

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

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
<p>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.</p>		
<p>Deductible (per calendar year)</p>	<p>\$6,000 Individual \$12,000 Family</p>	<p>\$6,000 Individual \$12,000 Family</p>
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. 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.</p>		
<p>Member Coinsurance</p>	<p>30%</p>	<p>50%</p>
<p>Applies to all expenses unless otherwise stated.</p>		
<p>Payment Limit (per calendar year)</p>	<p>\$6,850 Individual \$13,700 Family</p>	<p>\$24,000 Individual \$48,000 Family</p>
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.</p>		
<p>Lifetime Maximum Unlimited except where otherwise indicated.</p>		
<p>Payment for Non-Preferred Care**</p>	<p>Not Applicable</p>	<p>Professional: 105% of Medicare Facility: 140% of Medicare</p>
<p>Primary Care Physician Selection</p>	<p>Optional</p>	<p>Not Applicable</p>
<p>Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.</p>		
<p>Referral Requirement</p>	<p>None</p>	<p>None</p>
<p>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 be paid at the out-of-network benefit level or may not be covered at all.</p>		

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PREVENTIVE CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older Includes coverage for travel immunizations and any other medically necessary immunizations.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	50%; after deductible
Routine Gynecological Care Exams 1 exam per year	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms Women's Health 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.	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	\$30 copay; deductible waived	50%; after deductible
Specialist Office Visits	\$60 copay; deductible waived	50%; after deductible
Hearing Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	\$30 copay; deductible waived	50%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	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	Your cost sharing is based on the type of service and where it is performed

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DIAGNOSTIC PROCEDURES	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
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.	30%; after deductible	50%; after deductible
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.	30%; after deductible	50%; after deductible
Diagnostic Outpatient Complex Imaging 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.	30%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Urgent Care Provider	\$75 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	\$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	\$60 copay; deductible waived	50%; after deductible
Other Mental Health Services	30%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible

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Residential Treatment Facility	30%; after deductible	50%; after deductible
Substance Abuse Office Visits	\$60 copay; deductible waived	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	30%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Skilled Nursing Facility	30%; after deductible	50%; after deductible
Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	30%; after deductible	50%; after deductible
Hospice Care - Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$60 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation	\$60 copay; deductible waived	50%; after deductible
Limited to 25 visits per year. Includes speech, physical, occupational therapy		
Habilitative Services (Physical/Occupational/Speech Therapy)	Cost sharing same as any other physical, occupational, speech therapy expense.	Cost sharing same as any other physical, occupational, speech therapy expense.
Autism Behavioral Therapy	\$60 copay; deductible waived	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	30%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	\$60 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	\$60 copay; deductible waived	50%; after deductible
Autism Speech Therapy	\$60 copay; deductible waived	50%; after deductible
Durable Medical Equipment	30%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy	30%; after deductible	50%; after deductible
Administered in the home or physician's office		
Infusion Therapy	30%; after deductible	50%; after deductible
Administered in an outpatient hospital department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.

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Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	IN-NETWORK DESIGNATED PROVIDERS	OUT OF NETWORK/NON DESIGNATED PROVIDERS
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$20 copay	20% of submitted cost; after applicable copay
Mail Order	\$40 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$40 copay	20% of submitted cost; after applicable copay
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	\$70 copay	20% of submitted cost; after applicable copay
Mail Order	\$140 copay	Not Applicable
Value Plus Specialty Drugs		
Preferred Specialty	20%	20% of submitted cost; after applicable copay
	Maximum \$250	
Non-Preferred Specialty	20%	20% of submitted cost; after applicable copay
	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.	
Mail Order	A 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply Banner Health Aetna Specialty Network Value Plus Drug List	

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand-name. If the member requests brand-name when a 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.

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- 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
- Seasonal Vaccinations covered 100% in-network
- Preventive Vaccinations covered 100% in-network
- 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.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance 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.

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- 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
- 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.
- 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.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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 receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.



Diamond Ridge Development
Proposed Effective Date: 03-01-2019
Open Access Managed Plus - Arizona
AZ18 BA OA Managed plus 6000 70/50 Rx2 VP

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Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

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

For more information about Aetna plans, refer to **www.aetna.com**.

Aetna and MinuteClinic are both within the CVS Health family of companies.

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