SOUTH METRO DENVER REALTOR ASSOCIATION MEDICAL BENEFITS SUMMARY 2019

DRAFT DOCUMENT - SUBJECT TO CHANGE www.Aetna.com/asa

NETWORK Aetna OA Managed Choice POS II

	7150 Plan	3500 HDHP Plan	EPO 2500	CR 2000 Plan
Indivdual Deductible	$7,150 In-Network/ No Out-of-Network	$3,500 In-Network/$14,000 Out-of-Network	$2,500 In-Network/No Out-of-Network	$2,000 In-Network/No Out-of-Network
Family Deductible	$14,300 In-Network/ No Out-of-Network	$7,000 In-Network/$36,000 Out-of-Network	$5,000 In-Network/No Out-of-Network	$4,000 In-Network/No Out-of-Network
Plan Coinsurance Percentage(plan pays)	100% In-network / No Out of Network	80% In-Network	80 % In-network/No Out-of-Network	80% In-network/No Out-of-Network
Total Individual out-of-pocket maximum	$7,150 In-network/ No Out-of Network	$6,000 In-Network/$18,000 Out-of-Network	$5,500 In-Network/No Out-of-Network	$6,000 In-Network/No Out-of-Network
Total Family out-of-pocket maximum	$14,300 In-Network/ No Out-of-Network	Family total out-of-pocket maximum $12,000 In Network/$36,000 Out Network	Family total out-of-pocket maximum is $12,000 In Network Only	Family total out-of-pocket maximum is 2x the indivdual out of pocket maximum
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Office Visit Copay* (does not require referral)	Co-Pay for first 3 visits Primary: $40 copay : Specialist: $50 copay. No charge after deductible (all other services)	Ded, then 60%	$25 primary care provider, $40 specialist	Primary: $20 copay : Specialist: $40 copay / 1st 3 visit (office visit) / then 20%
Prescription Drugs				
Generic	$15	Deductible - 70% or $10	$10	$15
Preferred Brand	$50	Deductible - 25% or $30	$30	$40
Non-preferred Brand	$150	Deductible - 25% or $60	$50	$100
Other	50%	Deductible - 70% or $300 (whicever is greater)	$100	$200
Preventive Medical Services: including routine physical exams, associated imaging and laboratory services such as mammograms and PSA tests, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance	Paid at 100% - no deductible, coinsurance	Paid at 100% - no deductible, coinsurance	Paid at 100% - no deductible, coinsurance
Urgent Care Visit*	$100	60% After Deductible	$75	$50 for 1st $300, then 90%
Diagnostic X-Ray and Laboratory Services*	No charge after deductible	60% After Deductible	80% After Deductible	80% After Deductible
MRI, CT Scan, PET scan Ultrasound, EKG, chemotheraphy, dialysis and BRCA	No charge after deductible	60% After Deductible	80% After Deductible	80% After Deductible
Emergency Room Treatment Subject to a 30% penalty for non-emergency use*	No charge after deductible	60% After Deductible	$200	$400
Maternity	No charge after deductible	60% After Deductible	80% After Deductible	80% After Deductible
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Ded, then 100%	Deductible, then 100%	Deductible, then 80%	Deductible, then 80%
See SPDS for full details				

* Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance

To find a physician within the network please visit: www.aetna.com/docfind/custom/mymeritain

Please note: The above is only a partial description of benefits and services.

For a complete description of benefits and exclusions, please see the Schedule of Benefits; its terms prevail.