



Health Alliance™

Health Alliance Group Medicare Plans

2025 Benefit Highlights for POS 10 Rx

Please use this Benefit Highlight in conjunction with your Evidence of Coverage (EOC) to understand all of your benefits.

<p>If you receive a bill directly from Health Alliance, your premium is \$188. If you receive a bill from your employer group or retirement benefit administrator, please contact them for your 2025 premium.</p>		
	In-Network	Out-of-Network
Yearly Deductible	\$0	\$0
Yearly Out-of-Pocket Maximum	\$2,900	\$5,750 Total IN and OON Combined
Services/Benefits	Member Pays In-Network	Member Pays Out-of-Network
Inpatient Hospital Care	Days 1-7 - \$250 copayment per day Days 8+ - \$0 copayment per day	25% coinsurance
Inpatient Services (in a Psychiatric Hospital)	Days 1-9 - \$175 copayment per day Days 10-90 - \$0 copayment per day	25% coinsurance
Skilled Nursing Facility (SNF) Care (in a Medicare-certified skilled nursing facility)	Days 1-20: \$10 copayment per day Days 21-100: \$214 copayment per day	Days 1-20: \$85 copayment per day Days 21-100: \$225 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	Cardiac: \$30 copayment per visit Intensive Cardiac: \$30 copayment per visit Pulmonary: \$30 copayment per visit Supervised Exercise Therapy: \$30 copayment per visit
Emergency Care and Worldwide Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	Emergency Care: \$140 copayment per visit Worldwide Emergency Care: \$140 copayment per visit	Emergency Care: \$140 copayment per visit Worldwide Emergency Care: \$140 copayment per visit
Urgently Needed Services (This is NOT emergency care, and in most cases, is out of the service area.)	Urgent Care: \$30 copayment per visit Worldwide Urgent Care: \$30 copayment per visit	Urgent Care: \$30 copayment per visit Worldwide Urgent Care: \$30 copayment per visit
Partial Hospitalization	\$30 copayment per day	\$45 copayment per day
Home Health Agency Care	\$0 copayment per visit	\$30 copayment per visit
Physician/Practitioner Services, including doctor's visits (Primary Care Provider)	\$10 copayment per visit Telehealth: \$10 copayment per visit	\$40 copayment per visit Telehealth: Not Covered
Chiropractic Services	Medicare Covered: \$20 copayment per visit Non-Medicare Covered: Not Covered	Medicare Covered: \$45 copayment per visit Non-Medicare Covered: Not Covered

Physician/Practitioner Services, including doctor's office visits (Specialist Office Visits)	\$30 copayment per visit Telehealth: \$30 copayment per visit	\$40 copayment per visit Telehealth: Not Covered
Outpatient Mental Health Care	\$30 copayment per visit	\$40 copayment per visit
Acupuncture	Medicare Covered: \$20 copayment per visit Non-Medicare Covered: \$20 copayment per visit, 15 visit max.	Medicare Covered: \$20 copayment per visit Non-Medicare Covered: \$20 copayment per visit, 15 visit max.
Podiatry Services	Diabetic Foot care: \$30 copayment per visit Podiatry Services: \$30 copayment per visit	Diabetic Foot care: \$40 copayment per visit Podiatry Services: \$40 copayment per visit
Outpatient Rehabilitation Services	Physical Therapy: \$20 copayment Speech Therapy: \$20 copayment Occupational Therapy: \$20 copayment	Physical Therapy: \$30 copayment Speech Therapy: \$30 copayment Occupational Therapy: \$30 copayment
Virtual Primary Care (Virtual Only)	\$0 copayment per visit	Not Covered
Opioid Treatment Services	\$30 copayment per visit	\$40 copayment per visit
Outpatient Diagnostic Test and Therapeutic Services and Supplies (Labs & Radiological Services)	Labs: \$0 copayment per test A1c: \$0 copayment per test Complex Diagnostic: \$0 copayment per test General Diagnostic: \$0 copayment per test Therapeutic: \$0 copayment per test X Rays: \$0 copayment per test	Labs: \$30 copayment per test A1c: \$30 copayment per test Complex Diagnostic: \$30 copayment per test General Diagnostic: \$30 copayment per test Therapeutic: \$30 copayment per test X Rays: \$30 copayment per test
Outpatient Hospital Services	Surgery: \$0-\$300 copayment per visit See EOC for complete details. Observation Services: \$30 copayment per visit	Surgery: \$350 copayment per visit Observation Services: \$45 copayment per visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	\$0-\$300 copayment per visit See EOC for complete details.	\$350 copayment per visit
Outpatient Substance Abuse Services	\$30 copayment per visit	\$40 copayment per visit
Ambulance Services	Ground Ambulance: \$275 copayment per trip Air Ambulance: \$400 copayment per trip Worldwide Ground Ambulance: \$275 copayment per trip Worldwide Air Ambulance: \$400 copayment per trip	Ground Ambulance: \$275 copayment per trip Air Ambulance: \$400 copayment per trip Worldwide Ground Ambulance: \$275 copayment per trip Worldwide Air Ambulance: \$400 copayment per trip
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% Non-Preferred Test Strips covered with approval at 0% All other diabetic supplies have a member coinsurance of 0% Diabetic Shoes or Inserts 0% 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: 20% coinsurance Kidney Disease Education Services: \$0 copayment per service	Dialysis Services: 50% coinsurance Kidney Disease Education Services: \$30 copayment per service
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.	Not Covered
Over-the-Counter (OTC) products	\$35 per quarter allowance towards OTC products. May purchase online or with participating retailers. See EOC for complete details	\$35 per quarter allowance towards OTC products. May purchase online or with participating retailers. See EOC for complete details
Immunizations (Flu vaccine, pneumonia vaccine—for people with Medicare who are at risk, hepatitis B vaccine)	\$0 copayment per service	\$0 copayment per service
Annual Wellness Visit, Physical Exam/Visit	Annual Wellness: \$0 copayment per service Physical Exam: \$0 copayment per service	Annual Wellness: \$0 copayment per service Physical Exam: \$0 copayment per service
Bone Mass Measurement (for at-risk people with Medicare)	\$0 copayment per service	\$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	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
Nursing Advice Line (Non-Medicare Covered)	\$0 copayment per service	Not Covered

Fitness Benefit	Be Fit: Members will access up to \$360 per year towards fitness activities. See EOC for complete details.	
Virtual Visits (Acute Care Services)	\$0 copayment per visit	\$0 copayment per visit
Medicare Part B Prescription Drugs	Insulin: 0%-15% coinsurance, no more than \$35 per month 0%-15% coinsurance for Part B Drugs-Chemotherapy 0%-15% coinsurance for Part B Drugs-Other (non-Chemotherapy)	Insulin: 25% coinsurance, no more than \$35 per month 25% coinsurance for Part B Drugs-Chemotherapy 25% 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 \$2,000 per plan year for non-Medicare-covered dental services. You will be responsible for any cost above the \$2,000 maximum. Diagnostic and Preventative Dental Services: \$0 copayment Basic Dental Services: 20% coinsurance Major Dental Services: 40% coinsurance See EOC for Complete Details	
Dental Service (Medicare Covered)	Comprehensive Dental: \$20 copayment	
Vision Exams	Medicare Covered: \$0 Copayment Non-Medicare Covered: \$0 Copayment, 1 exam per year	Medicare Covered: \$40 Copayment Non-Medicare Covered: Not Covered
Eyewear: Glasses/Contacts	Medicare Covered: \$25 copayment Non-Medicare Covered: \$200 allowance towards glasses (lenses and frames)/contacts including upgrades. See EOC for complete details.	Medicare Covered: \$40 copayment Non-Medicare Covered: \$200 allowance towards glasses (lenses and frames)/contacts including upgrades. See EOC for complete details.
Routine Hearing	Medicare Covered: \$25 copayment Non-Medicare Covered: \$0 copayment	Medicare Covered: \$40 copayment Non-Medicare Covered: Not Covered
Hearing Aids	Plan covers up to two TruHearing-branded hearing aids every year (one per ear per year). 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 Maximum	\$2,000
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	25% coinsurance 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. Only applies to Tiers 1 and 2. 90-day supply applies to Tiers 1-4.
Retail (90-day)	3 x 30-day copayment. Only applies to Tiers 1-4.
Catastrophic Coverage (when out-of-pocket drug costs reach \$2,000)	
Generics & all other drugs	\$0 copayment
Out-of-Network Coverage	<ul style="list-style-type: none"> 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 HMO-POS with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.