simplete™

Simplete 3 (HMO-POS) / Simplete 2 (HMO)

2023 Summary of Benefits

January 1, 2023 – December 31, 2023

Call toll-free 1-877-634-3390 daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.
TTY 711
www.healthalliancemedicare.org

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This booklet gives you a summary of what our plans cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. For a complete list of covered services, call us and ask for the Evidence of Coverage.

Options for Getting Medicare Benefits

- Original Medicare (fee-for-service), which is run by the federal government
- Medicare Advantage through a private company, like Health Alliance Medicare

Tips for Comparing Medicare Options

This booklet allows you to compare costs and benefits for our plans.

- If you want to compare our plans with other Medicare Advantage plans, ask other plans for their Summary of Benefits booklets or use the Medicare Plan Finder at medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare and You* handbook. You can find it at medicare.gov. You can also get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Booklet Sections

- Things to Know
- Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Covered Benefits
- About Us

This document is available in other formats, such as Braille and large print. For more information, call 1-877-933-8475 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

THINGS TO KNOW

Hours of Operation

Call daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

Contact Info

- If you’re a current member: 1-877-933-8475 (TTY 711)
- If you’re not yet a member: 1-877-634-3390 (TTY 711)
- www.healthalliancemedicare.org

Eligibility
To join any of our Medicare Advantage plans, you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Our service area includes these counties in Illinois: Champaign, Grundy, Iroquois, Kankakee, Livingston, McLean, Piatt, Vermilion and Woodford.

Our service area includes these counties in Indiana: Benton, Fountain, Newton, Vermillion and Warren.

Doctors, Hospitals and Pharmacies
Our plans have a large network of doctors, hospitals, pharmacies, and other providers to choose from.

With our POS plans, you must have a primary care provider (PCP) to oversee your care and refer you to the specialists, but you also have the flexibility to see out-of-network providers.

You must use network pharmacies to fill your prescriptions in most cases.

You can see our provider directory and pharmacy directory at our website (www.healthalliancemedicare.org). You can call us, and we will send you a copy.

What We Cover
Like all Medicare Advantage plans, we cover everything Original Medicare covers, but we also cover more.

For some benefits, you may pay less in our plan than you would in Original Medicare, and for some, you may pay more. This booklet outlines many of our extra benefits and perks that Original Medicare doesn't cover.

We cover the prescriptions drugs listed in our formulary at www.healthalliancemedicare.org. You can read it online or call us for a copy.

Determining Drug Costs
Each of the drugs we cover is grouped into one of five tiers. The amount you pay depends on the drug's tier and what stage of the benefit you've reached (Initial Coverage, Coverage Gap or Catastrophic Coverage). You can find out what tier your drug is on in our formulary at www.healthalliancemedicare.org , and we discuss the benefit stages later in this booklet.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare Sales Associate at 1-877-634-3390.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit HealthAllianceMedicare.org or call 1-877-634-3390 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ For HMO-POS plans only: Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY		
Premium Each Month You must continue to pay your Medicare Part B premium.	**$48**	**$28**
This plan includes prescription drug coverage. For information on non-Rx plans, contact your broker or Health Alliance Medicare.		
Medical Deductible	**$0**	**$0**
Prescription Drugs Deductible	**$0**	**$0**
Maximum Out-of-Pocket Each Year The most you pay for copays, coinsurance and other costs for medical services for the year. You still need to pay your monthly premiums.		
In-network providers	**$4,950**	**$4,950**
In-network and Out-of-network providers	**$6,700**	**Not Covered**
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Care Our plan covers an unlimited number of days for an inpatient hospital stay. (may require prior authorization)		
Tier 1:	**• $250 copay per day for days 1 through 8** **• $0 copay per day for days 9 and beyond**	**• $250 copay per day for days 1 through 8** **• $0 copay per day for days 9 and beyond**
Tier 2 and Non-Medicare covered stay:	**• $250 copay per day for days 1 through 8** **• $0 copay per day for days 9 and beyond**	**• $250 copay per day for days 1 through 8** **• $0 copay per day for days 9 and beyond**
Out-of-network:	**• $600 copay per day for days 1 through 4** **• $0 copay per day for days 5 through 90**	**• $600 copay per day for days 1 through 4** **• $0 copay per day for days 5 through 90**
Outpatient Hospital Care (may require prior authorization)		
Tier 1:	**$200 copay**	**$200 copay**
Tier 2:	**25% of the cost**	**20% of the cost**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Out-of-network:	**50% of the cost**	**Not Covered**
DOCTOR VISITS		
Primary Care Physician Office Visits		
Tier 1:	**$5 copay**	**$5 copay**
Tier 2:	**$25 copay**	**$20 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Specialist Office Visits		
Tier 1:	**$25 copay**	**$25 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Virtual Visits Our plan covers visits with a provider by phone or online, 24/7.		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**Not Covered**
Preventive Care Our plan covers many preventive services, including but not limited to: • Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Obesity screening and therapy • Prostate cancer screenings (PSA) • Screening and counseling to reduce alcohol misuse • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “Welcome to Medicare” preventive visit (one-time)		

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**$50 copay**	**Not Covered**
EMERGENCY SERVICES		
Emergency Care If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.		
Tier 1	**$110 copay**	**$110 copay**
Tier 2	**$110 copay**	**$110 copay**
Out-of-network:	**$110 copay**	**$110 copay**
Urgent Care Services		
Tier 1	**$40 copay**	**$40 copay**
Tier 2	**$40 copay**	**$40 copay**
Out-of-network:	**$40 copay**	**$40 copay**
DIAGNOSTIC SERVICES Costs for these services may vary based on place of service and may require prior authorization.		
Diagnostic Tests, Procedures and Lab Services		
Tier 1:	**$0 copay for A1C lab test, $10 copay, for other services**	**$10 copay**
Tier 2:	**$25 copay**	**20% of the cost**
Out-of-network:	**$50 copay**	**Not Covered**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Diagnostic Radiology (such as MRIs, CT scans)		
Tier 1:	**$50 copay**	**$50 copay**
Tier 2:	**$150 copay**	**$150 copay**
Out-of-network:	**30% of the cost**	**Not Covered**
Outpatient X-rays (such as x-rays and ultrasounds)		
Tier 1:	**$10 copay**	**$10 copay**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**30% of the cost**	**Not Covered**
HEARING, DENTAL AND VISION		
Diagnostic Hearing Exam (Exam to diagnose and treat hearing and balance issues)		
Tier 1:	**$25 copay**	**$25 copay**
Tier 2:	**$25 copay**	**$25 copay**
Out-of-network:	**$40 copay**	**Not Covered**
Routine Hearing Exam (Must be with a TruHearing® provider) (Copayment is not subject to the maximum out-of-pocket) (1 exam per year)		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**Not Covered**	**Not Covered**
Hearing Aids Up to two TruHearing-branded® hearing aids every year (one per ear per year). Benefit is limited to the TruHearing-branded®		

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Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing® provider to use this benefit. Premium hearing aids are available in rechargeable style options for an additional $50 per aid. Limitations may apply. Copayment is not subject to the maximum out-of-pocket. Hearing aid purchases include: • Provider visits within first year of hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid		
Advanced:	**$699 copay per aid**	**$699 copay per aid**
Premium:	**$999 copay per aid**	**$999 copay per aid**
Medicare-covered Comprehensive Dental Services • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease • Non-covered procedures or services (e.g. tooth removal) if performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure • Dental exams prior to kidney transplantation		
Tier 1:	**$25 copay**	**$25 copay**
Tier 2:	**$25 copay**	**$25 copay**
Out-of-network:	**$25 copay**	**Not Covered**
Non-Medicare-covered Dental Services (up to $2,000 per plan year) You pay the applicable cost-sharing amount for Non-Medicare-covered Dental Services and your plan will pay a maximum of $2,000 per contract year. You will be responsible for 100% of the cost for the rest of the year once the plan has paid the $2,000 maximum amount.		
Class 1: Diagnostic and Preventive Services Emergency Palliative Treatment Radiographs	**0% Coinsurance for class 1 Dental.**	**0% Coinsurance for class 1 Dental.**
Class 2: Oral Surgery Services Endodontic Periodontics Restorative	**20% Coinsurance for class 2 Dental.**	**20% Coinsurance for class 2 Dental.**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Non-Routine Services **Class 3:** Prosthodontic Dentures	**40% Coinsurance for class 3 Dental.**	**40% Coinsurance for class 3 Dental.**
Vision Services Exam to diagnose and treat diseases and conditions of the eye.		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$25 copay**	**$25 copay**
Out-of-network:	**$40 copay**	**Not Covered**
Eyewear After Cataract Surgery (Medicare-covered) One pair of eyeglasses or contact lenses after each cataract surgery.		
Tier 1:	**$25 copay**	**$25 copay**
Tier 2:	**$25 copay**	**$25 copay**
Out-of-network:	**$40 copay**	**Not Covered**
Eyewear (non-Medicare covered)	Get access to vision services beyond what Original Medicare covers, including a routine vision exam with an in-network provider. Plus, get a $150 allowance for eyewear.	
Glaucoma Screening		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Routine Eye Exam (1 exam per plan year)		
Tier 1:	**$0 copay**	**$0 copay**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Tier 2:	**$40 copay**	**$0 copay**
Out-of-network:	**Not Covered**	**Not Covered**
MENTAL HEALTH CARE		
Outpatient Individual Mental Health Therapy Visit		
Tier 1:	**$40 copay**	**$40 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Outpatient Group Mental Health Therapy Visit		
Tier 1:	**$40 copay**	**$40 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Inpatient Mental Health Visit Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. (may require prior authorization)		
Tier 1:	**• $200 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**	**• $200 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**
Tier 2:	**• $250 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**	**• $250 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**
Out-of-network:	**• $470 copay per day for days 1 through 4** **• $0 copay per day for days 5 through 90**	**• $470 copay per day for days 1 through 4** **• $0 copay per day for days 5 through 90**
SKILLED NURSING FACILITIES		

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Skilled Nursing Facility (SNF) Our plan covers up to 100 days in an SNF. (may require prior authorization)		
Tier 1:	**• $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 100**	**• $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 100**
Tier 2:	**• $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 100**	**• $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 100**
Out-of-network:	**• $100 copay per day for days 1 through 20 • $200 copay per day for days 21 through 100**	**• $100 copay per day for days 1 through 20 • $200 copay per day for days 21 through 100**
PHYSICAL THERAPY		
Outpatient Physical Therapy (may require prior authorization)		
Tier 1:	**$40 copay**	**$40 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
TRANSPORTATION SERVICES		
Ambulance Authorization for non-emergency transportation by ambulance is required.		
Tier 1 and Tier 2 emergent:	**$250 copay**	**$250 copay**
Out-of-network non-emergent:	**$250 copay**	**$250 copay**
Transportation (within the U.S. and it's territories)	**Not Covered**	**Not Covered**

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Worldwide Emergency Transportation (outside the U.S. and it's territories)	**$250 copay**	**$250 copay**
MEDICARE PART B DRUGS		
Medicare Part B Drugs such as Chemotherapy Drugs (may require prior authorization)		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Other Medicare Part B Drugs (may require prior authorization)		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
PART D PRESCRIPTION DRUGS		
You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you have reached this amount, you will move to the next stage (the Coverage Gap Stage).		
Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply. You may get your drugs at network retail pharmacies and mail-order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy.		
Initial Coverage for Standard Retail Cost-Sharing		
Tier 1 - Preferred Generic		
30-day supply:	**$2 copay**	**$2 copay**
90-day supply:	**$6 copay**	**$6 copay**
Tier 2 - Generic		
30-day supply:	**$15 copay**	**$15 copay**
90-day supply:	**$45 copay**	**$45 copay**
Tier 3 - Preferred Brand		
30-day supply:	**$47 copay**	**$47 copay**
90-day supply:	**$141 copay**	**$141 copay**
Tier 4 - Non-Preferred Drug		
30-day supply:	**50% of the cost**	**50% of the cost**
90-day supply:	**50% of the cost**	**50% of the cost**
Tier 5 - Specialty Tier		
30-day supply:	**33% of the cost**	**33% of the cost**
90-day supply:	**33% of the cost**	**33% of the cost**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Initial Coverage for Standard Mail-Order Cost-Sharing		
Tier 1 - Preferred Generic		
30-day supply:	**$2 copay**	**$2 copay**
90-day supply:	**$4 copay**	**$4 copay**
Tier 2 - Generic		
30-day supply:	**$15 copay**	**$15 copay**
90-day supply:	**$30 copay**	**$30 copay**
Tier 3 - Preferred Brand		
30-day supply:	**$47 copay**	**$47 copay**
90-day supply:	**$94 copay**	**$94 copay**
Tier 4 - Non-Preferred Drug		
30-day supply:	**50% of the cost**	**50% of the cost**
90-day supply:	**50% of the cost**	**50% of the cost**
Tier 5 - Specialty Tier		
30-day supply:	**33% of the cost**	**33% of the cost**
90-day supply:	**33% of the cost**	**33% of the cost**

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Coverage Gap		
Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, for Tier 1, you continue to pay your copay; for Tiers 2-5 you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Our plan offers additional coverage through the gap for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $15 - $35 per month. Not everyone will enter the coverage gap.		
Catastrophic Coverage		
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		
ADDITIONAL BENEFITS		
Acupuncture (Covered for headache and neck pain) (Up to 15 visits per year)		
Tier 1:	**$5 copay**	**$5 copay**
Tier 2:	**$5 copay**	**$5 copay**
Out-of-network:	**$5 copay**	**Not Covered**
Chemotherapy For Part B chemotherapy drugs. (may require prior authorization)		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**

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Chiropractic Care Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). (may require prior authorization)		
Tier 1:	**$15 copay**	**$15 copay**
Tier 2:	**$20 copay**	**$20 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Durable Medical Equipment Wheelchairs, oxygen, etc. (may require prior authorization)		
Tier 1:	**0%- 20% of the cost, depending on the supply**	**0%- 20% of the cost, depending on the supply**
Tier 2:	**0%- 20% of the cost, depending on the supply**	**0%- 20% of the cost, depending on the supply**
Out-of-network:	**50% of the cost**	**Not Covered**
Diabetes Monitoring Supplies Manufacturer (Abbott Laboratories) limitations apply only to Blood Glucose Meters and Strips, and these items have a member coinsurance of 0% in-network. (may require prior authorization)		
Tier 1:	**0%-20% of the cost, depending on the supply**	**0%-20% of the cost, depending on the supply**
Tier 2:	**0%-20% of the cost, depending on the supply**	**0%-20% of the cost, depending on the supply**
Out-of-network:	**50% of the cost**	**Not Covered**
Diabetes Self-Management Training		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**

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Out-of-network:	**$50 copay**	**Not Covered**
Foot Care (Podiatry Services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.		
Tier 1:	**$50 copay**	**$50 copay**
Tier 2:	**$50 copay**	**$50 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Home Health Care		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Hospice $0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare. Please contact us for more details.		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Outpatient Cardiac Rehabilitation Service For a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks.		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Outpatient Occupational Therapy Visit (may require prior authorization)		

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Tier 1:	**$40 copay**	**$40 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Outpatient Speech and Language Therapy Visit (may require prior authorization)		
Tier 1:	**$40 copay**	**$40 copay**
Tier 2:	**$40 copay**	**$40 copay**
Out-of-network:	**$50 copay**	**Not Covered**
Outpatient Substance Abuse Group Therapy Visit		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Outpatient Substance Abuse Individual Therapy Visit		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Outpatient Surgery at an Ambulatory Surgical Center (may require prior authorization)		
Tier 1:	**$200 copay**	**$200 copay**
Tier 2:	**25% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**

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Outpatient Surgery at an Outpatient Hospital (may require prior authorization)		
Tier 1:	**$200 copay**	**$200 copay**
Tier 2:	**25% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Over-the-Counter Items Our plan covers up to 8 Over-the-Counter COVID tests per month, up to $12 per test.		
Tier 1:	**$0 copay**	**$0 copay**
Tier 2:	**$0 copay**	**$0 copay**
Out-of-network:	**Not Covered**	**Not Covered**
Prosthetic Devices and Related Medical Supplies Braces, Artificial Limbs, etc. (may require prior authorization)		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Renal Dialysis		
Tier 1:	**20% of the cost**	**20% of the cost**
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**
Therapeutic Shoes or Inserts for Diabetics		
Tier 1:	**20% of the cost**	**20% of the cost**

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Tier 2:	**20% of the cost**	**20% of the cost**
Out-of-network:	**50% of the cost**	**Not Covered**

WELLNESS PROGRAMS

***Be Fit* Fitness Benefit**
Get paid back for a variety of fitness activities. You choose how you want to work out, and we pay you back up to $360 a year. Activities include the following and more:

- Fitness class fees.
- Gym memberships.
- Online fitness subscriptions.
- Weight loss subscriptions.
- Ski memberships.
- Rowing.
- Golf.
- Bowling.
- Tennis.
- Pickleball.
- Recreational league fees.
- Pool exercise classes.
- 5k/10k race fees.

If your fees are more than $360 a year, you pay the difference. If they're less, we pay you back the amount you paid. Be Fit doesn't cover fitness trackers or personal equipment.

Wellness Rewards Program
With our Wellness Rewards program, you have the opportunity to earn a $50 gift card for doing specified wellness activities based on a point system.

Simplete plans are powered by Health Alliance Medicare - a Medicare Organization with a Medicare contract. Enrollment in a

	Simplete 3 (HMO-POS)	Simplete 2 (HMO)
Simplete plan depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat Health Alliance Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Other Pharmacies/Physicians/Providers are available in our network. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.		

ABOUT US

Health Alliance Medicare is part of a company that has served Illinois for over 35 years. We have more than 26,000 Medicare members.

True Service with a Local Touch

When you call, you speak with one of our helpful representatives, right in Champaign. They know our plans inside and out and can help you with the following.

- Answering your questions
- Signing you up for a seminar
- Arranging for someone to meet with you
- Enrolling you over the phone

Stop by weekdays from 8:30 a.m. to 4:30 p.m. in southwest Champaign. We're at 3301 Fields South Drive, Suite 105, right off Interstate 57 at the Curtis Road exit.

Some of Our Many Extra Perks and Programs

- Assist America global emergency services to help connect you to medical services while traveling, like helping replace lost prescriptions and getting you back home if you're sick
- 24-hour Nurse Advice Line to answer your health-related questions, day or night
- Be Fit fitness benefit to pay you back up to $360 per year for fitness activities
- Care coordination to help you deal with chronic conditions
- Health coaching to help you set and reach your health goals
- Get a 10% discount code for a wide variety of competitively priced over-the-counter (OTC) products with OTC4Me. You can order online or by phone, and all orders are shipped directly to you. Shipping is free on orders over $25.
- Connected to 24/7 help from veterinary technicians with WhiskerDocs. You can call, chat or e-mail with questions about your animals' health or well-being. The service helps with cats, dogs, birds, reptiles, and pocket pets (like rabbits or hamsters). About 60% of issues are taken care of over the phone without a visit to the veterinarian.
- Get up to 30 hours of in-home support yearly through Papa. Services include Companionship, transportation, technical support, light help around the house, light exercise and grocery shopping. You can receive in-home support services if you meet certain clinical criteria. An in-network doctor or licensed plan provider must request these services. Services are provided in two-hour increments.

Call 1-877-634-3390 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

Health Alliance™

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (800) 965-4022 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (800) 965-4022 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 (800) 965-4022 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 (800) 965-4022 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (800) 965-4022 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (800) 965-4022 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi (800) 965-4022 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

Health Alliance™

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (800) 965-4022 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (800) 965-4022 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (800) 965-4022 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا بمساعدتك. هذه خدمة مجانية على (TTY:711)800-965-4022 . سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (800) 965-4022 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (800) 965-4022 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (800) 965-4022 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (800) 965-4022 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (800) 965-4022 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、(800) 965-4022 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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DISCRIMINATION IS AGAINST THE LAW

Health Alliance™ complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity or sex, you can file a grievance with: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: (800) 965-4022; telephone for members in Washington:
(877) 750-3350 TTY: 711, fax: (217) 902-9705, MemberServices@HealthAlliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY: (800) 537-7697.
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame (800) 965-4022, WA Llame: (877) 750-3350 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 1-800-965-4022, WA: 呼叫 (877) 750-3350 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 965-4022, WA: Zadzwoń (877) 750-3350 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi (800) 965-4022, WA: Gọi (877) 750-3350 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 965-4022 IA, IL, IN, OH: 전화 WA: (877) 750-3350 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 965-4022, WA: Вызов (877) 750-3350 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag (800) 965-4022, WA: Tumawag (877) 750-3350 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-965-4022، ولاية واشنطن: اتصل بالرقم: 750-3350 (877) (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf (800) 965-4022, WA: Anruf (877) 750-3350 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez (800) 965-4022, WA: Appelez (877) 750-3350 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ (800) 965-4022,WA: કૉલ (877) 750-3350 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。 (800) 965-4022 IA, IL, IN, OH: コール (877) 750-3350 WA: コール（TTY: 711）。

LET OP: Services Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик (800) 965-4022, WA: Виклик (877) 750-3350 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare (800) 965-4022, WA: Chiamare (877) 750-3350 (TTY: 711).

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