Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

Banner | aetna CITY OF PHOENIX : Open Access EPO Plus - HMO

Coverage for: Individual + Family | Plan Type: EPO

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, www.HealthReformPlanSBC.com or by calling 1-855-220-6506 (Licensed Entity). 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 1-855-220-6506 (Licensed Entity) 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 plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	You will have to meet the deductible before the plan pays for any services
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Performance Network Medical (PNM): Individual $1,500 / Family $3,000. Broad Network Medical (BNM): Individual $2,500 / Family $5,000. Pharmacy Individual: $1,500 / Family $3,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/cityofphoenix or call 1-855-220-6506 for a list of Performance Medical providers.	You pay the least if you use a provider in Performance Medical Provider. You pay more if you use a provider in Broad Medical. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Performance Medical Provider (You will pay the least)	Broad Medical (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	$50 copay/visit	Not covered	None
	Specialist visit	$50 copay/visit	$80 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Pre-authorization is required for High-Tech Radiology Services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Not applicable	Not covered	Not covered	Check with Plan Sponsor for Prescription vendor.
	Preferred brand drugs	Not applicable	Not covered	Not covered	
	Non-preferred brand drugs	Not applicable	Not covered	Not covered	
	Specialty drugs	Not applicable	Not covered	Not covered	Check with Plan Sponsor for Prescription vendor.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	$200 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Performance Medical Provider (You will pay the least)	Broad Medical (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	$500 copay/visit	Out-of-network emergency use paid the same as in-network. Waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$75 copay/visit	$75 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/stay	$300 copay/stay	Not covered	Max copay/calendar year: $600 Performance In-Network, $900 Broad In-Network.
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $25 copay/visit	Office & other outpatient services: $50 copay/visit	Not covered	None
	Inpatient services	$200 copay/stay	$300 copay/stay	Not covered	Max copay/calendar year: $600 Performance In-Network, $900 Broad In-Network.
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Max copay/calendar year: $600 Performance In-Network, $900 Broad In-Network.
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	$200 copay/stay	$300 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Not covered	None
	Rehabilitation services	No charge	No charge	Not covered	None
	Habilitation services	No charge	No charge	Not covered	None
	Skilled nursing care	10% coinsurance	10% coinsurance	Not covered	None
	Durable medical equipment	No charge	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Performance Medical Provider (You will pay the least)	Broad Medical (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$25 copay/visit	$25 copay/visit	Not covered	1 routine eye exam/calendar year.
	Children's glasses	No charge	No charge	Not covered	$30 maximum credit - Frames 1 time per calendar year; $20-$40 maximum credit - single vision 1 time per calendar year.
	Children's dental check-up	Not covered	Not covered	Not covered	Check with Plan Sponsor for Dental vendor.

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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

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

- Acupuncture - Limited to 12 max per calendar year.
- Bariatric surgery
- Chiropractic care - 36 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/24 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.

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:

- For more information on your rights to continue coverage, contact the plan at 1-855-220-6506 (Licensed Entity).
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should

contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
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.

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

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-855-220-6506 (Licensed Entity). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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	**$50**
Hospital (facility) copayment	**$200**
Other copayment	**$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$270**

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	**$50**
Hospital (facility) copayment	**$200**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) copayment	**$200**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$610**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-220-6506 (Licensed Entity).

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.

TTY: 711

English -	**To access language services at no cost to you, call 1-855-220-6506 (Licensed Entity).**
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-855-220-6506 (Licensed Entity) ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-855-220-6506 (Licensed Entity).
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-855-220-6506 (Licensed Entity) հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-220-6506 (Licensed Entity).
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-855-220-6506 (Licensed Entity).
Chinese Traditional -	如欲使用免費語言服務，請致電 1-855-220-6506 (Licensed Entity).
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-855-220-6506 (Licensed Entity).
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-855-220-6506 (Licensed Entity).
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-855-220-6506 (Licensed Entity).
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-855-220-6506 (Licensed Entity) an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-855-220-6506 (Licensed Entity).
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોીર્ માટે, કોલ કરોr 1-855-220-6506 (Licensed Entity).
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-855-220-6506 (Licensed Entity) पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-855-220-6506 (Licensed Entity).
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-855-220-6506 (Licensed Entity).
Japanese -	言語サービスを無料でご利用いただくには、1-855-220-6506 (Licensed Entity) までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟုဉ်အီၤအဂီၤဘဉ်နှဉ် ကိး 1-855-220-6506 (Licensed Entity)
Korean -	무료 언어 서비스를 이용하려면 1-855-220-6506 (Licensed Entity) 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-855-220-6506 (Licensed Entity).
Mon-Khmer,	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-855-220-6506 (Licensed Entity) ។

Cambodian -

Navajo - T’áá ni nizaad k’ehjí bee níká a’doowoł doo bááh ílínígóó kojį’ hólne’ 1-855-220-6506 (Licensed Entity).

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-855-220-6506 (Licensed Entity).

Persian-Farsi - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-855-220-6506 (Licensed Entity) تماس بگیرید .

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-855-220-6506 (Licensed Entity).

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-855-220-6506 (Licensed Entity).

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-855-220-6506 (Licensed Entity) ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-855-220-6506 (Licensed Entity).

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-855-220-6506 (Licensed Entity).

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-855-220-6506 (Licensed Entity).

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-855-220-6506 (Licensed Entity).

Syriac-Assyrian - ܟܝ ܡܫܒܩܐ ܠܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ، ܡܢܚܬܐ: 1-855-220-6506 (Licensed Entity).

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-855-220-6506 (Licensed Entity).

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-855-220-6506 (Licensed Entity).

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-855-220-6506 (Licensed Entity).

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-855-220-6506 (Licensed Entity).