered)	$0 copayment per service
Fitness Benefit	BeFit: Members will access up to $360 per year towards fitness activities (Excluded: Fitness equipment). See EOC for complete details.
Virtual Visits (Acute Care Services)	$0 copayment per visit
Medicare Part B Prescription Drugs	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 and repairs, crowns, bridge work, root canals and extractions.	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
Dental Service (Medicare Covered)	Comprehensive Dental: $35 copayment
Vision Exams	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered
Eyewear: Glasses/Contacts	Medicare Covered: $0 copayment Non-Medicare Covered: Not Covered
Routine Hearing	Medicare Covered: $45 copayment Non-Medicare Covered: $45 copayment
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.

Pharmacy Highlights

Pharmacy Benefits	Member Pays In-Network
Deductible	$0
Does coverage continue through the Gap?	No
Initial Coverage	
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	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	Tier 1 drugs covered through coverage gap with same payments as initial coverage. Tier 2-5 drugs 25% for Generic Drugs and 25% for Brand drugs during the coverage gap.
Catastrophic Coverage (when out-of-pocket drug costs reach $8,000)	
Generics & All other drugs	$0 copayment

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

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