Allina Health Aetna Medicare Grand (PPO) H3219-003

Plan details | Prescriptions | Total costs

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	**$96.00 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)	**$1,152 annually**

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Not available Star rating

Monthly premium
$96.00

Add to cart

Benefits

Medical Coverage

Monthly Plan Premium	**$96**
Medical Deductible: In-Network	**$0**
Medical Deductible: Out-of-Network	**$0**
Maximum Out-of-Pocket (MOOP): Annual In-Network	**$3,100**
Maximum Out-of-Pocket (MOOP): Annual Combined In and Out-of-Network	**$5,150**
Primary Care Physician (PCP)	**$0 in-network / 20% out-of-network**
Specialist	**$20 in-network / $40 out-of-network**
Additional Telehealth Services	**PCP: $0 in-network / Specialist: $20 in-network / Urgently Needed Services: $20 in-network / Mental Health - Group Sessions: $20 in-network / Mental Health - Individual Sessions: $20 in-network / Psychiatric Services - Group Sessions: $20 in-network / Psychiatric Services - Individual Sessions: $20 in-network, for more information see Evidence of Coverage**

Inpatient Hospital	**$200 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/ $20 out-of-network, for more information see Evidence of Coverage**
Diagnostic Procedures	**Diagnostic Procedures/Tests: $20 in-network/ $0 Diagnostic Procedures/Tests: $0 in-network/ $30 out-of-network, for more information see Evidence of Coverage**
Imaging	**Xray: $20 in-network / $30 out-of-network / CT Scans: $100 in-network / Diagnostic Radiology other than CT Scans: $100 in-network / Diagnostic Radiology Mammogram: $0 in-network / $150 out-of-network, for more information see Evidence of Coverage**
Ambulatory Surgery Center (ASC)	**$150 in-network / ASC Screening Colonoscopy Polyp Removal: $0 in-network / $350 out-of-network, for more information see Evidence of Coverage**
Outpatient Mental Health	**Mental Health - Group Sessions: $20 in-network/ Mental Health - Individual Sessions: $20 in-network/ $40 out-of-network, for more information see Evidence of Coverage Psychiatric Services - Group Sessions: $20 in-network/ Psychiatric Services - Individual Sessions: $20 in-network/ $40 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	**$1,500 maximum benefit for preventive and comprehensive dental services combined - see**

	comprehensive dental services combined - see Evidence of Coverage.
Eyewear Coverage	**$275 reimbursement every year, for more information see the Evidence of Coverage**
Hearing Aid Coverage	**$1,000 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)	**$105 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
List of prescription drugs covered by the plan.	Formulary
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
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
We can mail you a kit with most of the items above if you can't print them. Please allow 7-15 business days for shipping.	Order Information Kit

Preferences

Provider