

## Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

**Prepared for:**

Employer:	Banner Health
Contract number:	MSA-285731
Plan name:	Open Access POS II - Value HDHP Banner Family Pharmacy
Schedule of benefits:	3A
Plan effective date:	January 1, 2024
Plan issue date:	August 6, 2024

**Third Party Administrative Services provided by Banner Health and Aetna Health  
Insurance Company**



## Schedule of benefits

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This schedule of benefits (schedule) lists the **deductibles, copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

### How your cost share works

- When we say:
  - “Banner Health Network”, we mean you get care from Banner **network providers** at the lowest cost share.
  - “Aetna Network Providers”, we mean you can get care from Aetna **network providers** at the higher cost share.
  - “Out-of-network coverage”, we mean you can get care from **providers** who are not Banner providers nor Aetna **network providers**. You will pay the most in out of pocket costs when you use an out of network provider
- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles, copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn’t cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between **designated network** and **non-designated network providers**
  - Separate limits for **designated network** and **non-designated network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this planSee the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Banner | Aetna benefits* section under Individuals & Families at <https://www.banneraetna.com/>

#### **Important note:**

**Covered services** are subject to the Calendar Year **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**

3. Then pay your **payment percentage**  
Your **copayment** does not apply to any **deductible**.

### **How your deductible works**

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **designated network, non-designated network** or **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

### **How your PCP or physician office visit cost share works**

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

### **How your maximum out-of-pocket works**

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

## **Contact us**

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

## Plan features

### Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	Banner Health Network	Aetna Network Providers	Out-of-network
Individual	\$2,800 per year		\$5,600 per year
Family	\$5,600 per year		\$11,200per year

### Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

### Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

### Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

### Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two, 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

### Deductible waiver provisions for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription** drug expenses:

#### Preventive:

Preventive drugs as defined in guidance issued by the U.S. Department of the Treasury and Internal Revenue Service (IRS) for Health Savings Accounts (HSAs) and qualified High Deductible Health Plans (HDHPs). This list will be reviewed periodically and is subject to change as federal guidelines change.

## Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Banner Health Network	Aetna Network Providers	Out-of-network
Employee Only	\$5,000 per year		\$10,000 per year
Employee plus Family	\$10,000 per year		\$20,000 per year

## General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

### Deductible provisions

**Covered services** that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

Designated network **covered services** will apply only to the designated network **deductible**. Non-designated network **covered services** will apply only to the non-designated network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

### Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

### Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

### Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

### Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**.

## Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments, payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

**Designated network covered services** will apply only to the **designated network maximum out-of-pocket limit**. **Non-designated network covered services** will apply only to the **non-designated network maximum out-of-pocket limit**.

## Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

## Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

## Limit provisions

**Covered services** will apply to the **designated network, non-designated network** and **out-of-network** limits.

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

## Prescription drug – outpatient deductible provisions

**Covered services** that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **deductible** may not apply to certain **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

### **Prescription drug – outpatient maximum out-of-pocket limit provisions**

**Covered services** that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments, payment percentage** and **deductible**, if any, for **covered services**.

## Covered services

### Acupuncture

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Acupuncture	80% per visit after deductible	80% per visit after deductible	50% per visit after deductible

### Ambulance services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Emergency services	80% per trip after deductible	Paid same as designated network	Paid same as designated network
Non-emergency services	Not covered	Not covered	Not covered

### Applied behavior analysis

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Autism spectrum disorder

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Inpatient services- <b>room and board</b> including <b>residential treatment facility</b>	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
Other inpatient services and supplies Other <b>residential treatment facility</b> services and supplies	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Outpatient office visit to a <b>physician or behavioral health provider</b>	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
<b>Physician or behavioral health provider telemedicine</b> consultation	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
Outpatient <b>mental health disorders telemedicine</b> cognitive therapy consultations by a <b>physician or behavioral health provider</b>	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> The cost share doesn't apply to in-network peer counseling support services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

### **Substance related disorders treatment**

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
<b>Inpatient services-room and board</b>	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
Other inpatient services and supplies during a <b>hospital stay</b>	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Outpatient office visit to a <b>physician or behavioral health provider</b>	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
<b>Physician or behavioral health provider telemedicine consultation</b>	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician or behavioral health provider</b>	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Other outpatient services including: <ul style="list-style-type: none"> <li>• Behavioral health services in the home</li> <li>• Partial hospitalization treatment</li> <li>• Intensive outpatient program</li> </ul> The cost share doesn't apply to in-network peer counseling support services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

### Clinical trials

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of- network</b>
<b>Experimental or investigational therapies</b>	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Diabetic services, supplies, equipment, and self-care programs

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Durable medical equipment (DME)

Description	Banner Health Network	Aetna Network Providers	Out-of-network
DME	80% per item after deductible	70% per item after deductible	Not covered

### Emergency services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Emergency room	80% per visit after deductible	70% per visit after deductible	70% per visit after deductible

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered	Not covered

**Emergency services important note: Out-of-network providers** do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

### Foot orthotic devices

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Orthotic devices	80% per item after deductible	70% per item after deductible	50% per item after deductible

### Habilitation therapy services

#### Physical (PT) and occupational (OT) therapies

Description	Banner Health Network	Aetna Network Providers	Out-of-network
PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

#### Speech therapy (ST)

Description	Banner Health Network	Aetna Network Providers	Out-of-network
ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Hearing aids

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Hearing aids	100% per item after deductible	70% per item after deductible	50% per item after deductible

Limit	\$5,000 every 3 years	\$4,000 every 3 years	\$2,500 every 3 years
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## Hearing exams

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months	1 visit every 24 months

## Home health care

A visit is a period of 4 hours or less

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Home health care	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Inpatient services - room and board	80% after deductible	70% after deductible	50% after deductible

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Other inpatient services and supplies	80% per admission after deductible	70% per admission after deductible	50% after deductible

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Outpatient services	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

Limit per lifetime	unlimited	unlimited	unlimited
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**Hospice important note:**

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

**Hospital care**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Inpatient services – room and board	80% after deductible	70% after deductible	50% after deductible

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Other inpatient services and supplies	80% per admission after deductible	70% per admission after deductible	50% after deductible

**Infertility services**

**Basic infertility**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Treatment of basic infertility	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

**Comprehensive infertility services**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Outpatient services	50% per visit after deductible	50% per visit after deductible	Not covered

**Advanced reproductive technology (ART)**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Outpatient services	50% per visit after deductible	50% per visit after deductible	Not covered

**Limits**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Limit per lifetime ART and Comprehensive services combined	\$15,000	\$15,000	Not applicable

## Maternity and related newborn care

Includes complications

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Inpatient services - <b>room and board</b>	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
Services performed in <b>physician or specialist</b> office or a facility	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
Other services and supplies	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

### Maternity and related newborn care important note:

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

## Nutritional support

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Nutritional support (Includes Eosinophilic Gastrointestinal Disorder)	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Obesity surgery

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Inpatient services - <b>room and board</b>	\$2,000 then the plan pays 80% per admission after <b>deductible</b>	\$2,000 then the plan pays 70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>	70% per admission after <b>deductible</b>	50% per admission after <b>deductible</b>

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Outpatient services	\$2,000 then the plan pays 80% per visit after <b>deductible</b>	\$2,000 then the plan pays 70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Limit per lifetime	\$20,000	\$20,000	\$20,000
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### Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Banner Health Network	Aetna Network Providers	Out-of- network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Prescription drugs - outpatient

#### Generic prescription drugs

Description	Banner Pharmacy Network	Aetna Pharmacy Network	Out-of-network
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	20% after <b>deductible</b>	30% after <b>deductible</b>	Not covered
More than a 31 day supply but less than a 93 day supply filled at a <b>Banner Family pharmacy</b>  <b>Banner Family Pharmacy is required</b> after 2 Retail Fills of maintenance medications.	20% after <b>deductible</b>	Not covered	Not covered

#### Brand-name prescription drugs

Description	Banner Pharmacy Network	Aetna Pharmacy Network	Out-of-network
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	20% after <b>deductible</b>	30% after <b>deductible</b>	Not covered
More than a 31 day supply but less than a 93 day supply filled at a <b>Banner Family pharmacy</b>  <b>Banner Family Pharmacy is required</b> after 2 Retail Fills of maintenance medications.	20% after <b>deductible</b>	Not covered	Not covered

### Brand-name specialty prescription drugs

Description	Banner Pharmacy Network	Aetna Pharmacy Network	Out-of-network
For each fill up to a 31 day supply filled at a <b>Banner specialty pharmacy</b>	20% after <b>deductible</b>	Not covered	Not covered

#### Important note:

After you have met your **deductible**, your cost share for **specialty prescription drugs**, under the **copayment** assistance program, will not count toward your **maximum out-of-pocket limit**. This includes cost shares that you, the plan or the program pay.

### Preventive maintenance drugs

Description	In network	Out-of-network
Certain preventive maintenance drugs for hypertension, high cholesterol, diabetes, asthma, seizures, transplant, and mental health are available with no deductible.	See generic/brand copays above, no <b>deductible</b> applies  For a current list of preventive maintenance drugs or more information, see the <i>Contact us</i> section	Not covered

### \$0 Banner Drug List

Description	In network	Out-of-network
Certain medications for cardiovascular disease, high cholesterol, Asthma/COPD, and diabetes are available for \$0 copay.	\$0 after <b>deductible</b>  For a current \$0 Banner Drug List or more information, see the <i>Contact us</i> section	Not covered

### Infertility drugs

Description	In-network	Out-of-network
Infertility drugs	Paid based on the tier of drug in the schedule	Not covered
Lifetime limit	\$10,000	Not covered

### Preventive Health Care Reform drugs and supplements

Description	In-network	Out-of-network
Preventive Health Care Reform drugs and supplements	\$0, no <b>deductible</b> applies	Not covered
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of covered preventive Health Care Reform drugs and supplements or more information, see the <i>Contact us</i> section</p>	Not covered

### Risk reducing breast cancer prescription drugs

Description	In-network	Out-of-network
Risk reducing breast cancer <b>prescription</b> drugs	\$0, no <b>deductible</b> applies	Not covered
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section</p>	Not covered

### Tobacco cessation prescription and OTC drugs

Description	In-network	Out-of-network
Tobacco cessation <b>prescription</b> and OTC drugs	\$0, no <b>deductible</b> applies	Not covered
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information.</p>	Not covered

#### Prescription drug important note:

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference does not apply toward your **prescription drug deductible** or **maximum out-of-pocket limit**.

## Outpatient surgery

Description	Banner Health Network	Aetna Network Providers	Out-of-network
At <b>hospital</b> outpatient department	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
At the <b>physician</b> office	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Physician and specialist services

### Physician services-general or family practitioner

Including surgical services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
<b>Physician</b> office hours (not surgical, not preventive)	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
<b>Physician</b> surgical services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Description	Banner Health Network	Aetna Network Providers	Out-of-network
<b>Physician</b> visit during inpatient <b>stay</b>	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Description	Designated network	Non-designated network	Out-of-network
<b>Physician telemedicine</b> consultation	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Description	Banner Health Network	Aetna Network Providers	Out-of-network
<b>Telemedicine provider</b> consultation	Covered based on type of service and <b>provider</b> from which it is received	Not covered	Not covered
Basic medical services			

## Specialist

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
<b>Specialist</b> office hours (not surgical, not preventive)	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
<b>Specialist</b> surgical services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
<b>Specialist telemedicine</b> consultation	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

## All other services not shown above

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
All other services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

## Preventive care

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Preventive care services	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	50% per visit after <b>deductible</b>
Breast feeding counseling and support limit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit	Not applicable
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months  Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months  Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months  Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump	Not applicable
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months	2 visits/12 months
Family planning services (female contraception)	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	50% per visit, no <b>deductible</b> applies

Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting  Counseling that exceeds this limit covered as a <b>physician</b> services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting  Counseling that exceeds this limit covered as a <b>physician</b> services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting  Counseling that exceeds this limit covered as a <b>physician</b> services office visit
Immunizations	100%, no <b>deductible</b> applies	100%, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>
Routine cancer screenings	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> or see the <i>Contact us</i> section

Routine lung cancer screening	100%, no <b>deductible</b> applies	100%, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Routine lung cancer screening limit	1 screening every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100%, no <b>deductible</b> applies	100%, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months
Well woman GYN exam	100%, no <b>deductible</b> applies	100%, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

### Prosthetic devices

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Prosthetic devices	80% per item after deductible	70% per item after deductible	Not covered
Cranial prosthetics (Medical wigs)	100% per item after deductible	100% per item after deductible	100% per item after deductible

### Reconstructive surgery and supplies

Including breast surgery

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
<b>Surgery</b> and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

#### Cardiac rehabilitation

<b>Description</b>	<b>Banner Health Network</b>	<b>Aetna Network Providers</b>	<b>Out-of-network</b>
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Pulmonary rehabilitation

Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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### Cognitive rehabilitation

Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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### Physical and occupational therapies

Description	Banner Health Network	Aetna Network Providers	Out-of-network
At the <b>physician</b> office	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible
At facility that is not a <b>hospital</b>	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible
At <b>hospital</b> outpatient department	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Speech therapy (ST)

Description	Banner Health Network	Aetna Network Providers	Out-of-network
At the <b>physician</b> office	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible
At facility that is not a <b>hospital</b>	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible
At <b>hospital</b> outpatient department	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Spinal manipulation

Description	Banner Health Network	Aetna Network Providers	Out-of-network
At the <b>physician</b> office	80% per visit after deductible	80% per visit after deductible	50% per visit after deductible

### Skilled nursing facility

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Inpatient services – <b>room and board</b>	80% per admission after deductible	70% per admission after deductible	50% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible	70% per admission after deductible	50% per admission after deductible

Day limit per year	90	90	90
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## Tests, images and labs – outpatient

### Diagnostic complex imaging services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Diagnostic lab work

Description	Banner Health Network	Aetna Network Providers	Out-of- network
	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Diagnostic x-ray and other radiological services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

## Therapies

### Chemotherapy

Description	Banner Health Network	Aetna Network Providers	Out-of- network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Gene-based, cellular and other innovative therapies (GCIT)

Description	Banner Health Network (GCIT-Banner Health Network facility/provider)	Out-of-network (Including providers who are otherwise part of Banner Health   Aetna's network but are not GCIT-designated facilities/providers)
Services and supplies	Covered based on type of service and where it is received	Not covered

### Infusion therapy

#### Outpatient services

Description	Banner Health Network	Aetna Network Providers	Out-of-network
	80% per visit after deductible	70% per visit after deductible	50% per visit after deductible

### Radiation therapy

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Respiratory therapy

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Transplant services

Description	Banner Health Network (IOE facility)	Out-of-network (Includes <b>providers</b> who are otherwise part of Banner   Aetna 's network but are non-IOE <b>providers</b> )
Inpatient services and supplies	80% per transplant after <b>deductible</b>	50% per transplant after <b>deductible</b>
<b>Physician</b> services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

### Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Urgent care facility	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Non-urgent use of an urgent care facility or <b>provider</b>	Not covered	Not covered	Not covered
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### Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Banner Health Network	Aetna Network Providers	Out-of-network
	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>

Visit limit	1 visit per year	1 visit per year	1 visit per year
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## Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a designated **network physician**.

Description	Banner Health Network	Aetna Network Providers	Out-of-network
Non-emergency services	80% per visit after <b>deductible</b>	70% per visit after <b>deductible</b>	50% per visit after <b>deductible</b>
Preventive care immunizations	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>
Preventive screening and counseling services	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule