Health care 101

Understanding the Health Insurance Marketplace®
2024 Individual & Family Plans

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Medical plans, plain and simple

If you find health insurance terms to be confusing, you're not alone. That's why we made this handy guide. No more jargon or complicated descriptions. Just straightforward explanations about plans, payments and easy ways to save.

What is health insurance?

When we talk about health insurance, we mean the kind of plan that covers eligible doctor bills, surgery, lab work, tests and hospital costs. Just like car insurance, you pick a health insurance plan and agree to pay a specific rate, or premium, for that policy. Your monthly premium payment gives you coverage for many of your medical expenses, depending on your plan. Health insurance exists to offset and lower the costs of medical expenses.

In some cases, you may even qualify for a low- or no-cost health plan and receive a subsidy from the government. In return, Banner|Aetna agrees to pay a percentage of your medical expenses for a specific list of medical services (covered services).

How does health insurance work?

In return for your insurance premium (the amount you pay for your health plan), Banner|Aetna agrees to share the cost of covered medical services with you. Those services are listed in your policy along with the out-of-pocket cost—copay, a deductible or coinsurance—for each service. Most insurance companies have negotiated rates, with doctors and facilities. Payments by your insurance company are usually based on these rates, and those doctors and facilities are called "in-network."

Getting in-network care saves you and your insurance company money, because you both pay a lower out-of-pocket cost and lower overall cost of care. Banner|Aetna individual and family plans do not have an out-of-network benefit for non-emergency care. This means if you receive care with an out-of-network doctor or at an out-of-network facility, you will be responsible for the full cost of care except for in medical emergencies. It's important to check to see if your doctor is in your health plan's network. Be sure to read your policy carefully so you know what to expect.

What makes Banner|Aetna different?

No-cost virtual care with 98point6®*

No- and low-cost MinuteClinic visits at CVS locations*

No primary care provider selection required

See any in-network doctor; no referral needed

Covered preventive care services*

Banner|Aetna mobile app and member portal

No-cost Nurse On-Call

Behavioral health in-network and virtual care services

Discounts on health and wellness services

Up to a $100 yearly allowance*
Use on over-the-counter wellness items at CVS retail stores and online. Choose from hundreds of CVS Health brand products like cold and allergy meds, pain relief and more.

20% off CVS Health brand products*
Your member ID card gets you exclusive access to 20% off CVS Health brand products at CVS retail stores. Just scan the barcode on the back of your card.

*FOR NO-COST OR LOW-COST VIRTUAL CARE: Members may be required to pay a cost-share based on what medical services were received and the type of a provider a member visits. Please consult benefit documents for more details. 98point6 is a registered trademark of 98point6 Inc. The $5 98point6 visit fee for eligible Banner|Aetna members enrolled in an HSA/high-deductible health plan is currently waived through December 31, 2024, in response to provisions of the Consolidated Appropriations Act, 2023. 98point6 and 98point6 physicians are independent contractors and are neither agents nor employees of Banner|Aetna or plans administered by Banner|Aetna.

*FOR MINUTECLINIC CARE AND SCHEDULING: For a complete list of participating walk-in clinics, log in to BannerAetna.com and use our provider search tool. Walk-in appointments are based on availability and are not guaranteed. Online scheduling is recommended. Includes select MinuteClinic services. Not all MinuteClinic services are covered. Please consult benefit documents to confirm which services are included. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered nonpreventive MinuteClinic services at no cost-share. However, such services are covered at negotiated contract rates. This benefit is not available in all states. Access to walk-in clinics varies by geography. Walk-in appointments are based on availability and are not guaranteed. Online scheduling is recommended. Age and service restrictions may apply.

*FOR EXCLUSIONS AND LIMITATIONS: Health benefits and health insurance plans contain exclusions and limitations. Please visit **bit.ly/Banner-EL** for a complete list.

*FOR $100 ALLOWANCE: $25 allowance each quarter to use on select CVS Health brand products. Unused allowances do not carry over to the next quarter.

*FOR 20% OFF CVS HEALTH BRAND PRODUCTS: The 20% savings is restricted to items purchased for the member, spouse or dependents. Excludes prescriptions, lottery tickets, postage stamps, gift cards, money orders, pre-paid cards, photofinishing, and CVS.com purchases. Not valid on other items reimbursed by a governmental program.

Affordable Care Act (ACA) health plan categories: Bronze, Silver, Gold and Platinum

Plans in the Marketplace are presented in four health plan categories: Bronze, Silver, Gold and Platinum. These plans are based on how you and your plan split the costs of your health care. The levels only refer to costs shared by you and the insurer. They do not reflect the quality of care you receive.

No matter which health plan category you choose, you may be eligible to save money on your monthly premium based on your income. When you fill out a Marketplace insurance application, you'll find out if you qualify for a subsidy.

Note: Plans in all categories provide free preventive care and virtual care visits through 98point6®.

How you and your insurance plan may split costs*

Plan category	The insurance company pays	You pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

*Estimated averages. Your costs will vary.

Which health plan category is right for you?

Bronze

- **Lowest** monthly premium
- **Highest** costs when you need care
- **Your deductibles**—the amount you pay before your insurance plan starts to pay—can be thousands of dollars a year. So, you may have a lower monthly premium, but you will pay higher out-of-pocket costs.
- **Good choice if** you want a low-cost way to protect yourself from worst-case medical scenarios, like serious illness or injury.

Gold

- **High** monthly premium
- **Low** costs when you need care
- **Your deductibles** are usually low.
- **Good choice if** you're willing to pay more each month to have more costs covered when you get medical treatment. If you use a lot of care, a Gold plan could be a good value.

Silver

- **Moderate monthly premium**
- **Moderate** costs when you need care
- **Your deductibles** are usually lower than those of Bronze plans.

Getting extra savings with a Silver plan

- **See if you qualify for extra savings**—you can only get a subsidy though the government.
- **Good choice if** you qualify for "extra savings"—or if you're willing to pay a slightly higher monthly premium than Bronze to have more of your routine care covered.

Platinum

- **Highest** monthly premium
- **Lowest** costs when you get care
- **Deductibles** are very low, meaning your plan starts paying its share earlier than the other plans
- **Good choice if** you usually use a lot of care and are willing to pay a high monthly premium, knowing nearly all other costs will be covered.

Paying for care

Understanding your health insurance can be tough. We get it.
We think it's safe to say that even the health insurance basics can be hard to understand.

Types of health plans

Knowing key health insurance terms is important. This will help you feel confident using your health plan.

Covered doesn't mean free. A covered health care service is one that your plan recognizes. Your plan only pays for this service after you've met the deductible, coinsurance or copay.

A referral is like a permission slip from your primary care physician (PCP) to see a specialist or another provider. Many doctors can send referrals electronically. Banner|Aetna individual and family plans do not require referrals, but many other health plans do.

Network providers participate in the Banner|Aetna network. And they offer special lower rates for Banner|Aetna members.

Processing

Claims

Claims are requests for your plan to pay for services you receive. Your in-network doctor or facility submits claims on your behalf and we review that claim against your plan's coverage. You can find claim information on your member portal or the Banner|Aetna Aetna Health℠ app.

Explanation of benefits (EOB)

An **Explanation of benefits** or EOB statement shows a breakdown of how we process your claims. It is not a bill and may not show the current balance you owe.

Doctor bills

Bills show the amount you actually owe for services. You'll get this from your provider.

Allowed amount

The **allowed amount** is the most the doctor is allowed to charge and the most your insurance will pay for a health care service covered by your plan.

In-network

In-network refers to a doctor or facility that has a contract with Banner|Aetna to provide services to members at a pre-negotiated rate.

Payments

Coinsurance

Coinsurance is the sharing of costs between your insurance and you for covered services after you've met your benefit period deductible. Coinsurance is usually shown as a percentage.

For example, if your coinsurance is 20%, that means you'll pay 20% of covered medical expenses after you've met your deductible (and your insurance will pay 80%) until you reach your out-of-pocket limit for the benefit period (usually a year). Once you reach the out-of-pocket limit, your insurance should pay 100% of all covered services for the remainder of the benefit period.

Deductible

A deductible is the set dollar amount you pay your provider toward covered medical services each plan year before Banner|Aetna starts paying toward those services.

Good to know: Your copays (the fees you pay when you check out at the doctor's office) don't go toward paying down, satisfying or meeting your annual deductible amount.

Copayment

A copayment is the fixed dollar amount you pay at the time a covered service is provided. Copayment amounts can vary depending on:

- The benefits or coverage included in your health plan
- What services you receive
- Using in-network instead of out-of-network doctors and hospitals
- Seeing a primary care provider (PCP) instead of a specialist
- Taking generic vs. brand-name prescription drugs

In other words: A copayment is the set dollar amount you pay (for example, the $20 you pay when you check out at the doctor's office) for certain medical services and prescription drugs at the time you get them.

Out-of-pocket limit

The out-of-pocket limit is the maximum amount you pay for covered health care in a year before your insurance starts paying all costs for covered services, including deductibles, coinsurance and copays (depending on your plan). Services that are not covered by your plan do not apply to your out-of-pocket limit.

In-network care

Who pays for what

Visit your doctor and show your ID card.

There's no need to pay at your visit unless you have a copay.
(Before you visit a doctor or facility, make sure they are in-network. Your plan does not include out-of-network care except for in an emergency.)

Your doctor files your claim.
(Out-of-network, you file your own claims.)

Remember: Out-of-network care is not covered except for in an emergency.

Your Banner|Aetna insurance processes a claim.
Your insurance pays your doctor or facility any amount it owes based on the negotiated rate.

Your doctor bills you for any amount you owe.

5 ways to save

1 Stay in-network

Except for emergent care, you must use in-network doctors, labs, hospitals and other health care providers. You can use the provider search tool at **BannerAetna.com** to find network providers.

2 Get preventive care

Keep up with preventive services to catch any problems early. You pay nothing as long as you stay in-network. Check your plan documents to see which preventive services are 100% covered.

3 Pay less for prescriptions

Generic drugs can be just as effective as name-brand, and they usually cost less. You can also save by using your plan's home delivery service for regular prescriptions.

4 Use the ER for emergencies only

Visit an urgent care center or walk-in clinic or use your no-cost 98point6 virtual care benefit for non-life-threatening medical issues.

5 Compare costs before you go

Use the cost-of-care tools on your member portal to compare costs before you go to the doctor. You also have 24/7 access to no-cost* virtual care with 98point6.

*The $5 98point6 visit fee for eligible Banner|Aetna members enrolled in an HSA/high-deductible health plan is currently waived through December 31, 2024, in response to provisions of the Consolidated Appropriations Act, 2023

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