

**Banner** : 2025 AZ BA Silver S: HNOnly CSR 94 + Adult Dental + Vision

Coverage for: Individual + Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0777808&Y=25, or by calling 1-844-365-7374. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-844-365-7374 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://aet.na/providersearch_banneraetna">https://aet.na/providersearch_banneraetna</a> or call 1-844-365-7374 for a list of in- <a href="network_providers">network_providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No charge; including virtual visits	Not covered	None
If you visit a health care	Specialist visit	\$10 copay/visit	Not covered	None
provider's office or clinic	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	Not covered	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not covered	None
	Preferred/non-preferred generic drugs	No charge (retail & mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order
If you need drugs to treat your illness or condition  More information about	Preferred brand drugs	Copay/ prescription, deductible does not apply: \$15 (retail), \$37.50 (mail order)	Not covered	prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's
prescription drug coverage is available at http://aet.na/azbhaivl25	Non-preferred brand drugs	Copay/ prescription: \$50 (retail), \$125 (mail order)	Not covered	contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage.
	Preferred/non-preferred specialty drugs	Copay/ prescription: \$150 for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to selected participating retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
modisal attention	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	\$5 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.

		What You Will Pay			
Common  Medical Event  Services You May Need		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Importan Information	
If you have a	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None	
hospital stay	Physician/surgeon fees	25% <u>coinsurance</u>	Not covered	None	
If you need mental health, behavioral health, or	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 25% coinsurance	Not covered	All other outpatient services includes Applied Behavioral Analysis (ABA) services.	
substance abuse services	Inpatient services	25% <u>coinsurance</u>	Not covered	None	
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	25% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC	
	Childbirth/delivery facility services	25% coinsurance	Not covered	(i.e., ultrasound).	
	Home health care	No charge	Not covered	Coverage is limited to 42 visits.	
	Rehabilitation services	No charge	Not covered	Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy & Speech Therapy combined.	
If you need help recovering or have other special health needs	Habilitation services	No charge; 25% coinsurance for developmental delays	Not covered	None	
oposiai noutin noodo	Skilled nursing care	25% coinsurance	Not covered	Coverage is limited to 90 days.	
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	25% coinsurance	Not covered	None	
	Children's eye exam	\$10 copay/visit	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.	
If your child needs dental or eye care	Children's glasses	\$10 <u>copay</u> /visit	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.	
	Children's dental check-up	Not covered	Not covered	Not covered.	

#### **Excluded Services & Other Covered Services:**

# Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion
- Acupuncture
- Cosmetic surgery
- Dental Care (Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- Routine foot care
- · Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Bariatric surgery
- Chiropractic care Coverage is limited to 20 visits.
- Dental care (Adult) Coverage is limited to ages 19 and up. Routine Cleaning (2 per calendar year).
   \$1,000 maximum for all dental services (Routine check-up, Basic & Major).
- Hearing aids Coverage is limited to 1 per ear.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) Coverage is limited to ages 19 and up. 1 routine eye exam, including dilation. Coverage does not include the office visit for the fitting of prescription contact lenses.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Arizona Department of Insurance and Financial Institutions, 602-364-2499, 602-364-2977 (Spanish), https://difi.az.gov/.

• For more information on your rights to continue coverage, contact the plan at 1-844-365-7374.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 or state health insurance marketplace or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

• Arizona Department of Insurance and Financial Institutions, 602-364-2499, 602-364-2977 (Spanish), https://difi.az.gov/.

# Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

# Does this plan meet Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

# **About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

# Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$0
Specialist copayment	\$10
Hospital (facility) coinsurance	25%
Other coinsurance	25%

# Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	\$0
Specialist copayment	\$10
Hospital (facility) coinsurance	25%
Other coinsurance	25%

# Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$0
Specialist copayment	\$10
Hospital (facility) coinsurance	25%
Other coinsurance	25%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700		
In this example, Peg would pay:	In this example, Peg would pay:		
Cost Sharing			
<u>Deductibles</u>	\$0		
Copayments	\$0		
Coinsurance	\$2,000		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$2,060		

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Diabetic supplies</u> (glucose meter)

<b>Total Example Cost</b>	\$5,600		
In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$200		
<u>Coinsurance</u>	\$30		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$250		

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$20	
Coinsurance	\$500	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$520	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7374.

# **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7374.

## **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

#### **Non-Discrimination**

Banner|Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512,

1-800-648-7817, TTY: 711,

Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Health benefits and health insurance plans are offered, underwritten, and/or administered by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Banner|Aetna is an affiliate of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Each insurer has sole financial responsibility for its own products. Aetna and Banner Health provide certain management services to Banner|Aetna. Aetna is part of the CVS Health family of companies.

#### TTY: 711

# **Language Assistance:**

For language assistance in your language call 1-844-365-7374 at no cost.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-844-365-7374.

Amharic - የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7374 ይደውሉ፡፡

مقرل ا على على الصال ا عاجر ل ا ، مقلكت يأنود من على التامدخل العلى على العرب العلى العرب العرب

Armenian - Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7374 հեռախոսահամարով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7374 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7374.

Bengali-Bangala - আপনাক বেনিামুক্য ভোষা প্রকিষা প্রপক হক্য এই নম্বক প্রেযক ান রেন: 1-844-365-7374।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7374.

Burmese - သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဂန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7374 သို့ ဖုန်းခေါ် ဆိုပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7374.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-844-365-7374.

Cherokee - GYOJ SULAOJ OGOLOJJ L ALOJ JCEGWJJ VY, OLABWOL 1-844-365-7374.

Chinese - 如欲使用免費語言服務,請致電 1-844-365-7374。

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7374.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7374.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-844-365-7374.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7374.

French Creole - Pou jwenn sèvis lang gratis, rele 1-844-365-7374.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7374 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7374.

Gujarati - તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેમિઓની પહોોર માટે, કોલ કરો 1-844-365-7374.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-844-365-7374 Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-844-365-7374 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-365-7374.

lgbo - Iji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-844-365-7374.

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-365-7374.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-365-7374.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-365-7374.

Japanese - 言語サービスを無料でご利用いただくには、1-844-365-7374 までお電話ください

Karen - လာတာ်ကမာန္နာ်ကိုြာအတာ်မာစားအတာ်ဖံးတာ်မာတဖဉ်လာတအို် ဒီးအပူးလာကဘဉ်ဟုဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-844-365-7374 တက္၏.

Korean - 무료 언어 서비스를 이용하려면 1-844-365-7374 번으로 전화해 주십시오.

Kru-Bassa - Μ dyi wudu-dù kà kò dò bě dyi móuń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-844-365-7374.

عمر اهڙ هب هڪ يين دن وو يه هي ، وَت وَ ب ن و و چيت عبيب ن اهز ير از و گئت مهز خ هب نتشيء هڪار عبيس مد وَ ب عدن دو ي هب ، وَت وَ ب ن و و چيت عبيب ن اهز ير از و گئت مهز خ هب نتشيء هڪار عبيب مدد و ي

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍປື້ເສຍຄື່າຕື້ກັບທີ່ານ, ໃຫ້ໂທຫາເບີ 1-844-365-7374.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-844-365-7374 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-844-365-7374.

Micronesian Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7374. Pohnpeyan -

Mon-Khmer ដ ្រីម្បីទទួលបានដវោកម្មភាសាដ លឥតគិតថ្លាម្រែរាប់ដរោកអ៊ុនក រូ មុដរៅទូរពែ្ទដៅកាន់ដលខ 1-844-365-7374។. Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ąh ílínígóó kojį' hólne' 1-844-365-7374.

Nepali - निःशूल्क भाषा सेवा प्राप्त गनन 1-844-365-7374 मा टेलिफोन गन्नहोस् ।

Nilotic-Dinka - Të koor yin wëër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-844-365-7374.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-844-365-7374.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-365-7374.

ديرىگب سامت 7374-365-1-844 هر امش اب ،ناگىار روط مب نابن تامدخ مب ىسرتسد ىار ب

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-365-7374.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-365-7374.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਸਿੇ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7374 'ਤੇ ਫ਼ੋਨ ਰਿੈ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-844-365-7374.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-365-7374.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-365-7374.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-844-365-7374.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-844-365-7374.

Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-365-7374.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-844-365-7374.

Syriac - : عبره عند معرف معرف عند معرف عند المار المار

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-365-7374.

Telugu - మీరు భష నేవలను ఉచితంగ అందుకున ందుకు, 1-844-365-7374 కు శల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7374.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-365-7374.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-365-7374.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-365-7374 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7374.

ںیرک تاب رپ 7374-365-844 ہے۔ کیل ےک ےنرک لصاح تامدخ مقلعتم ہس نابز تمیقالاب۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-365-7374.

Yiddish - 1-844-365-7374 צו צוטריט רארפשַ באדַינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-844-365-7374.