This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.bannerbenefits.com and clicking on Resources tab and clicking plan documents or by calling the Service Center at Banner Health Network at (800) 827-2464 or (480) 684-7070 in the Phoenix area.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network** **$500 Individual/$1000 Family** **Non-Network** **$1000 Individual/$2000 Family**	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	**No**	
Is there an out–of–pocket limit on my expenses?	**In –Network** **$4000 Individual /$8000 Family** **Non-Network** **$8000 Individual /$16000 Family**	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums, balance-billed charges, and health care this plan doesn't cover.**	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	**No**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**In-Network: Yes** **Non-Network No**	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	**In-Network: No** **Non-Network No**	If you use a non-network provider, no referral is necessary but what you pay for these services is higher.
Are there services this plan doesn't cover?	**Yes**	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

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If you aren't clear about any of the bolded terms used in this document, see the Glossary at www.bannerbenefits.com under the Resources tab

The chart below lists Common Medical Events and your costs associated with each event under this plan. The following terms apply to this chart:

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. Allowed amount is the maximum the plan pays for service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan encourages you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	After the deductible is met,		Limitations & Exceptions
		Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**25%**	**50%**	——————none——————
	Specialist visit	**25%**	**50%**	——————none——————
	Other practitioner office visit	**25%**	**50%**	——————none——————
	Naturopathic services	**$30**	**$30**	Deductible Waived for PPO and Indemnity options. Maximum Annual Benefit is $750.
	Acupuncture and Chiropractic	**$0**	**$0**	**20 visit limit for each.**
	Preventive care/screening/immunization	**$0 Deductible waived.**	**$0 Deductible waived.**	——————none——————
	Well woman Exam	**$0 Deductible waived.**	**$0 Deductible waived.**	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	**15%/25%**	**50%**	You pay 15% at a Banner Facility You pay 25% at a Participating Facility
	Imaging (CT/PET scans, MRIs)	**25%**	**50%**	May require precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**15%/25%/50%**	**50%**	You pay 15% at a Banner Facility You pay 25% at a Participating Facility You pay 50% if not pre-certified
	Physician/surgeon fees	**25%**	**50%**	——————none——————
If you need immediate medical attention	Emergency room services (Waived if admitted)	**$150**	**$150**	100% of allowed charge after copay
	Emergency medical transportation	**$0**	**$0**	——————none——————

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	Urgent Care (copay)	**$50**	**$80**	100% of allowed charge after copay
Common Medical Event	**Services You May Need**	**After the deductible is met,** **Your Cost If You Use a Participating Provider**	**Your Cost If You Use a Non-Participating Provider**	**Limitations & Exceptions**
If you have a hospital stay	Facility fee (e.g., hospital room)	**15%/25%/50%**	**50%**	You pay 15% at a Banner Facility You pay 25% at a Participating Facility You pay 50% if not pre-certified
	Physician/surgeon fee	**25%**	**50%**	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**25%**	**50%**	Services under the Banner and PPO Options are only covered when provided by a Banner or CIGNA Provider. Inpatient 15% at Banner Facility Inpatient 25% at CIGNA Facility
	Mental/Behavioral health inpatient services	**15%/25%**	**50%**	
	Substance use disorder outpatient services	**25%**	**50%**	
	Substance use disorder inpatient services	**15%/25%**	**50%**	
If you are pregnant	Prenatal care	**$0**	**50%**	——————none——————
	Postnatal care	**15%/25%**	**50%**	You pay 15% at a Banner Facility You pay 25% at a Participating Facility
	Delivery	**$0**	**50%**	——————none——————
	Inpatient services	**15%/25%**	**50%**	Inpatient 15% at Banner Facility Inpatient 25% at Participating Facility
If you need help recovering or have other special health needs	Home health care	**15%/25%**	**Not Covered**	15% using Banner Home Health 25% at Participating Home Health
	Rehabilitation services	**15%/25%**	**50%**	60 days per illness or injury 15% at Banner Facility 25% at Participating Facility
	Habilitation services	**Not Covered**		——————none——————
	Skilled nursing care	**15%/25%**	**50%**	90 days per calendar year. 15% at Banner Facility 25% at Participating Facility
	Durable medical equipment	**15%/25%**	**Not Covered**	You pay 15% at a Banner Facility You pay 25% at a Participating Facility
	Hospice service	**25%**	**50%**	——————none——————
If your child needs	Eye exam	**Not Covered**		Under separate Vision Plan

dental or eye care	Glasses	**Not Covered**	Under separate Vision Plan
	Dental check-up	**Not Covered**	Under separate Dental Plan

Prescription Drug Coverage

The chart below lists your costs associated with the Prescription Drug Coverage. The following terms apply to this chart:

- Approved listing of certain Maintenance Medications purchased at Banner Family Pharmacy Retail or by Mail Order are covered at a $0 copay
- Formulary refers to the list of medications that the plan has approved for coverage where your copay is the minimum for that prescription.
- Brand refers to the marketed name of a medication that has a trade name and protected by a patent (can be produced and sold only by the company holding the patent)
- Generic refers to the chemical makeup of a drug rather than to the advertised brand name under which the drug may be sold. Generic drugs are the same chemical equivalent of a Brand name drug.
- Non-formulary refers to medications that are "not" on the approved formulary listing for the plan.
- Specialty Drugs are high-cost injectable, infused, oral, or inhaled drugs that general require special monitoring of the patient's therapy.

	Banner Family Pharmacies	MedImpact Retail Pharmacies
31 Day Supply		
Generic -	**$7.50 copay**	**$10 copay**
Preferred Brand -	**$35 copay**	**$45 copay**
Non-formulary -	**$65 copay**	**$80 copay**
93 Day Supply		
Generic -	**$22.50 copay**	**$30 copay**
Preferred Brand -	**$105 copay**	**$135 copay**
Non-formulary -	**$195 copay**	**$240 copay**
93 Day Supply from Mail Order		
Generic -	**$18.75 copay**	**N/A**
Preferred Brand -	**$87.50 copay**	**N/A**
Non-formulary -	**$162.50 copay**	**N/A**

	Banner Family Pharmacies	MedImpact Retail Pharmacies
Specialty Drugs may require Prior Approval from the Plan before purchase and a 31 day supply purchased at the Banner Family Pharmacy will be a copay of $125.00		
Medical and Pharmacy Out-of-Pocket Maximum is combined **$4,000/$8000 per calendar year**		
More information about prescription drug coverage is available at www.bannerbenefits.com		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other Non-Covered Services.)

- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Hearing Aids (other than accidental injury, illness or congenital permanent childhood impairment.)
- Dental Care (Adult and Child) (other than accidental injury to sound natural teeth)
- Long-Term Care
- Private-duty Nursing
- Routine eye care (Adult and Child)
- Routine foot care
- Routine hearing tests
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery (Plan pays 100% after a $2000 copay only when provided at a Banner facility.) Deductible and Co-insurance waived. Two per lifetime.
- Infertility Treatment (50% copay of allowed charge only at Banner designated providers)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, a Federal law known as COBRA provides protections that allow you to continue your health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the contribution you are making while covered under the plan as an active employee. . Other limitations on your rights to continue coverage may also apply. Detailed information on your COBRA rights can be found in the plan document at www.bannerbenefits.com under the Resources tab.

For more information on your rights to continue coverage, contact Discovery Benefits at (866) 451-3399 or (701) 451-3399. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Service Center at Banner Plan Administration at (800) 827-2464 or (480) 684-7070 in the Phoenix area or visit the website www.bannerbenefits.com under the Resources Tab.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Asistencia para Miembros de Habla Hispana

Para obtener asistencia en Español, llame al (800) 827-2464 or (480) 684-7070.
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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator!

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
- **Plan pays** $6,670
- **Patient pays** $870

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$450
Limits or exclusions	$150
Total	**$870**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
- **Plan pays** $4,630
- **Patient pays** $770

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$210
Coinsurance	$230
Limits or exclusions	$80
Total	**$770**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.