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Allina Health Aetna Medicare Elite (PPO) H3219-004

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Plan Highlights

This plan includes extras like dental, vision & fitness benefits and limits what you have to pay for covered medical services. You can also get up to a 100-day supply of eligible medicines at network pharmacies.

Costs

Premium

\$152.00 monthly

Est. drug cost

Based on 0 drugs [Add/edit](#)

\$0 annually

Total est. annual cost

Based on premium and drug costs.
(Effective Jan 2022)

\$1,824 annually

Benefits

Medical Coverage

Monthly Plan Premium

\$152

Medical Deductible: In-Network

\$0

Medical Deductible: Out-of-Network

\$0

Maximum Out-of-Pocket (MOOP): Annual In-Network

\$2,800

Maximum Out-of-Pocket (MOOP): Annual Combined In and Out-of-Network

\$4,000

Primary Care Physician (PCP)

\$0 in-network / 20% out-of-network

Specialist

\$15 in-network / \$35 out-of-network

Additional Telehealth Services

PCP: \$0 in-network / Specialist: \$15 in-network / Urgently Needed Services: \$15 in-network / Mental Health - Group Sessions: \$15 in-network / Mental Health - Individual Sessions: \$15 in-network / Psychiatric Services - Group Sessions: \$15 in-network / Psychiatric Services - Individual Sessions: \$15 in-network, for more information see Evidence of Coverage

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Not available [Star rating](#)

Monthly premium

\$152.00

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Inpatient Hospital	\$150 per stay in-network / 20% per stay out-of-network
Skilled Nursing Facility (SNF)	\$0 per day, days 1-20; \$188 per day, days 21-100 in-network/ 20% per stay out-of-network, for more information see Evidence of Coverage
Emergency Room	\$90 If you are admitted to the hospital within 0 hours your cost share may be waived, for more information see the Evidence of Coverage
Ambulance	\$250 in-network / \$250 out-of-network
Lab Services	Lab Services: \$0 in-network/ \$0 Lab Services: \$0 in-network/ \$15 out-of-network, for more information see Evidence of Coverage
Diagnostic Procedures	Diagnostic Procedures/Tests: \$0 in-network/ \$0 Diagnostic Procedures/Tests: \$0 in-network/ \$25 out-of-network, for more information see Evidence of Coverage
Imaging	Xray: \$0 in-network / \$25 out-of-network / CT Scans: \$50 in-network / Diagnostic Radiology other than CT Scans: \$50 in-network / Diagnostic Radiology Mammogram: \$0 in-network / \$100 out-of-network, for more information see Evidence of Coverage
Ambulatory Surgery Center (ASC)	\$50 in-network / ASC Screening Colonoscopy Polyp Removal: \$0 in-network / \$300 out-of-network, for more information see Evidence of Coverage
Outpatient Mental Health	Mental Health - Group Sessions: \$15 in-network/ Mental Health - Individual Sessions: \$15 in-network/ \$35 out-of-network, for more information see Evidence of Coverage Psychiatric Services - Group Sessions: \$15 in-network/ Psychiatric Services - Individual Sessions: \$15 in-network/ \$35 out-of-network, for more information see Evidence of Coverage
Home Health Care	\$0 in-network / 20% out-of-network
Durable Medical Equipment (DME)	20% in-network / 20% out-of-network
Diabetic Monitoring Supplies	0% - 20% Higher cost-share applies to non-OneTouch/LifeScan diabetic supplies.
Preventive Benefits	\$0 copay for all preventive services covered under Original Medicare at zero cost sharing
Annual Physical	\$0 in-network / 20% out-of-network
Fitness	Memberships at participating fitness facilities at no added cost to you through our partnership with SilverSneakers. Also access to online wellness related tools, planners, newsletters, and classes.
Dental Coverage	\$2,250 maximum benefit for preventive and comprehensive dental services combined - see

	Comprehensive dental services combined - see Evidence of Coverage.
Eyewear Coverage	\$350 reimbursement every year, for more information see the Evidence of Coverage
Hearing Aid Coverage	\$2,000 per ear every year, for more information see the Evidence of Coverage
Acupuncture	\$20 in-network / \$20 out-of-network, eighteen visits every year, for more information see Evidence of Coverage
Chiropractic Routine Services	\$20 in-network/ \$20 out-of-network, eighteen visits every year, for more information see Evidence of Coverage
Meals	\$0 copay for 14 meals over 7 days after an inpatient or skilled nursing facility discharge, for more information see Evidence of Coverage
Transportation	Not Covered
Over The Counter (OTC)	\$120 every three months, for more information see Evidence of Coverage
Visitor/Traveler Program	See an Aetna PPO participating provider anywhere in the United States and pay in-network cost sharing.
Is my dentist in the network?	Find dentist

Prescription Drug Coverage

Annual Prescription Deductible	\$0
Initial Coverage Limit – Total amount you and the plan pay on prescription drugs before you enter the coverage gap	\$4,430
Additional Gap Coverage	Tier 1 and Tier 2 formulary drugs (see formulary guide)
True Out-of-Pocket Threshold Amount (TrOOP) – Amount you pay before reaching the catastrophic coverage level	\$7,050

Preferred Pharmacy - Retail (up to a 30 day supply)

Tier 1 - Preferred Generic Drugs	\$0
Tier 2 - Generic Drugs	\$0
Tier 3 - Preferred Brand Drugs	\$47
Tier 4 - Non-preferred Drugs	\$100

Tier 5 - Specialty Drugs	33%
Standard Pharmacy - Retail (up to a 30 day supply) ⓘ	
Tier 1 - Preferred Generic Drugs	\$15
Tier 2 - Generic Drugs	\$20
Tier 3 - Preferred Brand Drugs	\$47
Tier 4 - Non-preferred Drugs	\$100
Tier 5 - Specialty Drugs	33%

Mail Order pharmacy - (up to a 100 day supply) ⓘ

Tier 1 - Preferred Generic Drugs	\$0
Tier 2 - Generic Drugs	\$0
Tier 3 - Preferred Brand Drugs	\$141
Tier 4 - Non-preferred Drugs	\$300

Plan Documents

Gives a summary of the plan's benefits, costs and coverage.	Summary of Benefits
Ofrece un resumen de los beneficios, costos y cobertura del plan.	Resumen de Beneficios (Español)
List of prescription drugs covered by the plan.	Formulary
Lista de medicamentos recetados cubiertos por el plan.	Formulario (Español)
Work with your doctor to get pre-approval from us before we cover your drug.	Prior Authorization Information
You need to try certain drugs first before we cover your drug.	Step Therapy Information
Detailed information on the plan's benefits, costs and coverage.	Evidence of Coverage
Información detallada sobre beneficios, costos y cobertura.	Evidencia de Cobertura (Español)
Shows you what your monthly plan premium will be if you get Extra Help from Medicare to pay for your prescription drug costs.	Low Income Subsidy Information