



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 1-877-312-3862. 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 1-877-312-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual \$5,000 / Family \$10,000. Out-of-network: Individual \$10,000 / Family \$30,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care, emergency care, urgent care and prescription drugs in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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?	In-network: Individual \$6,850 / Family \$13,700. Out-of-network: Individual \$25,000 / Family \$75,000.	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, penalties for failure to obtain pre-authorization for services, and 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 http://www.aetna.com/dse/search?site_id=banneraetna1 or call 1-877-312-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetna.com/individuals-families/find-a-medication.html	Preferred generic drugs	Tier 1A: \$3 <u>copay</u> /prescription (retail), \$6 <u>copay</u> /prescription (mail order); Tier 1: \$10 <u>copay</u> /prescription (retail), \$20 <u>copay</u> /prescription (mail order), <u>deductible</u> does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available unless Dispense as Written. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Precertification and step therapy may be required. No coverage for mail order prescriptions out-of-network. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at Aetna Rx Home Delivery or CVS Pharmacy.
	Preferred brand drugs	\$45 <u>copay</u> /prescription (retail), \$90 <u>copay</u> /prescription (mail order), <u>deductible</u> does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	
	Non-preferred generic/brand drugs	\$70 <u>copay</u> /prescription (retail), \$140 <u>copay</u> /prescription (mail order), <u>deductible</u> does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	Preferred: 20% <u>coinsurance</u> up to a \$250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40% <u>coinsurance</u> up to a \$500 maximum/ prescription for up to a 30 day supply, <u>deductible</u> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay/visit</u> , <u>deductible</u> does not apply	\$350 <u>copay/visit</u> , <u>deductible</u> does not apply	<u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in-network. No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	\$75 <u>copay/visit</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network precertification required or \$400 penalty applies per occurrence.
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$60 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 0% <u>coinsurance</u>	Office visits and all other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network precertification required or \$400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network precertification required or \$400 penalty applies per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 120 visits/ per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	<u>Rehabilitation services</u>	\$60 <u>copay</u> /visit	30% <u>coinsurance</u>	Coverage is limited to 60 visits/ per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 100 days/ per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network precertification required or \$400 penalty applies per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	Coverage is limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

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| • Acupuncture | • Habilitation services | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult & Child) | • Long-term care | • Weight loss programs |
| • Glasses (Child) | | |

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

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| • Chiropractic care - Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined. | • Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months. |
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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 1-877-312-3862.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-312-3862.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 **\$5,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **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	\$12,800
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$5,000
Copayments	\$70
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,130
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$5,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$1,200
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$1,320
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Mia's Simple Fracture

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

- The plan's overall deductible **\$5,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **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	\$1,900
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$800
Copayments	\$700
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,500
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Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-312-3862.

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 1-877-312-3862.

Smartphone or Tablet

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

Non-Discrimination

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

Banner | Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-877-312-3862.

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

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711

Fax: 859-425-3379

Email: CRCoordinator@aetna.com

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

Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Plan Inc. and Banner Health and Aetna Health Insurance Company (Banner | Aetna). Banner | Aetna are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Banner | Aetna.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-312-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-877-312-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-312-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-877-312-3862 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-312-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-312-3862.
- Japanese - 日本語で援助をご希望の方は、1-877-312-3862 まで無料でお電話ください。
- Karen - လာတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အဂီၢ် ကိၣ် ကိး 1-877-312-3862 လၢတအိၣ်ဒီးတၢ်လၢတၢ်ညးလၢတၢ်စၢၤတၢ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-312-3862 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-877-312-3862
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-877-312-3862 به خورایی پیوندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-877-312-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-877-312-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-312-3862 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-312-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-877-312-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-312-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-877-312-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-877-312-3862 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-877-312-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-877-312-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-877-312-3862 aa. Es Aaruf koschtet nix.

- Persian - برای راهنمایی به زبان فارسی با شماره 1-877-312-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-312-3862.
- Portuguese - Para obter assistência linguística em português ligue para o 1-877-312-3862 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-312-3862
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-312-3862.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-312-3862 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-877-312-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-312-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-312-3862 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-312-3862 bila malipo.
- Syriac - ܠܚܘܒܐ ܕܥܝܢܐ ܕܡܘܨܘܪܐ ܕܥܝܢܐ ܕܡܘܨܘܪܐ ܕܥܝܢܐ ܕܡܘܨܘܪܐ ܕܥܝܢܐ ܕܡܘܨܘܪܐ 1-877-312-3862 ܗܘܐ ܡܘܨܘܪܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-312-3862 nang walang bayad.
- Telugu - భషణ్ణి సాయం కిరకు ఎలంటి ఖరీచు లేకుండా 1-877-312-3862 కు కల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-312-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-312-3862 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisinis chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-312-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-877-312-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-312-3862.
- Urdu - اریکل گفتف م رپ 1-877-312-3862 عیال کتت و اع م ی ن لیل ر م و در
- Vietnamese - Đê được hõ trợ ngôn ngữ bằng (ngôn ngữ), hã y gọi miễn phi đêh số 1-877-312-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-312-3862 פריי פון אפצאל.
- Yoruba - Fún iránlọwọ nípa èdè (Yorùbá) pe 1-877-312-3862 láí san owó kankan rárá.