

Keenan

Rancho Santiago CCD

HMO

Effective: January 1, 2025

	Stand-Alone
Carrier Name	Aetna
Rate Guarantee	1 year
Plan Name	HMO
General Plan Information	Full Network
Annual Deductible (Individual / Family)	\$0 / \$0
Annual Out-of-Pocket Limit (Individual / Family)	\$1,000 / \$2,000
Coinsurance	No charge
Physician Services	
Office Visit (Primary Care Physician)	\$10 copay
Office Visit (Specialist)	\$10 copay
Urgent Care	\$10 copay
Advanced Imaging (CT, MRI, etc.)	\$100 copay
Hospital Services	
Inpatient Hospitalization	No charge
Outpatient Surgery	No Charge
Emergency Services	
Emergency Room Copay (Waived if Admitted)	\$100 copay
Ambulance (Air & Ground)	\$100 copay
Mental Health & Substance Abuse	
Inpatient Care	No charge
Outpatient Care	No charge
Prescription Drug Benefits	
Rx Deductible (Individual/Family)	\$0 / \$0
Rx Annual Out-of-Pocket Limit (Individual/Family)	\$2,500 / \$5,000
Retail	
Generic / Preferred Brand / Brand / Specialty	\$5 / \$15 / \$30 / --
# of Days Supply	30 days
Mail Order	
Generic / Preferred Brand / Brand / Specialty	\$10 / \$30 / \$60 / By tier
# of Days Supply	90 days (30 days specialty)
Outpatient Rehabilitative Therapy Services	
Physical & Occupational	\$10 copay
Speech	\$10 copay
Chiropractic Manipulation	\$10 copay (20 visits/year)
Acupuncture	\$10 copay (20 visits/year)
Hearing	
Hearing Aids	Screening only

* Deductible waived for services marked with a 'star'

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PPO

Effective: January 1, 2025

	Stand-Alone	
Carrier Name	Aetna	
Rate Guarantee	1 year	
Plan Name	OA Managed Choice POS	
General Plan Information	Aetna OAMC	Non-PPO
Annual Deductible (Individual / Family)	\$250 / \$500	\$250 / \$500
Annual Out-of-Pocket Limit (Individual / Family)	\$1,000 / \$2,000	\$3,000 / \$6,000
Coinsurance	10%	30%
Physician Services		
Office Visit (Primary Care Physician)	\$20 copay * (\$0 visits 1-3)	30%
Office Visit (Specialist)	\$20 copay *	30%
Urgent Care	\$20 copay *	30%
Advanced Imaging (CT, MRI, etc.)	10%	30% (\$800/test max benefit)
Hospital Services		
Inpatient Hospitalization	10%	\$250 copay + 30%
Outpatient Surgery	10%	30% (\$350/visit max benefit)
Emergency Services		
Emergency Room Copay (Waived if Admitted)	\$50 copay + 10%	\$50 copay + 10%
Ambulance (Air & Ground)	10%	10%
Mental Health & Substance Abuse		
Inpatient Care	10%	\$250 copay + 30%
Outpatient Care	No charge	30%
Prescription Drug Benefits		
Rx Deductible (Individual/Family)	\$0 / \$0	\$0 / \$0
Rx Annual Out-of-Pocket Limit (Individual/Family)	\$2,500 / \$5,000	\$2,500 / \$5,000
Retail		
Generic / Preferred Brand / Brand / Specialty	\$5 / \$15 / \$30 / --	20% (\$250)
# of Days Supply	30 days	30 days
Mail Order		
Generic / Preferred Brand / Brand / Specialty	\$10 / \$30 / \$60 / --	Not covered
# of Days Supply	90 days (30 specialty)	
Outpatient Rehabilitative Therapy Services		
Physical & Occupational	10%	30%
Speech	10%	30%
Chiropractic Manipulation	10%	30%
Acupuncture	\$20 copay * (12 visits/year)	30% (12 visits/year)
Hearing		
Hearing Aids	100% up to \$4,000 (every36 months)	100% up to \$4,000 (every36 months)

* Deductible waived for services marked with a 'star'