2026 **BENEFITS GUIDEBOOK**



PRESENTED BY

RPS Benefits By Design

WELCOME TO YOUR

2026 BENEFITS GUIDEBOOK

Dear Employees,

This ‘Employees Benefit Guidebook’ is provided to you as a quick reference guide to address all of your benefit questions. We encourage you to share this guidebook with your family members and dependents to help you gain better understanding of the benefits available to you through our company. Based on eligibility, you are only able to join or make changes to your benefit elections during either the annual Open Enrollment period or due to a qualifying life event, such as starting a new job, getting married/divorced, loss of other coverage or for the birth of a child. In the case of qualifying life event, you will have 30 days from the date of the event to join the plan otherwise you may join the plan during the designated Open Enrollment period.

You are eligible for benefits if you work 20 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include: Your legally married spouse; Your registered domestic partner (RDP) and/or his/her children, where applicable by state law; your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply); Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

The Open Enrollment period generally occurs during the month of April, with benefit renewals becoming effective the 1st of May. The Benefit Waiting Period is the 1st of the month following or coinciding with 60 days of continuous employment.

Sincerely,
GD Barri & Associates

2026

MEDICAL PLANS



Advance your total health

Reach your wellness goals with added-value benefits

Take charge of your health

It's now easier than ever to aim high and feel your best. All while getting access to programs, tools and resources that fit your schedule.

Plus, cost savings along the way. And you can even access programs and certain in-network services at low or no cost* under your medical and pharmacy plans*.

Start today.

Log in to your member portal through **BannerAetna.com**.
There, you can check your benefits, connect with care, and view and pay claims.

BannerAetna.com

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*FOR LOW-COST OR NO-COST NOTE: If the member enrolls in a qualified high-deductible health plan, they can get preventive services at no cost. To get no-cost care on all covered, non-preventive services, the member will first need to meet their deductible.

*FOR PLANS NOTE: Some states and plan restrictions may apply.

Banner|Aetna Funding Advantage℠ plans are self-insured by the employer and administered by Banner|Aetna. Network providers are independent contractors and are not agents of Banner|Aetna. Provider participation may change without notice.

3655916-01-01 (8/24)

Access to Care

MinuteClinic®

Your plan gives you access to covered MinuteClinic services at no or a lower cost to you.*

If your plan is eligible for a health savings account, you can get preventive care at no extra cost. You'll also get care for covered minor illnesses and injuries at a lower cost than available to the public. And once you meet your deductible, you can get all covered services at no extra cost.

Find a clinic near you at **CVS.com/MinuteClinic**.

For a list of other in-network providers, log in to **BannerAetna.com** and use our search tool.

$0* virtual care delivered by 98point6®

Chat with a provider anytime, anywhere via secure in-app messaging. With 98point6, you can get treatment from a U.S.-based care team, including board-certified doctors. They can answer questions, diagnose and treat over 600 conditions, outline care options, prescribe medication, and order labs or imaging.

- On Demand 24/7/365 Care
- Audio, video and Spanish translation support are available
- Get referrals to in-network resources and specialists

You can easily access these low-or no-cost virtual primary care services. Just go to **BannerAetna.com** to log in to your member portal.

Visit **98point6.com/banner-aetnamembers** to download the app and learn more.

*FOR COST OF MINUTECLINICS SERVICES: Includes select MinuteClinic® services. Not all MinuteClinic services are covered. Please consult benefit documents to confirm what services are included. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive MinuteClinic services at no cost share. However, such services are covered at negotiated contract rates. This benefit is not available in all states and on indemnity plans. Visit **MinuteClinic.com** for age and service restrictions. This is for informational purposes only and is intended to be used only in connection with self-funded plans. It is not medical advice and is not intended to be a substitute for proper medical care provided by a physician.

*FOR $0 VIRTUAL CARE DELIVERED BY 98POINT6: Members enrolled in a health savings account (HSA) or qualified high-deductible health plan (HDHP) pay $5 per virtual care visit until their deductible is met, after which services will be provided at no cost-share. All other health plan members pay $0 per virtual care visit regardless of whether their deductible has been met. The $5 cost share for Banner|Aetna members, with HSA-compatible plans, will be waived for all 98point6 virtual care visits through December 31, 2024, in response to provisions of the Consolidated Appropriations Act, 2023.

98point6 and 98point6 physicians are independent contractors and are neither agents nor employees of Banner|Aetna or plans administered by Banner|Aetna, and does not guarantee that a prescription will be written. 98point6 physicians will not prescribe DEA controlled substances, non therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Physicians reserve the right to deny care for potential misuse of services.

Mental Well-Being

Employee Assistance Program (Aetna Resources For Living℠ made available through Banner|Aetna)

Through this program, you'll get support for stress management, work/life balance, depression and anxiety. Plus, we'll connect you with legal and financial help. This benefit is available to you and your eligible household members.

Know that we're here for you, 24/7.
Call us at **1-866-326-7172 (TTY: 711)**.
Or check out **Aet.na/AFA-RFL**
(Username: **SGEAP** Password: **EAP**).

Behavioral telehealth virtual providers and services

These services offer another way to get help from a licensed therapist or psychiatrist. And you can choose from a large network of providers.

Check out **virtual care providers**.
Or visit **BannerAetna.com**
to find another network provider.

Wellness Incentive Programs

Aetna Health Your Way™ - Engage

Get personalized resources and challenges to help you earn rewards of up to $100 per year. You'll start with a well-being assessment, and then interact with recommended resources to earn points and improve your health.* This way, you can stay on track and reach your goals.

Visit **BannerAetna.com** to log in to your member portal.

OTC Health Solutions®

Enjoy $25 every three months* to shop hundreds of CVS® products

Every three months, you'll get $25 to spend on select over-the-counter (OTC) health and wellness products at CVS®. This can help you take care of minor illnesses, have fewer doctor visits and save money.

3 Ways to Save

In Store

Visit any CVS store that participates in OTC Health Solutions. Go to **CVS Store Locator** to find one near you.

Online

Visit **CVS OTCHS login** for the fastest and easiest way to order anytime.

On the phone

Call **1-888-628-2770 (TTY: 711)** Monday to Friday, from 9 AM to 8 PM local time.

Discount program

The Banner|Aetna Discount Program helps you save on many health products and services. You'll save money on eyewear, hearing exams, healthy lifestyle services, natural health offerings and more.

Watch the savings add up.
Visit **BannerAetna.com** to log in to your member portal.

*January 1 - March 31; April 1 - June 30; July 1 - September 30; October 1 - December 31.

*FOR EARN POINTS NOTE: Not all recommended actions result in earning rewards.

DISCOUNT OFFERS ARE NOT INSURANCE. They are not benefits under your insurance plan. You get access to discounts off the regular charge on products and services offered by third-party vendors and providers. Banner|Aetna makes no payment to the third parties — you are responsible for the full cost. Check any insurance plan benefits you have before using these discount offers, as those benefits may give you lower costs than these discounts.

Managing Health

Banner|Aetna Care Advocate Team

We proactively reach out to help members with high risks manage chronic conditions. Meeting in-person, the team is able to identify a member's needs and, in collaboration with their primary care physician, create an individualized care plan.

To learn if you may be a good candidate call the number on your member ID card or call **1-866-269-4500 (TTY: 711)** for more information.

Enhanced Maternity Program

Going through a maternity journey is unique for each person. So whether you need support for family planning or postpartum care, we'll be right there as a trusted, reliable resource throughout your entire experience.

To learn more and sign up, call us at **1-800-272-3531 (TTY: 711)** weekdays from 8 AM to 7 PM ET. Or log in to your member portal at **BannerAetna.com** and look under "Health & Wellness."

Taking care of diabetes health

Diabetes reversal program powered by Virta®*

This program goes beyond just treating the symptoms of the disease. Learn to change how you eat so that your body burns fat for energy, instead of sugar/carbohydrates. This can help you naturally lower your blood sugar and reduce the need for diabetes medication.

Learn more at **banneraetna.com/diabetes**

Diabetic meter program

If you have diabetes, you know it's important to check your blood glucose levels regularly. And we want to help — with a new blood glucose meter. It's part of your prescription plan, and ordering one is easy!

To order, simply:
Visit: **Aetna.com/ManagingDiabetes**

If you have questions, call the number on your member ID card.

$0 Preferred diabetic benefit*

For another way to save, enjoy a new pharmacy benefit. You'll have no deductible and **$0 cost-share** for preferred insulin and supplies for diabetics.

Call the number on your member ID card to find out which insulins and diabetic supplies are included.

BannerAetna.com

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*FOR VIRTA BENEFIT: Virta is available to members between the ages of 18 and 79 who are enrolled in an eligible health plan through Banner|Aetna. This benefit is currently being offered to those with type 2 diabetes, prediabetes, and obesity (defined as having a BMI of 30 or greater). There are some medical conditions that would exclude patients from the Virta treatment. Start the application process now to find out if you qualify.

*FOR PREFERRED DIABETIC BENEFIT: HSA, IntRx, and Value plans: preventive deductible waiver and $0 preferred diabetic offering both waive the deductible. $0 preferred diabetic benefit also waives copay/coinsurance on preferred insulin/diabetic supplies. The $0 preferred diabetic benefit does not include diabetic drugs.

Aetna Resources For Living℠ is the brand name used for products and services offered through the Aetna group of companies. The EAP is administered by Aetna Behavioral Health, LLC; and in California for Knox-Keene plans, and Health and Human Resources Center, Inc. All EAP calls are confidential, except as required by law. This material is for informational purposes only. It contains only a partial, general description of programs and services and does not constitute a contract. EAP instructors, educators and network participating providers are independent contractors and are neither agents nor employees of Aetna. Aetna does not direct, manage, oversee or control the individual services provided by these persons and does not assume any responsibility or liability for the services they provide and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

For more information about Banner|Aetna plans, refer to **Banner|Aetna.com**.

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3655916-01-01 (8/24)

Banner | aetna : BAFA Broad Open POSII 3250 HSA 100/50 TE CY 25

Coverage for: Employee + Family | Plan Type: POS

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 $3,250 / Family $6,500 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care 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 $7,500 / Family $15,000. Out-of-Network: Individual $20,000 / Family $60,000.	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 www.myplanportal.com/dse/custom/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 provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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)	0% coinsurance	50% coinsurance	Applies to services received in office or in outpatient setting.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Applies to services received in office or in outpatient setting.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Copay/ prescription: Tier 1A: $3 (retail), $6 (mail order); Tier 1: $10 (retail), $20 (mail order)	50% coinsurance (retail)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to overall deductible or out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers. Deductible doesn't apply to certain preventive medications.
	Preferred brand drugs	Copay/ prescription: $50 (retail), $100 (mail order)	50% coinsurance (retail)	
	Non-preferred generic/brand drugs	Copay/ prescription: $80 (retail), $160 (mail order)	50% coinsurance (retail)	
	Specialty drugs	Preferred: 20% coinsurance for up to a 30 day supply; Non-preferred: 40% coinsurance for up to	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to selected participating retail

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)	
		a 30 day supply		pharmacies for certain specialty drugs. $250 (preferred) and $500 (non-preferred) maximum copay for each 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	0% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: 0% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	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	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	0% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	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	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - Coverage is limited to 10 visits.
- Chiropractic care - Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months.

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 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 toll free number at 1-877-312-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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	$3,250
Specialist coinsurance	0%
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,250
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,320**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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	$1,100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$3,250
Specialist coinsurance	0%
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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.

Banner | aetna : BAFA Broad Open POSII 5000 100/50 CY 25

Coverage for: Employee + Family | Plan Type: POS

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, 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 $7,500 / Family $15,000. 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 www.myplanportal.com/dse/custom/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 provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$75 copay/visit, deductible does not apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Copay/ prescription, deductible does not apply: Tier 1A: $3 (retail), $6 (mail order); Tier 1: $10 (retail), $20 (mail order)	50% coinsurance (retail), deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers.
	Preferred brand drugs	Copay/ prescription, deductible does not apply: $50 (retail), $100 (mail order)	50% coinsurance (retail), deductible does not apply	
	Non-preferred generic/brand drugs	Copay/ prescription, deductible does not apply: $80 (retail), $160 (mail order)	50% coinsurance (retail), deductible does not apply	
	Specialty drugs	Preferred: 20% coinsurance for up to a 30 day supply; Non-preferred: 40% coinsurance for up to a 30 day supply, deductible does not apply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to selected participating retail pharmacies for certain specialty drugs. $250 (preferred) and $500 (non-preferred) maximum copay for each 30 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit	$300 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 0% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	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	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	$75 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	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	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - Coverage is limited to 10 visits per year.
- Chiropractic care - Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months.

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 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 toll free number at 1-877-312-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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** **$5,000**
- **Specialist copayment** **$75**
- **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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,070**

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** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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	$100
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$75**
- **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,300
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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.

Banner | aetna : BAFA Broad Open POSII 1500 80/50 $0LXR CY 25

Coverage for: Employee + Family | Plan Type: POS

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 $1,500 / Family $3,000 Out-of-network: Individual $3,000 / Family $9,000.	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, 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 $5,500 / Family $11,000. Out-of-Network: Individual $13,000 / Family $39,000.	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 www.myplanportal.com/dse/custom/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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$75 copay/visit, deductible does not apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Copay/ prescription, deductible does not apply: Tier 1A: $3 (retail), $6 (mail order); Tier 1: $10 (retail), $20 (mail order)	50% coinsurance (retail), deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers.
	Preferred brand drugs	Copay/ prescription, deductible does not apply: $45 (retail), $90 (mail order)	50% coinsurance (retail), deductible does not apply	
	Non-preferred generic/brand drugs	Copay/ prescription, deductible does not apply: $75 (retail), $150 (mail order)	50% coinsurance (retail), deductible does not apply	
	Specialty drugs	Preferred: 20% coinsurance for up to a 30 day supply; Non-preferred: 40% coinsurance for up to a 30 day supply, deductible does not apply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to selected participating retail pharmacies for certain specialty drugs. $250 (preferred) and $500 (non-preferred) maximum copay for each 30 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $300 copay/visit	20% coinsurance after $300 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: No charge	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	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	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	$75 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	No charge	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	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	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

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- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months.

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- 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.

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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	**$1,500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$1,500
Copayments	$400
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,990**

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.

Banner | aetna : BAFA Perf Open POSII 2500 100/50 $0LXR CY 25 (Arizona Residents Only)

Coverage for: Employee + Family | Plan Type: POS

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 $2,500 / Family $5,000 Out-of-network: Individual $5,000 / Family $15,000.	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, 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 $6,000 / Family $12,000. Out-of-Network: Individual $15,000 / Family $45,000.	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 www.myplanportal.com/dse/custom/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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$75 copay/visit, deductible does not apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Copay/ prescription, deductible does not apply: Tier 1A: $3 (retail), $6 (mail order); Tier 1: $10 (retail), $20 (mail order)	50% coinsurance (retail), deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers.
	Preferred brand drugs	Copay/ prescription, deductible does not apply: $45 (retail), $90 (mail order)	50% coinsurance (retail), deductible does not apply	
	Non-preferred generic/brand drugs	Copay/ prescription, deductible does not apply: $75 (retail), $150 (mail order)	50% coinsurance (retail), deductible does not apply	
	Specialty drugs	Preferred: 20% coinsurance for up to a 30 day supply; Non-preferred: 40% coinsurance for up to a 30 day supply, deductible does not apply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to selected participating retail pharmacies for certain specialty drugs. $250 (preferred) and $500 (non-preferred) maximum copay for each 30 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit	$300 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: No charge	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	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	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	$75 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	No charge	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	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	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - Coverage is limited to 10 visits per year.
- Chiropractic care - Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months.

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 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 toll free number at 1-877-312-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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** **$2,500**
- **Specialist copayment** **$75**
- **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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,300
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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.



Maricopa, Coconino, Gila, Pima and Pinal Counties

Performance network coverage area

BannerAetna.com

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Our performance network includes:

Primary care, specialists, hospitals, health & urgent care centers and emergency rooms

3,370+ primary care doctors

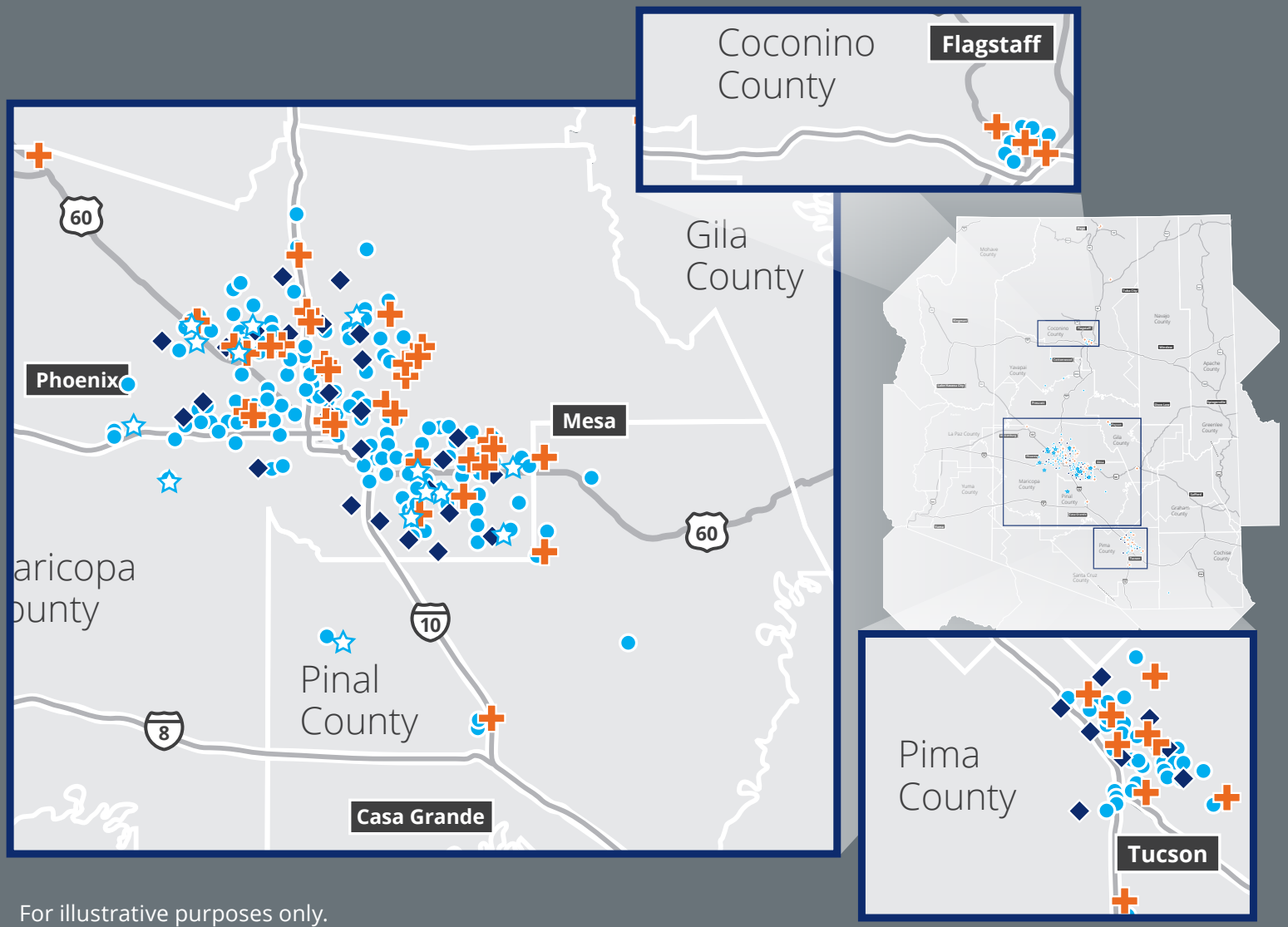
28,150+ specialists

49 hospitals

175 urgent care centers

15 Banner Health Centers

33 walk-in clinics



For illustrative purposes only.

Hospitals **Urgent Care Centers** **Walk-In Clinics** **Banner Health Centers**

Visit **BannerAetna.com** and select "Find A Doctor" to find in-network urgent care centers and the most up-to-date information on doctors and facilities.

Some providers practice solely within a facility setting and are not available to members for appointment.

☆ Banner Health Centers

City	Health Center
Buckeye	Health Center Verrado
Chandler	Health Center Chandler
Gilbert	Health Center Gilbert
Glendale	Health Center Glendale
Goodyear	Health Center Estrella
Maricopa	Health Center Maricopa
Mesa	Health Center East Mesa Health Center Mesa

City	Health Center
Peoria	Health Center Peoria (2)
Phoenix	Health Center Greenway Health Center Desert Ridge
Queen Creek	Health Center Queen Creek
Sun City West	Health Center Sun City West
Surprise	Health Center Surprise

◆ Walk-In Clinics

City	Walk-In Clinic
Cave Creek	MinuteClinic® Diagnostic of Arizona
Chandler	MinuteClinic Diagnostic of Arizona (3)
Gilbert	MinuteClinic Diagnostic of Arizona (2)
Glendale	MinuteClinic Diagnostic of Arizona
Goodyear	MinuteClinic Diagnostic of Arizona
Laveen	MinuteClinic Diagnostic of Arizona
Mesa	MinuteClinic Diagnostic of Arizona (3)
Oro Valley	MinuteClinic Diagnostic of Arizona
Peoria	MinuteClinic Diagnostic of Arizona

City	Walk-In Clinic
Phoenix	MinuteClinic Diagnostic of Arizona (5)
Queen Creek	MinuteClinic
Scottsdale	MinuteClinic Diagnostic of Arizona
Surprise	MinuteClinic Diagnostic of Arizona
Tempe	MinuteClinic Diagnostic of Arizona (2)
Tucson	MinuteClinic Diagnostic of Arizona (6)

Hospitals

City	Hospital
Apache Junction	Banner Goldfield Medical Center
Casa Grande	Banner Casa Grande Medical Center
Chandler	Banner Ocotillo Medical Center
Flagstaff	Flagstaff Medical Center
Gilbert	Banner Gateway Medical Center
Glendale	Banner Thunderbird Medical Center Encompass Health Valley of the Sun Rehabilitation Hospital
Globe	Cobre Valley Regional Medical Center
Mesa	Banner Baywood Medical Center Banner Desert Medical Center Banner Heart Hospital Banner Rehabilitation Hospital — East Cardon Children's Medical Center Encompass Health Rehabilitation Hospital of East Valley John J. Rhodes Rehabilitation Institute
Oro Valley	Oro Valley Hospital
Page	Page Hospital
Peoria	Banner Rehabilitation Hospital — West
Phoenix	Banner Estrella Medical Center Banner Payson Medical Center Banner Rehabilitation Hospital — Phoenix Banner University Medical Center Phoenix Campus HonorHealth Cardiac Rehab Center HonorHealth Deer Valley Medical Center HonorHealth John C. Lincoln Medical Center HonorHealth Sonoran Crossing Medical Center Phoenix VA Medical Center

City	Hospital
Queen Creek	Banner Ironwood Medical Center
Sahuarita	Northwest Sahuarita Medical Center
Scottsdale	Encompass Health Rehabilitation Hospital of Scottsdale HonorHealth Cardiac Rehab Center HonorHealth Greenbaum Specialty Surgical Hospital HonorHealth Rehabilitation Hospital HonorHealth Scottsdale Osborn Medical Center HonorHealth Scottsdale Shea Medical Center HonorHealth Scottsdale Thompson Peak Medical Center
Sun City	Banner Boswell Medical Center
Sun City West	Banner Del E Webb Medical Center
Tuba City	Tuba City Regional Health Care
Tucson	Banner University Medical Center South Banner University Medical Center Tucson Diamond Children's Medical Center Encompass Health Rehabilitation Hospital of Northwest Tucson Encompass Health Rehabilitation Institute of Tucson Northwest Medical Center Northwest Medical Center Houghton Tucson Medical Center
Wickenburg	Wickenburg Community Hospital

Urgent Care Centers

City	Urgent Care
Anthem	HonorHealth Medical Group and Urgent Care — Gavilan Peak
Apache Junction	NextCare Urgent Care
Avondale	Akos Urgent Care Banner Urgent Care Good Night Pediatrics Avondale, PC NextCare Urgent Care
Buckeye	1st Care Urgent Care Alliance Urgent Care
Casa Grande	Banner Urgent Care NextCare Urgent Care
Cave Creek	NextCare Urgent Care
Chandler	Banner Urgent Care (2) Chandler Valley Urgent Care Clinic HonorHealth FastMed Urgent Care Plus NextCare Urgent Care (2) Sun Valley Pediatric & Family Urgent Care, PC
Flagstaff	Concentra Urgent Care Flagstaff Urgent Care NextCare Urgent Care (2)
Fountain Hills	HonorHealth Urgent Care
Gilbert	Banner Urgent Care (4) Good Night Pediatrics East Valley, PC Health First Urgent Care HonorHealth FastMed Urgent Care Plus NextCare Urgent Care
Glendale	Akos Urgent Care Banner Urgent Care (3) HonorHealth Medical Group, Heart Group and Urgent Care NextCare Urgent Care (4)
Gold Canyon	Stripes Urgent Care

City	Urgent Care
Goodyear	Alliance Urgent Care Banner Urgent Care HonorHealth FastMed Urgent Care Plus NextCare Urgent Care
Green Valley	NextCare Urgent Care
Laveen	HonorHealth FastMed Urgent Care Plus NextCare Urgent Care
Litchfield Park	NextCare Urgent Care
Marana	Northwest Urgent Care
Maricopa	NextCare Urgent Care
Mesa	AllKids Urgent Care Banner Urgent Care (5) Concentra Urgent Care (2) HonorHealth FastMed Urgent Care Plus (3) HonorHealth Medical Group and Urgent Care — McKellips NextCare Urgent Care (3)
Oro Valley	Carbon Health Urgent Care (2)
Paradise Valley	Concentra Urgent Care
Payson	Banner Urgent Care
Peoria	Alliance Urgent Care Banner Urgent Care (2) Concentra Urgent Care HonorHealth FastMed Urgent Care Plus HonorHealth Medical Group and Urgent Care — Del Lago NextCare Urgent Care
Phoenix	Alliance Urgent Care Banner Urgent Care (9) Concentra Urgent Care (5) HonorHealth FastMed Urgent Care Plus (3) HonorHealth Medical Group and Urgent Care — Saguaro HonorHealth Medical Group and Urgent Care — Bethany Home NextCare Urgent Care (9) Urgent Care of Arizona

Urgent Care Centers (continued)

City	Urgent Care
Queen Creek	Alliance Urgent Care
San Tan Valley	Banner Urgent Care (2)
Scottsdale	Banner Urgent Care (3) HonorHealth FastMed Urgent Care Plus HonorHealth Medical Group and Urgent Care — Thompson Peak NextCare Urgent Care (2) Paradise Valley Complete Care — Urgent Care
Sun City	NextCare Urgent Care
Sun City West	Banner Urgent Care
Surprise	Banner Urgent Care HonorHealth FastMed Urgent Care Plus HonorHealth John C. Lincoln Medical NextCare Urgent Care
Tempe	Banner Urgent Care (3) Concentra Urgent Care (2) HonorHealth FastMed Urgent Care Plus (3) NextCare Urgent Care (2)

City	Urgent Care
Tolleson	Alliance Urgent Care HonorHealth FastMed Urgent Care Plus
Tucson	Banner Urgent Care (4) Carbon Health Urgent Care (8) Concentra Urgent Care (5) La Paloma Urgent Care NextCare Urgent Care (11) Northwest Urgent Care Northwest Urgent Care at Orange Grove Speedway Urgent Care TMC Urgent Care (2) Urgent Specialists (2)

This guide is informational only to help provide an overview of common health care facilities in the Banner|Aetna Performance Network. There are additional types of facilities, such as oncology treatment centers, behavioral health hospitals, Banner Health Clinics and more that could also be included in your health plan's network.

To find providers and additional health care facilities in your network, visit **banneraetna.com/providers**.

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Gila County providers and facilities will be added to the Performance Network for Individual and Family Plans and small group Affordable Care Acts (ACA) plans effective January 1, 2024. APCN+/APCN+ Multi-Tier plans will be effective January 1, 2025.

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Stay on top of your health care benefits

It's easier with the Aetna Health℠ app

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You're in charge

Staying healthy is important. So is keeping track of your benefits. But with everything else you have going on, managing it all can be a challenge.

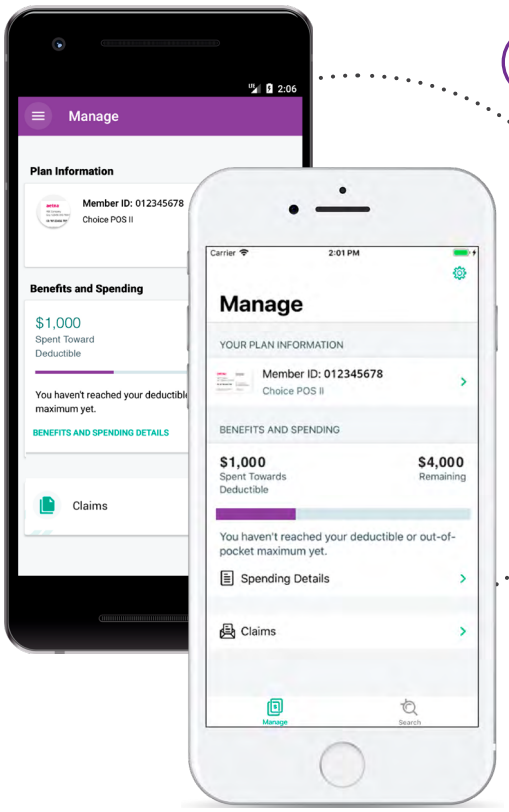
The Aetna Health app can help. From finding a doctor and comparing costs to paying claims and viewing your ID card, the app is your all-in-one resource for the information you need.

See for yourself how the Aetna Health app can make it easier to manage your benefits.

Text **"AETNA"** to **90156** to receive a link to download the Aetna Health℠ app.

(Message and data rates may apply.*)

Download on the App Store | GET IT ON Google Play



View benefits and pay claims for your whole family

Search for providers, procedures and medications

Get cost estimates before you get care

Track spending and progress toward meeting your deductible

Access your member ID card whenever you need it

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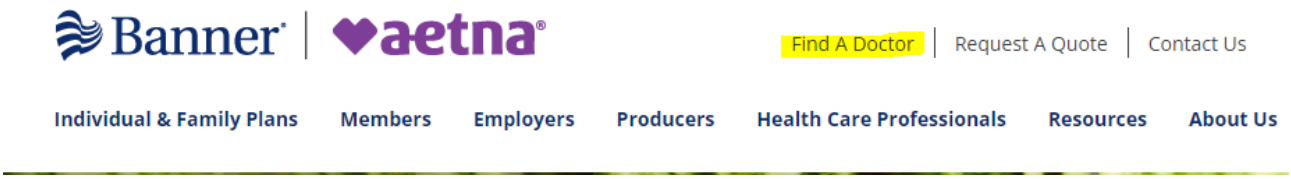
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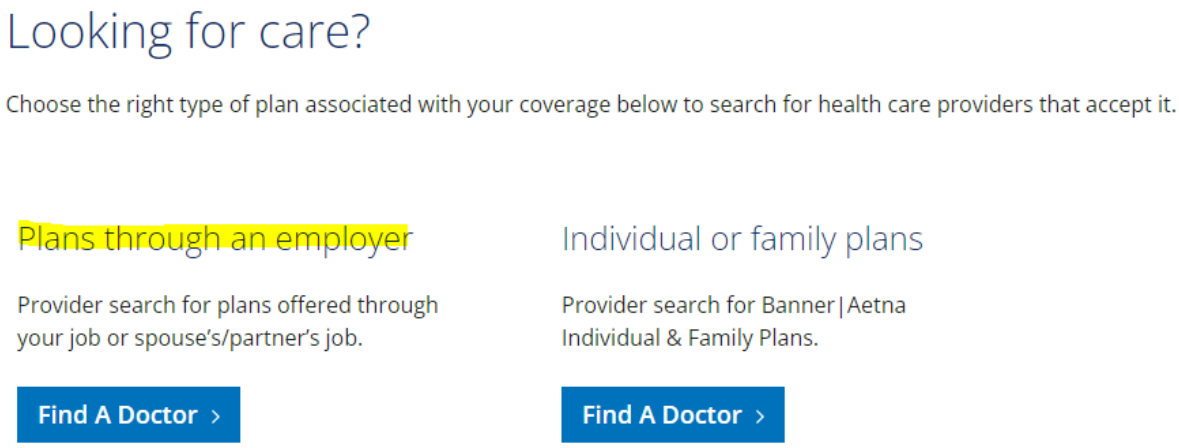
Banner|Aetna DocFind Guide for Small Group 2-100

1. Visit www.banneraetna.com for Arizona HQ'd Groups

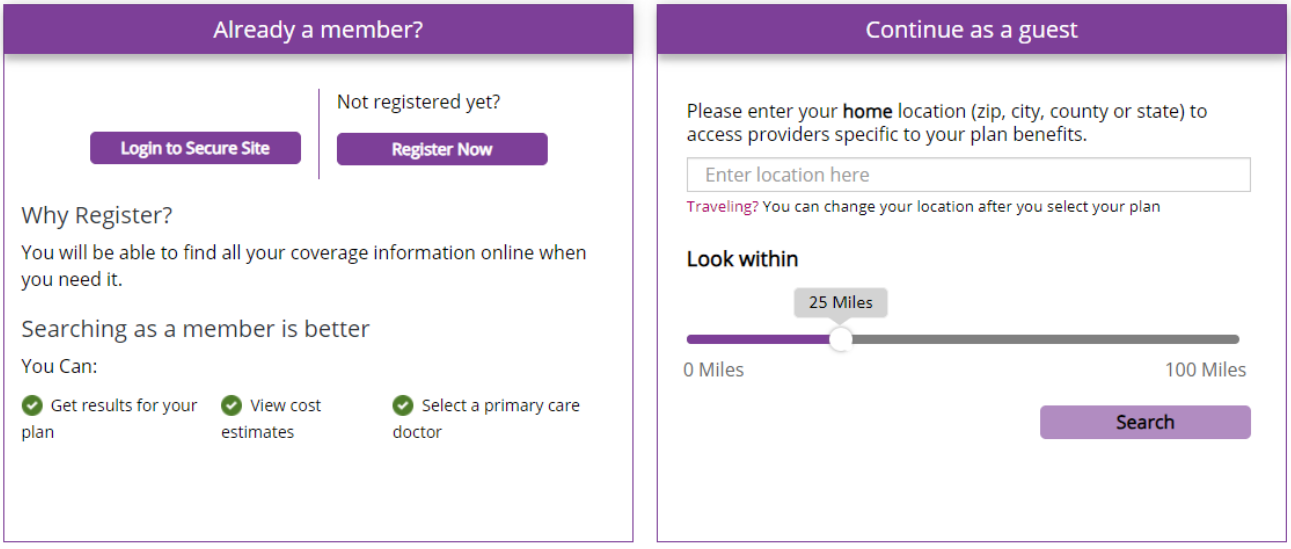
2. Select **Find A Doctor**



3. Select **Plans through an employer**

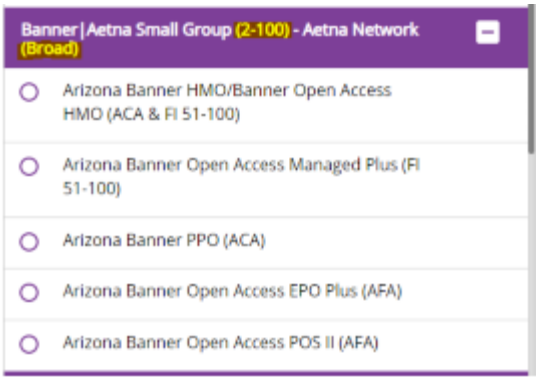


4. Select which field is applicable. Registered members will see more viewing options and content.

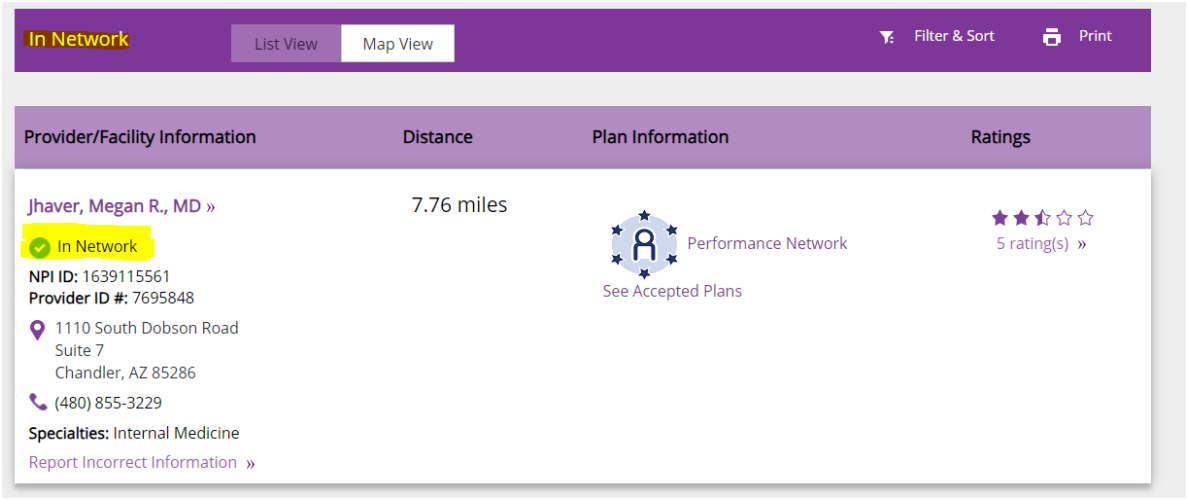


5. Select a Plan

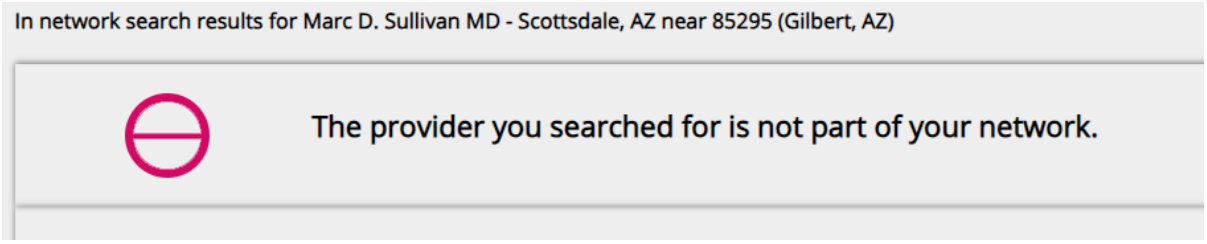
Select Broad Network, with AFA in parenthesis. See red circled plan options:



An In Network Provider result



An Out of Network Provider result



Out of state/non-AZ members - use BROAD links for OOS plans

2026

DENTAL PLANS



Policyholder: GD Barri & Associates

Group voluntary dental insurance
Benefit summary

Effective date: 05/01/2026

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
Option 1 (members electing low plan)	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	80%
Basic	$50	$50	80%	60%
Major	$50	$50	50%	40%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your in-network deductiblesfor basic and major services are combined. Your out-of-network deductibles for basic and major are combined. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Combined maximum	Your calendar year maximum for preventive, basic, and major in-network services are combined. Your calendar year maximum for preventive, basic, and major out-of-network services are combined. In-network calendar year maximums are $1,000 per person or out-of-network calendar year maximums are $1,000 per person. Your services applied to the in-network maximum will apply to the out-of-network maximum and vice versa.			
Maximum accumulation	Included			
Plan type	Scheduled			

Option 2 (members electing high plan)	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%

Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%

Additional provisions	
Family deductible	3 times the per person deductible amount
Combined deductible	Your in-network deductibles for services are combined. Your out-of-network deductibles for are combined. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.
Combined maximum	Your calendar year maximum for preventive, basic, and major in-network services are combined. Your calendar year maximum for preventive, basic, and major out-of-network services are combined. In-network calendar year maximums are $1,000 per person or out-of-network calendar year maximums are $1,000 per person. Your services applied to the in-network maximum will apply to the out-of-network maximum and vice versa.
Maximum accumulation	Included
Plan type	Unscheduled

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees can't purchase.
  - o If you’re on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you’re still considered actively at work, as long as you’re fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don’t, you’ll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Option 1

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 14)

Basic	
Sealants	Covered only for dependent children under age 14; once per tooth each 36 months
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Harmful habit appliance	Covered only for dependent children under age 14

Major	
Crowns	Each 120 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 120 months per tooth
Bridges	120 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Additional benefits

Scheduled / MAC design	In and out-of-network claim payments are based on the amounts agreed to by network dentist, known as a negotiated fee schedule. If the submitted charge is more than the scheduled amount you may be responsible for paying the difference for out of network claims.

Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

Option 2

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Twice per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 14)

Basic	
Sealants	Covered only for dependent children under age 14; once per tooth each 36 months
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Composite (tooth colored) filings	Covered on posterior teeth

Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered for only specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Harmful habit appliance	Covered only for dependent children under age 14

Major	
Crowns	Each 120 months per tooth if tooth cannot be replaced by a filling
Core buildup	Each 120 months
Bridges	120 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.

Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information. We strongly recommend submitting a predetermination to determine benefits.

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This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

2026

VISION PLANS



Policyholder: GD Barri & Associates

Group voluntary vision

Benefit summary for all members

Effective date: 05/01/2026

What's available to me?

Vision insurance is offered through Principal® and VSP® Vision Care. It provides choice, flexibility and savings through a VSP doctor.

If you buy this coverage, an established network of VSP doctors will provide quality care for you and your dependents.

VSP choice network	
Exams	Every 12 months, one exam is covered in full after $0 copay
Prescription glasses Lenses - 1 pair covered every 12 months Frames - covered up to $150 every 24 months; 20% off amount over allowance[1]	$10 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses • Polycarbonate lenses for dependent children under age 18
Lens enhancements	Standard progressive lenses covered once every 12 months with a $0 copay[1] Most other popular lens enhancements are covered after a copay, saving our members an average of 30%[1]
Elective contacts	Covered up to $150 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evaluation	Up to $60 copay
Necessary contacts	Covered in full after $10 copay every 12 months Contact lenses can be chosen instead of glasses.

[1]This can vary based on state laws and provider location Savings may not apply at participating retail chains.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees can't purchase.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period.
- If you're covered, you may buy coverage for your dependents.

Additional eligibility requirements may apply.

What's the difference between elective and necessary contacts?

- Elective - when vision can be corrected by glasses, but contacts are worn.
- Necessary - when vision can't be corrected with glasses due to extreme vision problems.

Why am I charged an additional copay for contact fitting and evaluation?

- Contact lens wearers require an additional evaluation of the eyes' measurements, and possible follow-up appointments, for fitting and training on proper use of contact lenses.
- For these additional services, you won't pay more than $60 at in-network providers.

Are benefits the same for all VSP doctors?

- Yes, with the exception of Costco®, Walmart®, and Sam's Club®. The frame allowance at these locations is $80 which is equivalent to a $150 allowance at other VSP doctor locations. Not all providers at participating retail chains are in-network for exam services.
- Benefits may also vary by location due to state law.

How do I find a VSP doctor?

- Visit vsp.com to locate VSP doctors close to you -- or to see if your current eye care professional is in the VSP network.
  - You'll need to choose the "Choice" doctor network to view the VSP doctors for your coverage.
- Call 800-877-7195.

Will I get an ID card?

- Yes, your card will have a unique member ID that your doctor will use to verify benefits.

Will my doctor submit my claim?

- If you're seeing a VSP doctor, they'll submit the claim for you.
- If you're seeing someone outside the VSP network, you're responsible for submitting your own claim. You can get that form from vsp.com after logging in as a member using your member ID. Or call 800-877-7195.

Are there any additional savings with VSP?

- Glasses and sunglasses - you can save an average of 20-25% off glasses or sunglasses from any VSP doctor within 12 months of your last covered vision exam.
- Laser vision correction - you pay an average of 15% off the regular price and 5% off the promotional price. You'll only receive these discounts from contracted clinics. Go to VSP.com and register using your member ID to see the laser vision promotions and find a contracted clinic.

These savings can vary based on state laws and provider location.

What benefits do I receive if my doctor is outside VSP's network?

Covered charges	Benefit	Frequency
Exams	Up to $45	Once every 12 months
Single lenses	Up to $30	One pair every 12 months
Lined bifocal lenses	Up to $50	One pair every 12 months
Lined trifocal lenses	Up to $65	One pair every 12 months
Lenticular lenses	Up to $100	One pair every 12 months
Frames	Up to $70	One set every 24 months
Elective contacts	Up to $105	Contacts are instead of frames and lenses
Necessary contacts	Up to $210	Contacts are instead of frames and lenses

What are the limitations of my benefits?

- Visual analysis or vision aids that aren't medically necessary aren't covered.
- No benefits will be paid for:
  - Non-prescription glasses
  - Medical or surgical treatment of the eyes
  - Claims submitted by a doctor who is part of your family

This benefit summary is a summary only. For a complete list of benefit information and limitations, please refer to your booklet.





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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

2026

ADDITIONAL PLANS

Policyholder: GD Barri & Associates

Group voluntary term life insurance

Benefit summary for all members

Effective date: 05/01/2026

What's available to me?

Protect what means the most to you – the people you love. If you passed away, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Minimum	Guaranteed issue[1]	Maximum	Benefit reduction[2]
You	Select a benefit in increments of $10,000	$10,000	If you're under 70: $150,000 If you're 70 or older: $10,000	$500,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your spouse[3]	Select a benefit in increments of $10,000	$10,000	If your spouse is under 70: $30,000 If your spouse is 70 or older: $10,000	$150,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your child(ren)[3]	Options[4]: • $10,000, or • $20,000				

[1]Amount of coverage you may buy within 31 days of initial eligibility for coverage without providing health information.

[2]As you get older, your life insurance benefit amount decreases.

[3]Amount of coverage may not exceed 100% of your benefit.

[4]Dependent children under 14 days old receive a $1,000 benefit.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you may need to provide health information for review, or if you have a qualifying event.
  - If you and your spouse are both employed at GD Barri & Associates and are eligible for benefits, you're not eligible to have benefits as both an employee and a spouse.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity).

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above for you and your spouse may require you to provide health information.

May I increase my benefit later?

- You may be able to enroll for or increase your benefit and your dependent's benefit two increments per year during your open enrollment period without providing health information.
- If you have a qualifying life event (marriage, birth of a child, etc.), you may enroll or increase your benefit up to the guaranteed issue amount within 31 days without having to provide health information.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you or your spouse are accidentally injured on or off the job, you may receive a benefit equal to your life benefit.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000
Repatriation - If you die at least 100 miles from your home	Up to $2,000
Education - If your children are enrolled in an accredited post-secondary school at the time of your death	$3,000/year for up to 4 years
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium.
Portability	If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.
Conversion of terminated coverage	If you terminate employment, you may be able to convert coverage to an individual policy.

What are the limitations and exclusions of my coverage?

This benefit summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

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This is a summary of voluntary term life coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: GD Barri & Associates

Group voluntary short-term disability insurance

Benefit summary for all members

Effective date: 05/01/2026

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits payable	
Primary weekly benefit	60% of your earnings up to $2,500
Benefit amount	Your primary weekly benefit minus other income sources
Elimination period	Benefits begin on the 15th day for accidents and 15th day for sickness
Benefit payment period	Up to 11 weeks
Maternity	Pregnancy and childbirth are treated the same as any other disability
Limitations & exclusions	
Pre-existing conditions	3 months prior / 12 months insured
Other limitations	A complete list is included in your booklet

What's available to me?

Help protect one of your most valuable assets - the ability to earn an income. If you're temporarily disabled and can't work for a short amount of time, you can rely on short-term disability insurance to replace a portion of your weekly income.

Your primary weekly benefit is 60% of your earnings prior to your disability up to $2,500 minus other income sources. Other income sources could include but aren't limited to Social Security, other earnings, worker's compensation and state disability (if applicable), and salary continuance.

Your benefits are determined by your base wage with bonus and commissions. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is completed and benefits begin on the 15th day for accidents and the 15th day for sickness. The elimination period is the amount of time before you start receiving benefits.

Once I start receiving benefits, how long will they continue?

Short-term disability benefits can continue up to 11 weeks.

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During your elimination period and your benefit payment period (how long benefit is paid), one of the following must apply:

- You're unable to perform the majority of substantial duties of your own job; or
- You're unable to earn 80% of your income prior to your disability while working in a modified capacity.

Do I qualify if I have a preexisting condition?

You may. If you haven't been seen by a doctor or prescribed medication for an injury or sickness in the last 3 months or if your disability happens after 12 consecutive months of coverage, you may qualify.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Rehabilitation incentive benefit	If you're totally disabled and satisfy the requirements of an individual rehabilitation plan, your benefit percentage may increase by 5%.
Mandatory rehabilitation	You may be paid for any expenses associated with an approved rehabilitation plan.

What are the limitations and exclusions of my coverage?

Preexisting conditions

A preexisting condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you:

- Received medical treatment, consultation, care or service; or
- Were prescribed or took prescription medications

In the event an investigation is necessary to determine if a disability is preexisting, benefits may be payable for up to six weeks while The Principal is conducting its preexisting condition investigation. Once the investigation is complete and if the disability is deemed to be a preexisting condition, no further benefits will be payable. Benefits will not be paid beyond the date six weeks following the date of disability for disabilities resulting from preexisting conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months. No benefits will be paid for a subsequent claim subject to a preexisting condition investigation for the same condition.

No benefits will be paid for any disability that is caused by, a complication of, or resulting from the same preexisting condition that you had previously received benefits for.

Preexisting condition limitations also apply to benefit increases due to:

- Policy amendments
- Changes in earnings of 25% or greater

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This is a summary of short-term disability coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: GD Barri & Associates

Group voluntary long-term disability insurance

Benefit summary for all members

Effective date: 05/01/2026

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits payable	
Primary monthly benefit	60% of your earnings up to $10,000
Benefit amount	Your primary monthly benefit minus other income sources
Elimination period	Benefits begin after 90 days
Own occupation period	2 year
Benefit payment period	Varies based on your age when you become disabled, see chart below
Limitations & exclusions	
Pre-existing conditions	3 months prior / 12 months insured
Other limitations	A complete list is included in your booklet

What's available to me?

Your income is important - you depend on it for almost everything. If you're too sick or hurt to work for a long period of time, you can rely on long-term disability insurance to replace a portion of your monthly income.

Your primary monthly benefit is 60% of your earnings prior to your disability up to $10,000 minus other income sources. Other income sources could include but aren't limited to Social Security for you and your dependents, other earnings, worker's compensation, state disability (if applicable) and salary continuance.

Your benefits are determined by your base wage with bonus and commissions. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is 90 days. The elimination period is the amount of time before you start receiving benefits.

If you recover and return to work during your elimination period and become disabled again, you may not have to satisfy a new elimination period. If you qualify for this, your elimination period will pick up at the point where it was left off when you recovered.

Once I start receiving benefits, how long will they continue?

Age disability occurs	Benefits are payable until the later of:
Under age 65	Social Security Normal Retirement Age (SSNRA) or 36 months
Age 65-67	SSNRA or 24 months
Age 68-69	SSNRA or 18 months
Age 70-71	SSNRA or 15 months
Age 72 and over	SSNRA or 12 months

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During the first 2 years of receiving benefits, your disability is based on your own occupation, known as the own occupation period. This is the occupation you're routinely performing at the time of disability. After 2 years, we'll evaluate for any occupation based on education, training or experience.

During your elimination period and your own occupation period, one of the following must apply:

- You're unable to perform the majority of the substantial and material duties of your own occupation; or
- You're unable to earn 80% of your indexed income prior to your disability while working in a modified capacity.

After completing the own occupation period, one of the following must apply:

- You're unable to perform the majority of the substantial and material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience.
- You're performing the substantial and material duties of your own occupation or any occupation on a modified basis and are unable to earn more than 80% of your indexed income prior to your disability.

Do I qualify if I have a preexisting condition?

- You may. If you haven't been seen by a doctor or prescribed medication for an injury or sickness in the last 3 months or if your disability happens after 12 consecutive months of coverage, you may qualify.

Are mental nervous, drug/alcohol and special conditions covered?

- It'll be considered a disability if it's caused by:
  - A mental health condition for up to a lifetime maximum of 24 months
  - Abuse, dependency, or addiction to alcohol, drug, or chemicals for up to a lifetime maximum of 24 months
  - A special condition such as (but not limited to) chronic fatigue syndrome, musculoskeletal or connective tissue disorders for up to a lifetime maximum of 24 months
- The amount of time you receive benefits for these covered conditions will be limited to a combined lifetime maximum of 24 months.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit for 12 months. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Rehabilitation incentive benefit	If you're totally disabled and satisfy the requirements of an individual rehabilitation plan, your benefit percentage may increase by 5%.
Return to work child care benefit	You may be paid to help cover the cost of child care expenses if you remain on the job or return to work. You may be reimbursed 100% of your total child care expense up to $350 per month for up to 12 months.
Mandatory rehabilitation	You may be paid for any expenses associated with an approved rehabilitation plan.
Survivor benefit	If you haven't been paid an accelerated survivor benefit, your survivors will receive 3 times your primary monthly benefit.

What are the limitations and exclusions of my coverage?

Preexisting conditions	A preexisting condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you: • Received medical treatment, consultation, care or service; or • Were prescribed or took prescription medications Benefits will not be paid for disabilities resulting from preexisting conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months. Preexisting condition exclusions also apply to benefit increases due to policy amendments and changes in earnings of 25% or greater.

Treatment of mental health conditions, drug and alcohol abuse conditions and special conditions	A disability is considered due to alcohol, drug or chemical abuse, dependency or addiction or a mental health condition or a special condition if the disability is caused by one of these condition(s) and not by other disabling conditions. Maximum benefit payment periods for: Mental health conditions – 24 months Alcohol, drug or chemical abuse conditions – 24 months Special conditions – 24 months The benefit payment period listed above is a lifetime maximum for all periods of disability. All disabilities from conditions with the same maximum benefit payment period contribute towards one lifetime maximum. However, if at the end of the benefit payment period, you are confined in a hospital or any other type of facility providing treatment for any of these conditions, the benefit payment period may be extended to include the time period you are confined for treatment. Special conditions are considered to be Thoracic outlet syndrome / Headaches, such as functional, migraine, organic, sinus and tension / Chronic fatigue syndrome / Fibromyalgia/ Temporomandibular joint (TMJ) / Cumulative trauma disorder, overuse syndrome, or repetitive stress disorder including carpal tunnel and ulnar tunnel syndrome / Environmental allergies and multiple chemical sensitivity / Musculoskeletal and connective tissue disorders of the neck and back, including any disease or disorder of the cervical, thoracic and lumbosacral back and surrounding soft tissue, including sprains and strains of joints and adjacent muscles.

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This is a summary of long-term disability coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Voluntary rates

Presented to: GD Barri & Associates
Effective date: May 1, 2026

The volume, lives, monthly costs and annual costs will be determined upon final enrollment.

Voluntary term life monthly rate[1] per $1,000 members electing low plan, members electing high plan		
Age	**Employee**	**Spouse**
29 & under	$.077	$.077
30 - 34	$.092	$.092
35 - 39	$.115	$.115
40 - 44	$.189	$.189
45 - 49	$.278	$.278
50 - 54	$.455	$.455
55 - 59	$.728	$.728
60 - 64	$.990	$.990
65 - 69	$1.578	$1.578
70 & over	$2.709	$2.709

Rate guarantee: two years, unless volume increases or decreases by more than 25%

[1]Voluntary term life rates do not include the AD&D rate. The spouse is charged based upon his/her individual age.

Child(ren) monthly rate:

$10,000 of coverage for $2.00 per family

$20,000 of coverage for $4.00 per family

Voluntary Accidental Death and Dismemberment (AD&D) monthly rate per $1,000 members electing low plan, members electing high plan	
Employee and spouse	$.028

AD&D is automatically added to any voluntary term life benefit elected. Employee and spouse are charged separately.

Voluntary long-term disability % of CME[1]	
Age	**Monthly rate**
24 & under	$.14
25 - 29	$.14
30 - 34	$.26
35 - 39	$.37
40 - 44	$.64
45 - 49	$.84
50 - 54	$1.18
55 - 59	$1.52
60 - 64	$1.18
65 - 69	$.88

Voluntary rates

Presented to: GD Barri & Associates
Effective date: May 1, 2026

70 & over	$.64

Rate guarantee: two years, unless covered monthly earnings increase or decrease by more than 25% since the last policy anniversary

[1]Covered monthly earnings

Voluntary short-term disability per $10 of weekly benefit	
Age	**Monthly rate**
24 & under	$.18
25 - 29	$.19
30 - 34	$.20
35 - 39	$.18
40 - 44	$.17
45 - 49	$.22
50 - 54	$.31
55 - 59	$.36
60 - 64	$.41
65 - 69	$.50
70 & over	$.66

Rate guarantee: two years, unless covered weekly earnings increase or decrease by more than 25% since the last policy anniversary

2026
WHAT'S NEXT?



Consider your options

Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefit coverage.



Keep this guide handy

Refer to the information in this guide and online at our website to help you make wise benefit choices.

If you still have unanswered questions, please contact:

Jeffrey A. Wenger
Phone: 623-773-0410
Email: Jeff.Wenger@gdbarri.com

2026-2027

BENEFITS GUIDEBOOK

Presented By: GD Barri & Associates

CONTACT US:

Jeffrey A. Wenger
Phone: 623-773-0410
Email: Jeff.Wenger@gdbarri.com

This brochure summarizes the health care and income protection benefits that are available to employees and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Please note: This enrollment guide is a summary of some of the benefits provided to eligible employees. We reserve the right to modify, amend, suspend, or terminate any plan at any time for any reason without prior notification. The plans described in this bulletin are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this bulletin as accurate as possible. However, should there be any discrepancy between this bulletin and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern.

The written descriptions in the insurance contracts or plan documents will always govern.