Health Alliance Medicare POS Choice Rx (HMO-POS) / Health Alliance Medicare POS 10 Rx (HMO-POS) / Health Alliance Medicare POS Basic Rx (HMO-POS)

2025 Summary of Benefits

January 1, 2025 – December 31, 2025

Call toll-free 1-888-382-9771 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 Medical Plans Insurance Company

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 1-800-965-4022 (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: 1-800-965-4022 (TTY 711)
- If you’re not yet a member: 1-888-382-9771 (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 this county in Iowa: Scott

Our service area includes these counties in Illinois: Boone, Brown, Bureau, Carroll, Cass, Champaign, Christian, Clark, Clay, Coles, Crawford, Cumberland, De Witt, DeKalb, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Grundy, Hamilton, Hancock, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jo Daviess, Johnson, Kankakee, Knox, La Salle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Marion, Marshall, Mason, McDonough, McLean, Menard, Mercer, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Putnam, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Wayne, White, Whiteside, Williamson, Winnebago and Woodford

Our service area includes these counties in Indiana: Benton, Daviess, Fountain, Knox, Newton, Pike, 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 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 1-888-382-9771 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit HealthAllianceMedicare.org or call 1-888-382-9771 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, 2026.
- ☐ 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, 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.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

	Health Alliance Medicare POS Choice Rx (HMO-POS)	Health Alliance Medicare POS 10 Rx (HMO-POS)	Health Alliance Medicare POS Basic Rx (HMO-POS)
MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY			
Premium Each Month You must continue to pay your Medicare Part B premium.	**$0**	**$188**	**$73**
These plans include prescription drug coverage. For information on non-Rx plans, contact your broker or Health Alliance Medicare.			
Medical Deductible			
In-network:	**$0**	**$0**	**$0**
Out-of-network:	**$500**	**$0**	**$0**
Prescription Drugs Deductible	**$0**	**$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 (does not include Part B prescription drugs).			
In-network providers	**$4,500**	**$2,900**	**$5,500**
In-network and Out-of-network providers	**$9,000**	**$5,750**	**$11,300**
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital Care (may require prior authorization) Our plan covers an unlimited number of days for an inpatient hospital stay.			
In-network:	**• $290 copay per day for days 1 through 10** **• $0 copay per day for days 11 and beyond**	**• $250 copay per day for days 1 through 7** **• $0 copay per day for days 8 and beyond**	**• $460 copay per day for days 1 through 4** **• $0 copay per day for days 5 and beyond**
Out-of-network:	**• $290 copay per day for**	**25% of the cost**	**• $600 copay per day for**

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	days 1 through 10 • $0 copay per day for days 11 and beyond		**days 1 through 6 • $0 copay per day for days 7 through 90**
Outpatient Hospital Care (may require prior authorization)			
In-network:	**$0-$295 copay**	**$0-$300 copay**	**0% - 25% of the cost**
Out-of-network:	**$295 copay**	**$350 copay**	**25% of the cost**
Outpatient Surgery at an Ambulatory Surgical Center (may require prior authorization)			
In-network:	**$0-$295 copay**	**$0-$300 copay**	**0% - 25% of the cost**
Out-of-network:	**$295 copay**	**$350 copay**	**25% of the cost**
DOCTOR VISITS			
Primary Care Physician Office Visits			
In-network:	**$0 copay**	**$10 copay**	**$15 copay**
Out-of-network:	**$0 copay**	**$40 copay**	**$50 copay**
Specialist Office Visits			
In-network:	**$40 copay**	**$30 copay**	**$50 copay**
Out-of-network:	**$40 copay**	**$40 copay**	**$65 copay**
Virtual Primary Care Physician Visits through Vendor Our plan covers visits with a provider by phone or online, 24/7. Connect by phone or secure video through your Hally® account on the MyChart app or hally.com/.			
Primary Care Provider In-network:	**$0 copay**	**$0 copay**	**$0 copay**

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Primary Care Provider Out-of-network:	**Not Covered**	**Not Covered**	**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)			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$0 copay**	**$0 copay**
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.			
In-network:	**$125 copay**	**$140 copay**	**$125 copay**
Out-of-network:	**$125 copay**	**$140 copay**	**$125 copay**
Worldwide Emergency Care (Outside the U.S. and its territories.)	**$125 copay**	**$140 copay**	**$125 copay**
Urgent Care Services			
In-network:	**$55 copay**	**$30 copay**	**$55 copay**
Out-of-network:	**$55 copay**	**$30 copay**	**$55 copay**

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Worldwide Urgent Care (Outside the U.S. and its territories.)	**$55 copay**	**$30 copay**	**$55 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			
In-network:	**$0 copay for A1C lab test, $0 copay for other services**	**$0 copay for A1C lab test, $0 copay for other services**	**$0 copay for A1C lab test, $20 copay for other services**
Out-of-network:	**$0 copay for A1C lab test, $0 copay for other services**	**$30 copay for A1C lab test, $30 copay for other services**	**$50 copay for A1C lab test, $50 copay for other services**
Diagnostic Radiology (such as MRIs, CT scans)			
In-network:	**$210 copay**	**$0 copay**	**$50 copay**
Out-of-network:	**$210 copay**	**$30 copay**	**$50 copay**
Outpatient X-rays (such as x-rays and ultrasounds)			
In-network:	**$0 copay**	**$0 copay**	**$25 copay**
Out-of-network:	**$0 copay**	**$30 copay**	**$50 copay**
HEARING, DENTAL AND VISION			
Medicare-Covered Diagnostic Hearing Exam (Exam to diagnose and treat hearing and balance issues)			
In-network:	**$45 copay**	**$25 copay**	**$25 copay**
Out-of-network:	**30% of the cost**	**$40 copay**	**$40 copay**
Routine Hearing Exam			

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(Must be with a TruHearing® provider) (Copayment is not subject to the maximum out-of-pocket) (1 exam per year)			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**Not Covered**	**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 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: (In-network)	**$699 copay per aid**	**$699 copay per aid**	**$699 copay per aid**
Premium: (In-network)	**$999 copay per aid**	**$999 copay per aid**	**$999 copay per aid**
Medicare-covered 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			
In-network:	**$40 copay**	**$20 copay**	**$20 copay**
Out-of-network:	**$40 copay**	**$20 copay**	**$20 copay**
Non-Medicare-covered Dental Services (up to $3,000 for POS Choice Rx HMO-POS, up to $2,000 for POS 10 Rx HMO-POS and up to $2,000 for POS Basic Rx HMO-POS per plan year) You pay the applicable cost-sharing amount for Non-Medicare-covered Dental Services and your plan will pay a maximum per contract year. You will be responsible for 100% of the cost for the rest of the year once the plan has paid the maximum amount. You or your dental provider can submit a claim directly to your plan utilizing the instructions on the back of your health plan ID card. For additional help, you can call member services listed on the back of your health plan ID card.			
In- and Out-of-network:	**Up to $3,000 per plan year**	**Up to $2,000 per plan year**	**Up to $2,000 per plan year**

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Basic Services: Diagnostic and Preventive Services Emergency Palliative Treatment Radiographs	**0% Coinsurance for Basic Dental Services.**	**0% Coinsurance for Basic Dental Services.**	**0% Coinsurance for Basic Dental Services.**
Minor Services: Oral Surgery Services Endodontic Periodontics Restorative Non-Routine Services	**20% Coinsurance for Minor Dental Services.**	**20% Coinsurance for Minor Dental Services.**	**20% Coinsurance for Minor Dental Services.**
Major Services: Prosthodontic Maxillofacial Prosthetics Dentures Implant Services Adjunctive General Services	**40% Coinsurance for Major Dental Services.**	**40% Coinsurance for Major Dental Services.**	**40% Coinsurance for Major Dental Services.**
Vision Services Exam to diagnose and treat diseases and conditions of the eye.			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$40 copay**	**$50 copay**
Eyewear After Cataract Surgery (Medicare-covered) One pair of eyeglasses or contact lenses after cataract surgery.			
In-network:	**$0 copay**	**$25 copay**	**$25 copay**

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Out-of-network:	**$0 copay**	**$40 copay**	**$40 copay**
Glaucoma Screening			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$30 copay**	**$50 copay**
Routine Eye Exam (1 exam per plan year)			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**Not Covered**	**Not Covered**
MENTAL HEALTH CARE			
Outpatient Individual Mental Health Therapy Visit			
In-network:	**$40 copay**	**$30 copay**	**$40 copay**
Out-of-network:	**$40 copay**	**$40 copay**	**$50 copay**
Outpatient Group Mental Health Therapy Visit			
In-network:	**$40 copay**	**$30 copay**	**$40 copay**
Out-of-network:	**$40 copay**	**$40 copay**	**$50 copay**
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)			
In-network:	**• $245 copay per day for days 1 through 10** **• $0 copay per day for days**	**• $175 copay per day for days 1 through 9** **• $0 copay per day for days**	**• $395 copay per day for days 1 through 4** **• $0 copay per day for days**

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	11 through 90	**10 through 90**	**5 through 90**
Out-of-network:	**• $245 copay per day for days 1 through 10** **• $0 copay per day for days 11 through 90**	**25% of the cost**	**• $470 copay per day for days 1 through 4** **• $0 copay per day for days 5 through 90**
SKILLED NURSING FACILITIES			
Skilled Nursing Facility (SNF) Our plan covers up to 100 days in an SNF. (may require prior authorization)			
In-network:	**• $10 copay per day for days 1 through 20** **• $214 copay per day for days 21 through 100**	**• $10 copay per day for days 1 through 20** **• $214 copay per day for days 21 through 100**	**• $10 copay per day for days 1 through 20** **• $214 copay per day for days 21 through 100**
Out-of-network:	**• $10 copay per day for days 1 through 20** **• $214 copay per day for days 21 through 100**	**• $85 copay per day for days 1 through 20** **• $225 copay per day for days 21 through 100**	**• $100 copay per day for days 1 through 20** **• $225 copay per day for days 21 through 100**
PHYSICAL THERAPY			
Outpatient Physical Therapy (may require prior authorization)			
In-network:	**$25 copay**	**$20 copay**	**$20 copay**
Out-of-network:	**$25 copay**	**$30 copay**	**$50 copay**
TRANSPORTATION SERVICES			
Ambulance Authorization for non-emergency transportation by ambulance is required.			

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In- and Out-of-network emergent:	**$300 copay (Ground Ambulance)** **$300 copay (Air Ambulance)**	**$275 copay (Ground Ambulance)** **$400 copay (Air Ambulance)**	**$350 copay (Ground Ambulance)** **$425 copay (Air Ambulance)**
In- and Out-of-network non-emergent:	**$300 copay**	**$275 copay**	**$350 copay**
Transportation (within the U.S. and its territories) In-Network:	**Not Covered**	**Not Covered**	**Not Covered**
Out-of-network:	**Not Covered**	**Not Covered**	**Not Covered**
Worldwide Emergency Transportation (outside the U.S. and its territories) In- and out-of-network:	**$300 copay (Ground Ambulance)** **$300 copay (Air Ambulance)**	**$275 copay (Ground Ambulance)** **$400 copay (Air Ambulance)**	**$350 copay (Ground Ambulance)** **$425 copay (Air Ambulance)**
MEDICARE PART B DRUGS			
Medicare Part B Drugs such as Chemotherapy Drugs (may require prior authorization)			
In-network:	**0% - 20% of the cost**	**0% - 15% of the cost**	**0% - 20% of the cost**
Out-of-network:	**20% of the cost**	**25% of the cost**	**25% of the cost**
Other Medicare Part B Drugs (may require prior authorization)			
In-network:	**0% - 20% of the cost**	**0% - 15% of the cost**	**0% - 20% of the cost**
Out-of-network:	**20% of the cost**	**25% of the cost**	**25% of the cost**

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PART D PRESCRIPTION DRUGS 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. Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.			
Deductible	**$0 copay**	**$0 copay**	**$0 copay**
Initial Coverage for Standard Retail Cost-Sharing			
Tier 1 - Preferred Generic			
30-day supply:	**$2 copay**	**$2 copay**	**$2 copay**
90-day supply:	**$6 copay**	**$6 copay**	**$6 copay**
Tier 2 - Generic			
30-day supply:	**$15 copay**	**$15 copay**	**$15 copay**
90-day supply:	**$45 copay**	**$45 copay**	**$45 copay**
Tier 3 - Preferred Brand			
30-day supply:	**25% of the cost**	**25% of the cost**	**25% of the cost**
90-day supply:	**25% of the cost**	**25% of the cost**	**25% of the cost**
Tier 4 - Non-Preferred Drug			
30-day supply:	**50% of the cost**	**50% of the cost**	**50% of the cost**
90-day supply:	**50% of the cost**	**50% of the cost**	**50% of the cost**
Tier 5 - Specialty Tier			
30-day supply:	**33% of the cost**	**33% of the cost**	**33% of the cost**
90-day supply:	**Not Covered**	**Not Covered**	**Not Covered**
Vaccine Tier	**$0 copay**	**$0 copay**	**$0 copay**

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Initial Coverage for Standard Mail-Order Cost-Sharing			
Tier 1 - Preferred Generic			
30-day supply:	**$2 copay**	**$2 copay**	**$2 copay**
90-day supply:	**$4 copay**	**$4 copay**	**$4 copay**
Tier 2 - Generic			
30-day supply:	**$15 copay**	**$15 copay**	**$15 copay**
90-day supply:	**$30 copay**	**$30 copay**	**$30 copay**
Tier 3 - Preferred Brand			
30-day supply:	**25% of the cost**	**25% of the cost**	**25% of the cost**
90-day supply:	**25% of the cost**	**25% of the cost**	**25% of the cost**
Tier 4 - Non-Preferred Drug			
30-day supply:	**50% of the cost**	**50% of the cost**	**50% of the cost**
90-day supply:	**50% of the cost**	**50% of the cost**	**50% of the cost**
Tier 5 - Specialty Tier			
30-day supply:	**33% of the cost**	**33% of the cost**	**33% of the cost**
90-day supply:	**Not Covered**	**Not Covered**	**Not Covered**
Catastrophic Coverage			
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, you enter a catastrophic coverage stage. During this stage, the plan pays full cost of covered Part D drugs. You pay nothing and will remain in this phase until the end of the plan year.			
Cost-Sharing may change depending on the pharmacy you choose.			
ADDITIONAL BENEFITS			
Acupuncture (Medicare-covered)			

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In-network:	**$10 copay**	**$20 copay**	**$15 copay**
Out-of-network:	**$10 copay**	**$20 copay**	**$15 copay**
Acupuncture (Non-Medicare-covered) (Covered for headache and neck pain) (Up to 15 visits per year)			
In-network:	**$10 copay**	**$20 copay**	**$15 copay**
Out-of-network:	**$10 copay**	**$20 copay**	**$15 copay**
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)			
In-network:	**$20 copay**	**$20 copay**	**$15 copay**
Out-of-network:	**$20 copay**	**$45 copay**	**$50 copay**
Durable Medical Equipment Wheelchairs, oxygen, etc. (may require prior authorization)			
In-network:	**0%-35% of the cost, depending on the supply**	**0%-20% of the cost, depending on the supply**	**0%-20% of the cost, depending on the supply**
Out-of-network:	**0% - 35% of the cost, depending on the supply**	**20% of the cost**	**20% of the cost**
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)			
In-network:	**0%-25% of the cost, depending on the supply**	**0% of the cost, depending on the supply**	**0% of the cost, depending on the supply**
Out-of-network:	**0% - 25% of the cost,**	**20% of the cost**	**20% of the cost**

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	depending on the supply		
Diabetes Self-Management Training			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$30 copay**	**$50 copay**
Foot Care (Podiatry Services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.			
In-network:	**$40 copay**	**$30 copay**	**$50 copay**
Out-of-network:	**$40 copay**	**$40 copay**	**$50 copay**
Home Health Care			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$30 copay**	**$50 copay**
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.			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$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.			
In-network:	**$0 copay**	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$30 copay**	**$50 copay**
Outpatient Occupational Therapy Visit			

	Health Alliance Medicare POS Choice Rx (HMO-POS)	Health Alliance Medicare POS 10 Rx (HMO-POS)	Health Alliance Medicare POS Basic Rx (HMO-POS)
(may require prior authorization)			
In-network:	**$40 copay**	**$20 copay**	**$40 copay**
Out-of-network:	**$40 copay**	**$30 copay**	**$50 copay**
Outpatient Speech and Language Therapy Visit (may require prior authorization)			
In-network:	**$25 copay**	**$20 copay**	**$20 copay**
Out-of-network:	**$25 copay**	**$30 copay**	**$50 copay**
Outpatient Substance Abuse Group Therapy Visit			
In-network:	**20% of the cost**	**$30 copay**	**$50 copay**
Out-of-network:	**20% of the cost**	**$40 copay**	**$50 copay**
Outpatient Substance Abuse Individual Therapy Visit			
In-network:	**20% of the cost**	**$30 copay**	**$50 copay**
Out-of-network:	**20% of the cost**	**$40 copay**	**$50 copay**
Outpatient Surgery at an Outpatient Hospital (may require prior authorization)			
In-network:	**$0-$295 copay**	**$0-$300 copay**	**0% - 25% of the cost**
Out-of-network:	**$295 copay**	**$350 copay**	**25% of the cost**
Over-the-Counter Items Our plan covers up to $140 a year, up to $35 every three months, with no rollover allowance, while using your Benefits Mastercard® Prepaid Card for commonly used OTC products. You can use your card allowance to purchase products online and at participating retailers from many categories including but not limited to: • Cold, flu and allergy.			

	Health Alliance Medicare POS Choice Rx (HMO-POS)	Health Alliance Medicare POS 10 Rx (HMO-POS)	Health Alliance Medicare POS Basic Rx (HMO-POS)
• Dental and denture care. • Diabetes care. • Eye and ear care. • First aid and medical supplies. • Personal care. • Sleep aids. Visit HealthAlliance.NationsBenefits.com to see a complete list of eligible OTC products available to order online.			
Prosthetic Devices and Related Medical Supplies Braces, Artificial Limbs, etc. (may require prior authorization)			
In-network:	**25% of the cost**	**20% of the cost**	**20% of the cost**
Out-of-network:	**25% of the cost**	**20% of the cost**	**20% of the cost**
Renal Dialysis			
In-network:	**20% of the cost**	**20% of the cost**	**20% of the cost**
Out-of-network:	**20% of the cost**	**50% of the cost**	**50% of the cost**
Therapeutic Shoes or Inserts for Diabetics			
In-network:	**25% of the cost**	**$0 copay**	**$0 copay**
Out-of-network:	**25% of the cost**	**20% of the cost**	**20% of the cost**
WELLNESS PROGRAMS			
***Be Fit* Fitness Benefit** Get the most out of your fitness activities with Be Fit. You get to choose how you want to work out, and your $360-per-year Benefits Mastercard® Prepaid Card benefit will take care of the payment. • Fitness class fees. • Gym memberships. • Online fitness subscriptions.			

	Health Alliance Medicare POS Choice Rx (HMO-POS)	Health Alliance Medicare POS 10 Rx (HMO-POS)	Health Alliance Medicare POS Basic Rx (HMO-POS)
• Weight loss subscriptions. • Ski memberships. • Rowing. • Golf. • Bowling. • Tennis. • Pickleball. • Pool exercise classes. • Fitness trackers. If your fees are more than $360 a year, you pay the difference. Be Fit doesn't cover league fees, personal equipment, protein bars and shakes, etc., or Non-Medicare and Medicare-covered services (physical therapy, chiropractic care, etc.).			
Health Alliance Medicare is an HMO-POS plan with a Medicare contract. Enrollment in Health Alliance Medicare 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. The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated. Card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access.			

ABOUT US

Health Alliance Medicare is part of a company that has served Illinois for over 35 years. We have more than 25,000 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

- 24-hour ***Nurse Advice Line*** to answer your health-related questions, day or night. Contact information (855) 815-5188.
- 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. Contact by phone located on the back of your health plan ID card.
- Health coaching to help you set and reach your health goals. Contact by phone located on the back of your health plan ID card.
- 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.

Call 1-888-382-9771 (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.

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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 .

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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 على (TTY:711)800-965-4022. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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。

Form CMS-10802
(Expires 12/31/25)

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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 or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). 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 or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822, telephone for members: (800) 965-4022 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. Llame (800) 965-4022 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫 (800) 965-4022 (TTY: 711)。

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń (800) 965-4022 (TTY: 711).

LƯU Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi (800) 965-4022 (TTY: 711).

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 965-4022로 전화하세요. (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Звоните (800) 965-4022. (TTY: 711).

Aird: Má tá Gaeilge agat, tá seirbhísí cúnaimh teanga, saor in aisce, ar fáil duit. Glaoigh ar (800) 965-4022 (TTY: 711).تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة
متاحة اللغوية. مجانًا لك (النصي الهاتف: 711) بالرقم اتصل (800) 965-4022

Aufmerksamkeit: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufen Sie (800) 965-4022 an (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique, gratuits, sont à votre disposition. Appelez le (800) 965-4022 (ATS : 711).

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. (800) 965-4022 પર કૉલ કરો (TTY: 711).

注意: 日本語を話せる場合は、言語支援サービスを無料でご利用いただけます。 (800) 965-4022 に電話してください。(TTY: 711)

LET OP: Als u Nederlands spreekt, zijn er gratis taalhulpdiensten voor u beschikbaar. Bel (800) 965-4022 (TTY: 711).

УВАГА: Якщо ви володієте українською мовою, вам надаються послуги мовної допомоги, безкоштовні. Телефонуйте (800) 965-4022 (TTY: 711).

ATTENZIONE: Se parli italiano sono a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il numero (800) 965-4022 (TTY: 711).

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