PLAN DESIGN & BENEFITS
PROVIDED BY BANNER HEALTH AND AETNA HEALTH PLAN, INC. - FULL RISK

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.	
Deductible(per calendar year)	$500 Individual $1,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.	
Out-of-Pocket Maximum(per calendar year)	$2,000 Individual $4,000 Family
In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required
Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may not be covered.	
PREVENTIVE CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per 12 months for members age 22 and older. Includes coverage for travel immunizations and any other medically necessary immunizations.	
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived

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Colorectal Cancer Screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%; deductible waived
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay; deductible waived
Specialist Office Visits	$50 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	$30 copay; deductible waived
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK DESIGNATED PROVIDERS**
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; deductible waived
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; deductible waived
Diagnostic X-ray for Complex Imaging Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; deductible waived
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Urgent Care Provider	$75 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$150 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100% for Physician maternity services; deductible waived;20% for Facility services; after deductible

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Outpatient Hospital	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$50 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	20%; after deductible
Substance Abuse Office Visits	$50 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Skilled Nursing Facility	20%; after deductible
Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	20%; deductible waived
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	20%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	$50 copay; deductible waived
Treatment over a 60 day consecutive period per incident of illness or injury beginning with the first day of treatment. Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy Limited to 20 visits per year	$50 copay; deductible waived
Habilitative Services (Physical/Occupational/Speech Therapy)	Cost sharing same as any other physical, occupational, speech therapy expense.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	$50 copay; deductible waived
Autism Occupational Therapy	$50 copay; deductible waived
Autism Speech Therapy	$50 copay; deductible waived
Durable Medical Equipment	20%; deductible waived
Prosthetics	Covered 100%; deductible waived
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived

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Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	30%
Mail Order	30%
Non-Preferred Generic and Brand-Name Drugs	
Retail	50%
Mail Order	50%
Specialty Drugs	
Preferred Specialty	35% Maximum $250
Non-Preferred Specialty	35% Maximum $250
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay. Percentage copays will not be doubled
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply Value Plus Specialty Drug List

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Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Oral fertility drugs included.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.

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• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s) receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

A medical emergency shall include those services provided to a member in a licensed facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:
a. Serious jeopardy to the member's health.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.