Table of Contents

Understand Medicare

What is Medicare?

What is Original Medicare?

Medicare is the government-run insurance program for those 65 and older, or certain people with disabilities or end-stage renal disease (permanent kidney failure).

What's covered on Medicare is based on federal and state laws, national decisions made by Medicare about whether something is covered, and local decisions made by companies who process Medicare claims and decide whether something is medically necessary and should be covered in their area.

Medicare has 4 different parts, which can be mixed and matched through different plans to give you the coverage that's right for you.

What is Medicare Part A?

What is Medicare Part B?

What is Medicare Advantage?

What is Medicare Part D?

What is Medicare Part A?

Medicare Part A is also called hospital insurance, and it covers:

- Inpatient hospital stays
- Skilled nursing facility stays
- Hospice care
- Nursing home care
- Home health care

What is Medicare Part B?

Medicare Part B is also called medical insurance, and it covers certain care from doctors, outpatient care, medical supplies, and preventive care, which includes:

- Services like flu shots
- Clinical research
- Ambulances
- Durable medical equipment
- Mental health care
- Limited prescription drugs

What is Medicare Advantage?

Medicare Advantage Plans, or Part C plans, are plans from private companies, like us, that take the place of your Original Medicare. You can also add prescription drug coverage to combine Part A, Part B, and Part D into one easy package.

What is Medicare Part D?

Medicare Part D adds prescription drug coverage. You can buy Part D from insurance companies to go with your Original Medicare coverage or your Medicare Supplement coverage, or you can choose a Medicare Advantage plan that includes Part D prescription drug coverage.

Am I Eligible for Medicare?

You're eligible for Original Medicare, or Part A and Part B, if you:

- Are age 65 or older
- Are disabled
- Have End-Stage Renal Disease

Am I eligible for Medicare Advantage?

What if I'm still covered at work?

Am I Eligible for Medicare Advantage?

To be eligible for a Medicare Advantage plan, you:

- Must have Medicare Parts A and B.
- Must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicare or by another third party.
- Must live in the plan's service area.
- Must have no employer or union coverage.
- Cannot have end-stage renal disease (permanent kidney failure).

With an HMO plan, if you get care from out-of-network providers, neither Medicare nor we will be responsible for the costs.

What If I'm Still Covered at Work?

You can keep the health plan you have and enroll in Medicare when you retire.

- If you keep medical coverage through your job and wait to get Part B, you'll have 8 months from when you retire to add Part B without a penalty. When you're ready to add Part B coverage, contact your local Social Security office.
- If you keep getting drug coverage through your job, you won't pay a penalty if you add Part D later.

It's important to talk to your employer before choosing to stay on your group plan or enroll in Medicare.

What Is a monthly premium?

Your monthly premium is the set amount you pay each month to have your plan. You pay it even if you don’t receive any medical care that month. Like other bills, this premium can rise when it’s time to renew your plan for the next year.

What Are out-of-pocket costs?

Out-of-pocket costs are what you must pay when you get care. These costs depend on how much care you actually get and your yearly out-of-pocket maximum. Once you hit this limit, your insurance pays for all of your care. There are 3 types of out-of-pocket costs:

> **Deductible:** The set amount you pay for care before we start helping with the cost. Premiums and copays don't count towards this amount.
>
> **Copay:** The set fee you pay each time you use a certain medical service covered by your plan. You either pay this or coinsurance.
>
> **Coinsurance:** The percentage of the cost you pay each time you use a certain medical service covered by your plan. You either pay this or a copay.

What do I pay for Medicare Part A?

You usually don't pay a monthly premium for Part A if you or your spouse paid Medicare taxes while you were working.

You can get Part A without a premium if:

- You already get a Social Security or Railroad check for retirement
- You're eligible to get Social Security or Railroad benefits, but haven't filed for them yet
- You or your spouse had Medicare-covered government employment

Usually, if you choose to buy Part A, you must also have Part B. If you buy Part A, you'll pay up to $413 each month, plus Part B costs. Then, you must also pay coinsurance or copayments for most care.

What do I pay for Medicare Part B?

Some people get Part B automatically when they turn 65, and some must sign up for it. Learn how and when you can sign up for Part B.

For Part B, you pay:

- A premium each month.
    - If you get Social Security or a Railroad check, this premium will be taken out of this automatically. If you don't get these, you'll get a bill.
- A Part B deductible.
- After you meet your deductible, 20% coinsurance for most care.

See more details of what you pay for Part B.

Calculate your Original Medicare Premiums on Medicare.gov.

What do I pay for Medicare Advantage?

For Medicare Advantage plans, you pay:

- A set monthly premium.
- Your monthly Part B premium.
- Copayments or coinsurance each time you use medical services, like when you visit the doctor. With some plans though, you'll pay nothing for certain services.
- Once you hit your yearly spending limit, or out-of-pocket maximum, we pay for everything else for the rest of the year

What do I pay for Medicare Part D?

For a Medicare Part D plan, you'll pay:

- A set monthly premium
- A Part D deductible
- Copayments or coinsurance for your drug costs
- Costs in the Coverage Gap
- All your other Medicare or Medicare Supplement costs

Your actual drug costs can also change based on:

- The drugs you use and if they're covered
- The plan you choose
- Using an in-network pharmacy
- If you get extra help paying for Part D
- If you have to pay a late enrollment penalty

Visit Your Benefits to learn more about your drug coverage and ways to save with our plans.

What do I pay for Medicare

When can I sign up for Medicare?

With Medicare, timing is key. If you already get a Social Security or Railroad check for retirement, you'll automatically be enrolled you in Original Medicare. You don’t need to apply. If you're automatically enrolled, you'll get your Medicare card in the mail 3 months before your 65th birthday.

Do I need to sign up for Medicare Part A and Part B?

How can I sign up for Part A and Part B?

Otherwise, there are certain periods when you can sign up for Medicare, Medicare Advantage, and Medicare Supplement plans.

Initial Enrollment Period

General Enrollment Period

Annual Enrollment Period

Medicare Advantage Enrollment Period

Special Enrollment Periods

Do I Need to Sign Up for Medicare Part A and Part B?

You'll need to sign up for Part A and Part B if you:

- Aren't getting Social Security or Railroad benefits, for example, because you're still working. (What if I'm still working?)
- Get Medicare because you have end-stage renal disease (permanent kidney failure).

How Can I Sign Up for Medicare Part A and Part B?

- Apply online through Social Security's website
- Visit your local Social Security office.
- Call Social Security at 1-800-772-1213, TTY 1-800-325-0778.
- Fill out the Application for Enrollment in Part B. Remember, you must already have Part A to apply for Part B.

Initial Enrollment Period

Your Initial Enrollment Period (IEP) is the 7-month period you have when you first become eligible to sign up for Medicare. It includes the 3 months before the month of your birthday, your birth month, and the 3 months after the month of your birthday.

During this time, you can sign up for Medicare Part A, Part B, Medicare Advantage, and Part D.

If you sign up before your birth month, your coverage starts the first day of your birth month. If you sign up after the start of your birth month, your coverage starts the first day of the next month.

General Enrollment Period

If you didn't sign up for Original Medicare or Medicare Supplement when you're first eligible, you can sign up during the General Enrollment Period, between January 1 and March 31 each year.

If you enroll during this time, your coverage will start July 1. You may have to pay a higher premium for late enrollment in Part A and Part B.

Annual Enrollment Period

The Annual Enrollment Period (AEP) is each year from October 15 to December 7, and it's when you can make changes to your Medicare coverage.

At this time, you can enroll in or leave a Medicare Advantage plan, you can switch Medicare Advantage companies or plans, and you can add a Part D plan.

You must make changes during this period or you won't be able to get coverage unless you have a Special Enrollment Period (SEP).

Any new coverage you get during this time will start on January 1.

Special Enrollment Periods

Outside the Annual Enrollment Period, you can only enroll in a plan after a special event with a Special Enrollment Period (SEP).

These are the different kinds of SEPs.

- Moved to a new service area or to an area with new plan options
  - You can switch to a new Medicare Advantage or Part D plan, or if you move outside your Medicare Advantage plan's service area, you can also return to Original Medicare.
  - If you tell your plan before you move, your SEP begins the month before the month you move and goes for 2 full months after you move.
  - If you tell your plan after you move, your SEP begins the month you tell your plan, plus 2 more full months.
- Moved back to the U.S. after living outside the country
  - You can join a Medicare Advantage or Part D plan.
  - Your SEP lasts for 2 full months after the month you move back.
- Moved into an institution, like a skilled nursing facility or long-term care hospital
  - You can join or switch Medicare Advantage or Part D plans, drop your Medicare Advantage plan and return to Original Medicare, or drop your Part D plan.
  - Your SEP lasts for as long as you live in the institution and for 2 full months after you leave the institution.
- Released from jail
  - You can join or switch Medicare Advantage or Part D plans, drop your Medicare Advantage plan and return to Original Medicare, or drop your Part D plan.
  - Your SEP lasts for 2 full months after the month you're released.
- Eligible for both Medicare and Medicaid
  - You can join, switch, or drop a Medicare Advantage or Part D plan.
  - You can do this at any time.
- No longer eligible for Medicaid
  - You can join a Medicare Advantage or Part D plan.
  - Your SEP lasts for 2 full months after the month you find out you’re no longer eligible for Medicaid.
- Qualified for extra help paying for Medicare prescription drug coverage
  - You can join, switch, or drop a Medicare Advantage or Part D plan.
  - You can do this at any time.
- Won't be eligible for extra help the following year
  - You can join or switch Medicare Advantage or Part D plans, drop your Medicare Advantage plan and return to Original Medicare, or drop your Part D plan.
  - Your SEP is between January 1 and March 31.
- Have a chance to enroll in employer or union coverage
  - You can drop your current coverage to enroll in this private plan.
  - Your SEP is whenever your employer or union allows you to make changes in your plan.
- Left employer or union coverage
  - You can join a Medicare Advantage or Part D plan.
  - Your SEP lasts for 2 full months after the month your coverage ends.
- Have or are enrolling in other drug coverage as good as Medicare's, like TRICARE or VA coverage
  - You can join a Medicare Advantage or Part D plan.
  - Your SEP lasts for 2 full months after the month your coverage ends.
- Lost creditable drug coverage through no fault of your own, or it changed and is no longer creditable

    - You can join a Medicare Advantage plan with drug coverage or a Part D plan.
    - Your SEP lasts for 2 full months after the month you lose creditable coverage or are notified of the loss of creditable coverage, whichever is later.
- Weren't told that you were losing creditable coverage
    - You can join a Medicare Advantage plan with drug coverage or a Part D plan.
    - Your SEP lasts for 2 full months after the month you get a notice from Medicare about the error.
- Weren't told that your private drug coverage wasn't creditable coverage
    - You can join a Medicare Advantage plan with drug coverage or a Part D plan.
    - Your SEP lasts for 2 full months after the month you get a notice from Medicare about the error.
- Left your Medicare Cost Plan drug coverage
    - You can join a Part D plan.
    - Your SEP lasts for 2 full months after the month you drop your Medicare Cost Plan.
- Enrolled in a PACE plan
    - You can drop your current Medicare Advantage plan with drug coverage or your Part D plan.
    - You can do this at any time.
- Dropped your coverage in a PACE plan
    - You can join a Medicare Advantage or Part D plan.
    - Your SEP lasts for 2 full months after the month you drop your PACE plan.
- Enrolled in a State Pharmaceutical Assistance Program (SPAP)
    - You can join a Medicare Advantage plan with drug coverage or a Part D plan.
    - You can do this once during the calendar year.
- Lost your SPAP eligibility
    - You can join a Medicare Advantage plan with drug coverage or a Part D plan.
    - Your SEP starts either the month you lose eligibility or are notified of the loss, whichever is earlier, and ends 2 months after either the month of the loss of eligibility or notification of the loss, whichever is later.
- Dropped a Medicare Supplement plan the first time you joined a Medicare Advantage plan
    - You can drop your Medicare Advantage plan and enroll in Original Medicare with special rights to buy a Supplement plan.
    - You can drop your Medicare Advantage plan for 12 months after you join it for the first time.
- Joined a Medicare Chronic Care SNP plan available for your condition
    - You can join a Medicare Chronic Care SNP for people with your condition.
    - You can join any time, but you can't make changes using this SEP once you've joined.
- Live in the service area of Medicare Advantage or Part D plans with an overall quality rating of 5 stars.
    - You can join a Medicare Advantage, Medicare Cost, or Part D plan with an overall quality rating of 5 stars.
    - You can do this one time between December 8 and November 30.
    - *Medicare evaluates plans based on a 5-Star Rating System. Star Ratings are calculated each year and may change from one year to the next.*
- Medicare took an official action, or sanction, because of a problem with your plan that affects you
    - You can switch from your Medicare Advantage or Part D plan to another plan.
    - Your SEP is determined by Medicare on a case-by-case basis.
- Your plan's contract ends during the contract year
    - You can switch from your Medicare Advantage or Part D plan to another plan.
    - Your SEP starts 2 months before and ends 1 full month after the contract ends.
- Your plan's contract isn't renewed for the next contract year
    - You can switch from your Medicare Advantage or Part D plan to another plan.
    - You can do this between October 15 and the last day in February.
- Joined or didn't join a plan because of a federal employee's error
    - You can join or switch Medicare Advantage or Part D plans, drop your Medicare Advantage plan

and return to Original Medicare, or drop your Part D plan.
    - Your SEP lasts for 2 full months after the month you get a notice from Medicare about the error.
- Enrolled in Part B coverage during the General Enrollment Period without having Part A coverage
    - You can sign up a Part D plan.
    - You can do this between April 1 and June 30.

Medicare Advantage Open Enrollment Period

Between January 1–March 31 each year, you can make the following changes during the Medicare Advantage Open Enrollment Period.

- If you are on a Medicare Advantage plan (with or without drug coverage) you can switch to another Medicare Advantage plan (with or without drug coverage).
- You can disenroll from your Medicare Advantage plan and return to Original Medicare. If you choose to do so, you'll be able to join a Medicare prescription drug plan.

During this Open Enrollment Period, you cannot:

- Switch from Original Medicare to a Medicare Advantage plan.
- Join a Medicare prescription drug plan if you have Original Medicare.
- Switch from one Medicare prescription drug plan to another if you have Original Medicare.

You can only make one change during this period, and any changes you make will be effective the first of the month after the health plan gets their request.

How to enroll in a Medicare plan?

The 2020 Annual Enrollment Period is from Oct 15 - Dec 7.

Outside those dates, you must qualify for a Special Enrollment Period to enroll in a plan.

Our plans are only available in certain places. Make sure you live in our service area.

Other Ways to Enroll

By Phone

- Contact Us

By Mail

- 2019 Health Alliance Medicare Enrollment Request Form – Simplete HMO and POS Plans

To enroll during a Special Enrollment Period, include this form with your application:

- Attestation of Eligibility Form

Mail applications to:

> **Health Alliance Medicare**
> **Application Processing Center**
> **3310 Fields South Drive**
> **Champaign, IL 61822**

In-Person

> Health Alliance Connections
> 3301 Fields South Drive
> #105
> Champaign IL 61822
> *8 a.m. to 5 p.m. weekdays*

How Do I Choose a Plan Type?

When you're shopping for Medicare plans, it's important to find a plan type that meets your needs. Do you need personal care? Are your doctors covered in this plan's network? Knowing what comes with each type of Medicare Advantage plan is the first step in choosing the plan that's right for you.

What is an HMO?

What is a POS?

What Is an HMO?

An HMO (Health Maintenance Organization) plan gives you personal care from a set network of doctors and hospitals. You'll get peace of mind with:

- The comfort of having an in-network primary care provider (PCP) to oversee all your care and refer you to see specialists
- Doctors in our large provider network that you must see for care
- The freedom to go out-of-network for emergency and urgent care
- Focus on strong doctor-patient relationships and getting to know your provider network

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What Is a POS?

A POS (Point of Service) plan gives you personal care and the freedom to go in- and out-of-network. You'll get:

- The comfort of having an in-network PCP to oversee all your care
- Flexibility to see out-of-network providers
- Savings by seeing doctors in our large provider network rather than going out-of-network
- A balance between security and freedom

How Does Medicare Part D Coverage Work?

Each Medicare Advantage plan with prescription drug coverage or Part D plan has its own list of covered drugs, called a formulary. Our pharmacy department and doctors decide which drugs to include based on quality, safety, and how well they work.

Every drug listed in our formularies is put into a cost group called tiers. For the lowest tier, you pay the lowest copayment. As you take a step up to the next tier, what you pay increases.

What is the Coverage Gap?

What is the Part D Late Enrollment Penalty?

What Is the Coverage Gap?

Medicare prescription drug coverage has 3 different phases of coverage — initial coverage, the coverage gap, and catastrophic coverage.

Initial Coverage

During initial coverage, your prescription drug coverage works like normal health insurance. Once you meet your deductible, you just pay copayments for your drugs based on what tier they fall under, and we pay the rest.

Talk to your doctor about generic drugs for extra savings, or look at ways to save on our plans.

The Coverage Gap

The coverage gap, also called the donut hole, is a temporary limit on what a plan will cover for drugs. It begins after you and your drug plan have spent a certain amount on covered drugs. Not everyone will enter the coverage gap.

What you must pay during this time is going down each year to help close the coverage gap.

Catastrophic Coverage

Catastrophic coverage makes sure you only pay a small coinsurance or copayment for drugs for the rest of the year after you leave the coverage gap.

If you get extra help, you won't enter the coverage gap.

What Is the Part D Late Enrollment Penalty?

The Part D late enrollment penalty is a an amount added to your Part D monthly premium because you didn't sign up for drug coverage when it was available to you. If you go without a Part D plan or a Medicare Advantage plan with drug coverage for 63 days or more in a row after your Initial Enrollment Period (IEP) is over, you might have to pay this penalty.

How Can I Avoid the Part D Penalty?

Join a Medicare Advantage plan with drug coverage or a Part D plan when you're first eligible.

> During your IEP, if you sign up for a plan with drug coverage, you won't have to pay a penalty.

Don't go 63 days or more in a row without drug coverage.

> After 63 days, you will have to pay a penalty to add drug coverage.
>
> Get covered by a Medicare Advantage plan with drug coverage, a Part D plan, or other creditable prescription drug coverage, like coverage from an employer or union, TRICARE, or the Department of Veterans Affairs, before then to avoid this.
>
> Your plan must tell you each year if your drug coverage is creditable coverage. Keep this information because you might need it to join a Medicare drug plan later.

Tell your plan about any other drug coverage you had.

> When you join a Medicare drug plan, they'll send you a letter if they think you went 63 days or more without creditable drug coverage. That letter will also have a form asking about any other drug coverage you had.
>
> Fill this out with the information you saved and return it to your plan by the deadline in the letter to make sure you don't have to pay a penalty.

How Much Is the Part D Penalty?

Your penalty depends on how long you went without prescription drug coverage.

Medicare calculates it by multiplying 1% of the national base beneficiary premium by the number of full, uncovered months you didn't have coverage. This is rounded to the nearest 10 cents and added to your monthly Part D premium.

The national base beneficiary premium changes each year, so your penalty amount might increase each year.

Example

> If you don't sign up for 6 months after your IEP, your penalty will be 6% (1% for each of the 6 months) of $35.63 (the national base beneficiary premium in 2017).
>
> **0.06** (6% penalty) x **$35.63** (2017's national base beneficiary premium) = **$2.14**

> **$2.14** rounded to the nearest $0.10 =**$2.15**
>
> **$2.15 = your monthly late enrollment penalty**

This number will be re-calculated each year with that year's national base beneficiary premium, and that new number will be added to your premium for that year.

If you get extra help, you won't pay the late enrollment penalty.

Turning 65

Getting Ready for Your 65th Birthday

A Year Before

- Start thinking about your move to Medicare.

- Make sure you understand the difference between Medicare plan options.
- Start looking into what options are available in your area.
- Make sure you're eligible for Original Medicare and Medicare Advantage plans.
- See if you'll be enrolled in Original Medicare automatically. If you won't be, contact Social Security to learn more about eligibility and enrollment.

6 Months Before

- Look at our plans online or request more information to look at specific benefits and costs.
- Talk with your employer about available group coverage.

5 Months Before

- Narrow down your plan options by deciding what kind of Medicare plan you want and what type of plan you need.
- Make sure your doctor and pharmacy are in-network.
- Compare out-of-pocket costs between plans.

3 Months Before

Congratulations! If you were enrolled in Original Medicare automatically, you should get your Medicare card in the mail.

- If you have to apply for Original Medicare benefits through Social Security, you can enroll now.
- **Start applying for other coverage, like Medicare Advantage, Medicare Supplement, and Medicare Part D plans now.**

Find a Plan

2 Months Before

- Talk to your employer about your decisions to make a smooth switch from group coverage to Medicare.
- If your spouse or any dependents were covered under your employer's group plan, make arrangements for them to be covered with your employer or on an individual plan after you've switched to Medicare.

You're 65! Happy Birthday!

If you've already enrolled:

- Make sure you have your Medicare card and ID cards for any other coverage you enrolled in.
- Tell your doctors and pharmacy about your new coverage.
- Learn more about using your new coverage.

If you haven't enrolled yet:

- **Enroll now.** You still have your birth month and the 3 months after that to sign up for a Medicare plan.

Make sure you don't miss your enrollment periods because you might have to pay a higher premium for late enrollment in Parts A and B or a **penalty to add prescription drug coverage** later.

In what service areas are plans offered?

Plan offerings depend on the service area and county where you live.

Simplete plans are available in five Central Illinois counties and three Indiana counties where we've partnered with local, trusted healthcare providers in Illinois (Champaign, Vermilion, Piatt, McLean, and Woodford) and in Indiana (Vermillion, Warren and Fountain).

Simplete Riverside plans are available in five of Riverside HealthCare's core counties in Illinois (Kankakee, Iroquois, Livingston, Grundy) and in Indiana (Benton and Newton).

My Coverage

What's my coverage and how do I use it?

How do I find a doctor or provider?

How do I find a pharmacy?

Do I need a preauthorization?

Is my drug covered?

Is this benefit covered under wellness?

How to get paid back for gym or fitness fees with Be Fit?

Medicare Advantage fitness discounts

What's my coverage and how do I use it?

How do I find a doctor or provider?

How do I find a pharmacy?

Do I need a preauthorization?

Is my drug covered?

Is this benefit covered under wellness?

How to get paid back for gym and fitness fees with Be Fit?

Medicare Advantage members can get fit at the gym of their choice with our fitness benefit, Be Fit. Use Be Fit to get paid back monthly, quarterly, or yearly for your gym memberships and fitness class fees.

With Be Fit, you'll:

- Get paid back up to $360 per year
- Have the freedom to pick your gym anywhere you go, even while traveling

And check out our Medicare Advantage fitness discounts for other ways to save.

Getting Paid Back

What you send us to get paid back depends on how your gym works.

If your gym can give you a receipt, send us:

- A dated receipt showing:
  - The amount charged
  - Your name
  - Name of the gym or fitness facility
    or
  - Description of the class
    or
  - Description of the charge for membership fee

If your gym can't give you a receipt, send us:

- A bank or credit card statement showing proof of your payment
- Your fitness agreement or contract (which you only have to send us once)

If you send us a receipt without our reimbursement form:

- You'll be reimbursed up to $360, but you will get a denial letter in the mail for any balance on the receipt above $360.

You can Submit Online or

Fill out the Be Fit Fitness Reimbursement Form and send:

By Mail

Claims Processing Center
3310 Fields South Drive
Champaign, IL 61822

By Email

BeFitClaims@healthalliance.org

By Fax

217-337-8008

How You're Refunded

We can't pay the gym directly, so you have to pay the full cost first, and then send us details for reimbursement. You can send in your receipts monthly, quarterly, or annually for reimbursement up to the $360 annual maximum.

You must send us all receipts by January 31 of the following year to be eligible for reimbursement.

Medicare Advantage fitness discounts

These discounts are only available to our Medicare Advantage members.

Curves

Champaign & Savoy, IL
217-352-9922
Call club for details

Monticello, IL
217-762-3534
Call club for details

Olney, IL
618-392-6128
Call club for details

Bloomington, IL
309-827-6228
Call club for details

Peoria, IL
309-685-4100
Call club for details

Wellness Rewards

Our incentive program, Wellness Rewards, gives you an extra boost to be your best. Complete important preventive care, focus on healthy eating and exercise, and earn a $50 gift card on your way to a healthy lifestyle.

Track activities using our 2019 Wellness Rewards checklist.

Earn a total of 50 points for completed activities, including your annual Primary Care Provider (PCP) visits.

Send us your finished checklist by December 15, 2019 and earn your $50 gift card. Mail to:

Health Alliance Medicare
3310 Fields South Drive
Champaign, IL 61822

TruHearing Select

As our Medicare Advantage member, we also help you save on hearing aids with our TruHearing Select benefit.

Coverage includes:

- $45 initial hearing exam
- 2 hearing aids per year through TruHearing
- 3 follow-up visits with a TruHearing network provider to have your new hearing aids fitted and adjusted
- 45-day trial period
- 3-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 batteries per hearing aid

Learn More and Get Started

Visit TruHearing Select Website

Call 1-855-205-5059

Choosing Hearing Aids

TruHearing hearing aids come in a variety of sizes, colors, and styles, with advanced features to fit your needs.

TruHearing Advanced

Advanced Hearing Aids
14 channels | 4 programs

$699 per aid

- Compatible with iPhone®, iPad®, iPod touch®, and many Android™smartphones
- 2.4 GHz wireless
- DFS Ultra™ II advanced feedback supression
- Advanced NoiseTracker™ noise reduction
- Advanced directionality
- Advanced speech enhancement
- WindGuard™

TruHearing Premium

Premium Hearing Aids
17 channels | 4 programs

$999 per aid

- Compatible with iPhone®, iPad®, iPod touch®, and many Android™smartphones
- 2.4 GHz wireless

- DFS Ultra™ II advanced feedback supression
- Advanced NoiseTracker™ noise reduction
- Premium directionality
- Premium speech enhancement
- WindGuard™

Getting Hearing Aids

1. Call TruHearing at **1-855-205-5059**
2. A hearing consultant will help you set up a hearing exam with a TruHearing audiologist or hearing instrument specialist in your area
3. If your audiologist or hearing instrument specialist finds hearing loss at your appointment, they'll help you choose and order the right hearing aids through TruHearing
4. Once you get your new hearing aids, you'll go back to your audiologist or hearing instrument specialist to have them fitted and programmed

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What are the ratings for our plans?

91%

issues resolved by Customer Service representatives on the first call

90%

claims processed within 13 business days

85%

of our employer groups stay with us from year to year

96.4%

providers very satisfied with Health Alliance

NCQA Rankings

Health Alliance Medical Plans' Medicare is one of the highest-rated health insurance plans in the nation according to the NCQA's Medicare Health Insurance Plan Ratings 2017 to 2018.

> Our **Medicare HMO in Illinois** was rated 4.0 out of 5 nationally.
>
> Our **Medicare HMO in Washington** was rated 3.0 out of 5 nationally.

NCQA is a nonprofit organization dedicated to improving our nation's health care system. Since its founding in 1990, NCQA has been a central figure in health care improvement, and its seal is a widely recognized symbol of quality and service.

Our Star Ratings

Our Medicare Advantage plans received these ratings from the Centers for Medicare & Medicaid Services (CMS):

- 2019 Star Ratings IA
- 2019 Star Ratings IL/IN
- 2019 Star Ratings QUA
- 2019 Star Ratings REID
- 2019 Star Ratings RIV
- 2019 Star Ratings WAC
- 2019 Star Ratings WAY
- 2019 Star Ratings CAR

Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

Quality Improvement Program

Our Quality Improvement (QI) Program drives our accomplishments, setting aside time and resources to improve care and service for members. Whether it's reviewing how well a procedure works or making our

appeal process more simple, our QI Program focuses on getting better.

> Learn more about our QI Program.

HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare health care quality. NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90% of the nation's health plans.

> View our Complete HEDIS Score Report for 2017.
>
> See the detailed structure of our Quality Management Program.

Register for a Seminar

Join us for a deep dive into Medicare Advantage plans. We offer free educational events at convenient locations. We encourage you to register to make sure enough seating is available. Family members and friends are welcome.

Find a Seminar

We'll also be at health fairs, senior expos, and other events in the community, ready to meet you.

Attend an Event

Your Pharmacy Info

Find a pharmacy

Estimate drug cost

High risk medication chart

Specific drug requirements (utilization management)

Medication Therapy Management

Medicare Part D Transition process

High Risk Medication Chart

View the High Risk Medication Chart

Low Income Subsidy (LIS) Info

You might be able to get extra help paying for your prescription drug premiums and costs.

- Simplete Low Income Subsidy Rates
- Illinois Low Income Subsidy Rates

For more info and to see if you qualify, contact:

- Medicare.gov at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048
  - 24 hours a day, 7 days a week
- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
  - 7 a.m. to 7 p.m., Monday through Friday
- Medicaid in Illinois

Check the Best Available Evidence (BAE) for info about cost-sharing from CMS.

My Account

How do I order a new ID card?

How can I check my claims?

How can I see my preauthorizations?

How to file an grievance or appeal a coverage decision?

Where can I get an Appointment of Representative form?

How do I authorize release of protected health info (HIPAA)?

What is my spending on services?

How can I change or cancel / disenroll from my plan?

What are my rights and responsibilities upon disenrollment?

What are our plan ratings?

National Coverage Determinations

How to file a grievance or appeal a coverage decision?

Medicare Part C (Medicare Advantage) and Medicare Part D (Prescription Coverage)

To file or check the status of a grievance or an appeal, contact us at:

- **Grievances:** 1-800-965-4022, 8 a.m. to 8 p.m., Monday through Friday, TTY/TDD 711
- **Appeals:** 1-800-500-3373, 8 a.m. to 8 p.m., Monday through Friday
- **Fax:** 217-337-3425
- **Mail:**
  Health Alliance Medicare
  Services Appeals Processing Center
  3310 Fields South Drive
  Champaign, IL 61822

You can file a coverage determination right away by emailing: *TEAM-RXCOORDINATORS@healthalliance.org

You can file a redetermination (appeal) right away by emailing: MemberServices@healthalliance.org

Where can I find an appeal form?

There are no specific appeal forms. If you need to register an urgent appeal and it's after business hours, you can leave a message at our appeals phone number at 1-800-500-3373, and we'll call you back the same day.

Where can I get an Appointment of Representative form?

If a member wants someone who is not already authorized under state law to act for him or her, the member and that person must sign and date an Appointment of Representative form to give that person legal permission to be an appointed representative.

How do I file a grievance?

You or your appointed representative can call the grievances phone number to file a grievance.

For more on this process, see "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" in your Evidence of Coverage.

What if I don't want to file my complaint through Health Alliance Medicare?

You can also go directly through Medicare.gov or call 1-800-MEDICARE to file a complaint.

You can also get help with Medicare-related complaints, grievances, and information requests from Medicare's Ombudsman.

How do I request a coverage determination or medical exception for a drug?

You, your authorized representative, or your prescribing doctor can use our Coverage Determination Request form to ask for a coverage determination. You can also file an urgent request by calling us.

How do I get an aggregate number of grievances, appeals, and exceptions?

You have the right to get information about the number of appeals, grievances, and exceptions that members have filed against us in the past. To get this information, call the number above.

How do I request a coverage determination or medical exception for a drug?

You, your authorized representative, or your prescribing doctor can ask for a coverage determination.

- Mail us a Coverage Determination Request Form to:

  Health Alliance Medicare
  3310 Fields South Drive
  Champaign, IL 61822

- Call us at **1-800-851-3379, option 4**, Monday through Friday, 8 a.m. to 5 p.m.

How can I change or cancel / disenroll from my plan?

Changing Plan Types

The Annual Enrollment Period (AEP) is the time each year, chosen by the Centers for Medicare and Medicaid Services (CMS), when you can enroll in a plan or switch to a new one. Unless you qualify for a Special Enrollment Period (SEP), this is the only time of year you can make changes.

The AEP is October 15 through December 7. If you enroll during this time, your coverage begins on January 1. Contact us if you have questions.

What are my rights and responsibilities upon disenrollment?

What are my rights and responsibilities upon disenrollment?

If you decide to disenroll from your Health Alliance Medicare Advantage plan, you are ending your membership. Disenrollment can be voluntary (your choice) or involuntary (not your choice). For more information on enrollment or disenrollment, see your Evidence of Coverage.

If you decide you want to leave your plan, you can do this for any reason. However, there are limits to when you can leave, how often you can make changes, and what type of plan you can join after you leave. Call us for more information.

Health Alliance Medicare may disenroll you for these reasons:

- If you move permanently out of the plan's service area and do not voluntarily disenroll, or if you live outside the plan's service area for more than 6 months out of a year
- If your entitlement to Medicare Part A or Medicare Part B ends
- If you supply fraudulent information or make any misrepresentations on your enrollment request form that materially affect your eligibility to enroll in the plan
- If your behavior is disruptive, unruly, abusive, or uncooperative to the extent that your membership in your plan seriously impairs our ability to arrange covered services for you or other individuals enrolled in the plan
- If you knowingly permit abuse or misuse of your Health Alliance Medicare Advantage ID card
- If you fail to pay plan premiums, copayments, coinsurance, or other payments required by the plan
- If the contract between Health Alliance Medicare and CMS, which certifies Medicare Advantage plans, is terminated

National Coverage Determinations

When the Centers for Medicare & Medicaid Services (CMS) makes changes to the services that are covered, they update them through National Coverage Determinations. Learn more about National Coverage Determinations on their website. CMS has issued these National Coverage Determinations:

Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing, Effective February 2016

Centers for Medicare and Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add preventative coverage for HPV testing under specified conditions. In accordance with CMS guidance, Health Alliance will allow for coverage of this service when the specified criteria are met.

Screening for Human Immunodeficiency Virus (HIV) Infection, Effective February 2016

Centers for Medicare and Medicaid Services (CMS) has determined that, effective for dates of service on or after April 13, 2015, evidence is sufficient to add preventative coverage for HIV testing under specified conditions. In accordance with CMS guidance, Health Alliance will allow for coverage of this service when the specified criteria are met.

Percutaneous Left Atrial Appendage Closure (LAAC), Effective May 2016

Centers for Medicare & Medicaid Services (CMS) have determined that, effective for dates of services on or after February 8, 2016, evidence is sufficient to add coverage for percutaneous Left Atrial Appendage Closure (LAAC) when all specified conditions are met. In accordance with CMS guidance, Health Alliance will allow for coverage of this service when the specified criteria are met.

Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes, Effective July 2016

Centers for Medicare & Medicaid Services (CMS) issued a final decision, effective for dates of service or on after January 27, 2016, to expand national coverage of items and services necessary for research in an approved clinical study via Coverage with Evidence Development for allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for treatment of Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria. In accordance with CMS guidance, Health Alliance will allow for coverage of this service when the specified criteria are met.

Specific Drug Requirements

Certain covered drugs have special rules or limits, like step-therapy, preauthorization, and quantity limits, to keep you safe. Learn more about these and which drugs have them.

How do I request a coverage determination or medical exception for a drug?

Step-Therapy

Step-therapy helps control your costs for some kinds of drugs. If we say a certain drug requires step-therapy, you have to try the cheapest drug in that category first. We call this a prerequisite medication.

In most cases, this drug will work for you. If it doesn't, or if a doctor thinks it's medically necessary to skip the prerequisite, they can request preauthorization.

Drugs that need step-therapy are marked in our formularies, or you can check this list:

- Medicare Step-Therapy Drug List

Preauthorization

Preauthorization is approval of a drug or medical procedure before you get it. It's a review process to make sure that you meet certain requirements before we agree to cover it.

This is to help keep you safe and to control your costs.

- Medicare Preauthorization Drug List

Quantity Limits

This is a limit to how much of a drug we'll cover per prescription or over a certain period of time.

For example, if it's considered safe to take only one pill per day of a certain drug, we may only cover that drug for one pill per day.

- Medicare Quantity Limits Drug List

Quality Assurance Procedures

We have quality assurance policies in place to protect you. For details, check your plan's Evidence of Coverage in the chapters "Using the plan's coverage for your medical service" and "Using the plan's coverage for your Part D prescription drugs."

Part B Versus Part D Drugs

Drugs that are identified as Part B versus Part D may be covered under Medicare Part B or D depending upon the situation. More info may need to be submitted describing the use and setting of the drug to determine what it should be covered under. You or your doctor will be contacted in this situation.

Medication Therapy Management

Our Medication Therapy Management (MTM) program gives you free, personalized help to make sure you take your meds just as your doctor prescribed. You get one-on-one time talking with a registered pharmacist or licensed pharmacy intern. You can review your dosing schedule, ask questions about your meds, and talk about ways to lower your risk of side effects.

View the CMS Part D Medication Therapy Management (MTMP) program requirements and information.

How do I qualify?

We automatically enroll you in our MTM program if you have 2 or more of these conditions and are on at least 8 covered Part D meds:

- Chronic Heart Failure
- Diabetes
- High Cholesterol (Dyslipidemia)
- High Blood Pressure (Hypertension)
- Osteoporosis
- Rheumatoid Arthritis
- Depression
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- HIV/AIDs

After you're enrolled, we'll send you a welcome packet within 60 days with details about the program. We'll also talk to you to schedule a medication review. These reviews take about 30 minutes. Our pharmacists use this time to evaluate the meds you are taking, help you eliminate side effects, find medication alternatives, and simplify your routine. They can help you make your meds work better for you.

After the review, we'll send you a Patient Medication List (PML) and a Medication Action Plan (MAP). The PML will include your current medications. The MAP will summarize what you and the pharmacist discussed during the review.

Does my doctor know about this?

Yes. We will talk to your doctors about any concerns or changes to your meds that come from your review. And you and your doctor will both get written summaries of your reviews.

The program works with your doctor. It does not take the place of your doctor and their orders.

How long does this program last?

Medication reviews are offered once a year, but may occur more frequently as you're diagnosed with new diseases or start new medications.

How do I get more information?

We're happy to answer your questions. Call **1-866-352-5305**, (TTY 711), Monday through Friday, 8 a.m. to 8 p.m.

Medicare Part D Transition Process

As a new or continuing member, you might be taking drugs that are not on our formulary, or list of covered drugs, that require you to meet certain requirements, like preauthorization, step therapy, or quantity limits.

If you're in the first 90 days of coverage for this plan year, we'll cover a temporary 30-day supply of your drug at any in-network pharmacy to give you time for you and your doctor to plan your future treatment. If you're at a long-term care facility, we will cover a temporary 91-day supply of your drug at any in-network pharmacy.

Talk to your doctor about whether you should switch to a drug on our formulary or request an exception to see if we can cover the drug you're taking. View our full policy on transition periods to learn more. If you need help requesting an exception or have questions about the transition process, contact us.

Browse Our Help

Understand Medicare

Your Plan Coverage

Your Pharmacy Info

Your Account

How to enroll in a Medicare plan?

Where to find a seminar?

How do I change or cancel/disenroll from my plan?

What are the ratings for our plans?

How to file a grievance or appeal a coverage decision?

Widget Test

Help

KO Initial Way - Click here to open an article.