

SECTION 6**Product Outline**

Overview

Health Alliance has contracted with the Centers for Medicare & Medicaid Services (CMS) to offer Health Alliance Medicare Advantage HMO (health maintenance organization) and POS (point of service) plans for Medicare-eligible individuals. Since CMS recognizes these plans, Medicare contracted providers should also consider Health Alliance to be Medicare for billing and coverage purposes. To enroll in a Medicare Advantage HMO or POS plan, a Medicare beneficiary must have both Medicare Parts A and B and live in the service area.

Health Alliance Medicare members receive a written health risk assessment during their first month of enrollment. Members are designated as “well,” “moderate” or “at-risk”. This information is used to qualify members for our complimentary outreach services. “At-Risk” members would be eligible for Case Management or a home assessment with a Nurse Practitioner. Based on the member’s location, this home assessment can be carried out by a Health Alliance Nurse Practitioner or a contracted Nurse Practitioner through our partnership with Focus Care.

Health Alliance also offers Medicare Supplement plans A, G, High-Deductible G and N, and a stand-alone prescription drug plan for employer groups.

Medicare HMO

Health Alliance Medicare members may only see contracted providers at offices within the service area (see links to service area maps below). Contracted providers with offices both in and out of the service area must be mindful of this requirement and not see Health Alliance Medicare HMO members out of the service area.

The plan structures are similar to a traditional HMO product and allow the member to receive the comprehensive benefits provided by HMOs, including routine physicals, mammograms, prostate exams, telehealth, and routine vision care. Members must receive their care within the contracted network of providers to be eligible for benefits. Care received outside of the designated network (except emergency care, urgently needed care and out-of-area renal dialysis) must have prior written approval from a Health Alliance medical director.

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The PCP is responsible for coordinating the member's health care and directing specialty care services. Some services may require preauthorization from Health Alliance Medical Management. Preauthorization is obtained by the ordering provider's office. Copayments are required at the time of appointment regardless of the member's benefit plan.

Medicare POS

Health Alliance Medicare POS members may seek services from any physician, specialist or hospital, regardless if the provider is part of the Health Alliance Medicare network or not. However, if a member visits a provider outside our network, the member may have to pay more for the services received and may have to follow special rules for coverage.

The PCP is responsible for coordinating the member's health care and directing specialty care services. Some services may require preauthorization from Health Alliance Medical Management. Preauthorization is obtained by the ordering provider's office. Copayments are required at the time of appointment regardless of the member's benefit plan.

OSF MedAdvantage

The OSF MedAdvantage plans were designed in partnership with OSF HealthCare. These plans provide lower premiums and the lowest out-of-pocket costs when the member sees a provider in the Tier 1 provider network. Within a tiered provider network, out-of-pocket costs depend on the type of provider a member sees. OSF MedAdvantage HMO-POS plans have two in-network tier levels. OSF MedAdvantage HMO-POS plans also include a third tier, which is out-of-network coverage, and members pay the most out-of-pocket when seeking care out of network. Members may choose a PCP in either Tier 1 or Tier 2. Members can also see other providers in either Tier 1 or Tier 2, but out-of-pocket costs will be less for a Tier 1 provider. In the provider directory, providers are marked with a badge indicating either Tier 1 or Tier 2.

Please note: The network of providers for OSF MedAdvantage plans differs from the Health Alliance Medicare and commercial networks, so it is vital to consult the Medicare Provider Directory at [HealthAlliance.org/Directories](https://www.healthalliance.org/directories) when making referrals for specialty care. Some services may require preauthorization from Health Alliance Medical Management. Preauthorization is obtained by the ordering provider's office."

Simplete

Simplete HMO plans have a tiered network. These plans include “Simplete” in the plan name. The Simplete plans were designed in partnership with key local healthcare systems. These plans provide lower premiums and the lowest out-of-pocket costs when the member sees a provider in the Tier 1 provider network.

Within a tiered provider network, out-of-pocket costs depend on the type of provider a member sees. Simplete HMO-POS plans have two in-network tier levels. Simplete HMO-POS plans also include a third tier, which is out-of-network coverage, and members pay the most out-of-pocket when seeking care out of network. Members may choose a PCP in either Tier 1 or Tier 2. Members can also see other providers in either Tier 1 or Tier 2, but out-of-pocket costs will be less for a Tier 1 provider. In the provider directory, providers are marked with a badge indicating either Tier 1 or Tier 2.

Please note: The network of providers for Simplete plans differs from the Health Alliance Medicare and commercial networks, so it is vital to consult the Medicare Provider Directory at [HealthAlliance.org/Directories](https://www.healthalliance.org/directories) when making referrals for specialty care. Some services may require preauthorization from Health Alliance Medical Management. Preauthorization is obtained by the ordering provider’s office.

Service Area Maps

[2021 Iowa Service Area Map](#)

[2021 Illinois/Western Indiana Service Area Map](#)

[2021 Reid Health Service Area Map](#)

[2021 Washington Service Area Map](#)

[2021 Simplete Service Area Map](#)

[2021 OSF MedAdvantage Service Area Map](#)