Allina Health Aetna Medicare Premier (PPO) H3219-002

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.

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Not available Star rating

Monthly premium
$47.00

Add to cart

Costs

Premium	**$47.00 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)	**$564 annually**

Benefits

Medical Coverage

Monthly Plan Premium	**$47**
Medical Deductible: In-Network	**$0**
Medical Deductible: Out-of-Network	**$0**
Maximum Out-of-Pocket (MOOP): Annual In-Network	**$3,800**
Maximum Out-of-Pocket (MOOP): Annual Combined In and Out-of-Network	**$6,000**
Primary Care Physician (PCP)	**$0 in-network / 20% out-of-network**
Specialist	**$25 in-network / $45 out-of-network**
Additional Telehealth Services	**PCP: $0 in-network / Specialist: $25 in-network / Urgently Needed Services: $25 in-network / Mental Health - Group Sessions: $25 in-network / Mental Health - Individual Sessions: $25 in-network / Psychiatric Services - Group Sessions: $25 in-network / Psychiatric Services - Individual Sessions: $25 in-network, for more information see Evidence of Coverage**

Inpatient Hospital	**$500 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	**$315 in-network / $315 out-of-network**
Lab Services	**Lab Services: $0 in-network/ $0 Lab Services: $0 in-network/ $30 out-of-network, for more information see Evidence of Coverage**
Diagnostic Procedures	**Diagnostic Procedures/Tests: $30 in-network/ $0 Diagnostic Procedures/Tests: $0 in-network/ $45 out-of-network, for more information see Evidence of Coverage**
Imaging	**Xray: $30 in-network / $45 out-of-network / CT Scans: $150 in-network / Diagnostic Radiology other than CT Scans: $150 in-network / Diagnostic Radiology Mammogram: $0 in-network / $200 out-of-network, for more information see Evidence of Coverage**
Ambulatory Surgery Center (ASC)	**$250 in-network / ASC Screening Colonoscopy Polyp Removal: $0 in-network / $400 out-of-network, for more information see Evidence of Coverage**
Outpatient Mental Health	**Mental Health - Group Sessions: $25 in-network/ Mental Health - Individual Sessions: $25 in-network/ $45 out-of-network, for more information see Evidence of Coverage Psychiatric Services - Group Sessions: $25 in-network/ Psychiatric Services - Individual Sessions: $25 in-network/ $45 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	**$800 maximum benefit for preventive and comprehensive dental services combined - see**

	comprehensive dental services combined - see Evidence of Coverage.
Eyewear Coverage	**$250 reimbursement every year, for more information see the Evidence of Coverage**
Hearing Aid Coverage	**$750 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)	**$90 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 Deductible on Tier(s) 1, 2, 3; $150 Deductible on Tier(s) 4, 5**
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	**30%**
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	**30%**
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