

**BANNER HEALTH
&
LABORATORY SCIENCES OF ARIZONA**

SUMMARY PLAN DESCRIPTION

Medical:

Banner Choice Plus

Banner Select \$500

Banner Select \$250

Prescription Drug

Dental

Effective January 1, 2011

**Arizona
Colorado
Nebraska
Wyoming**

Banner Health Medical, Prescription Drug and Dental Plans

Banner Health (Banner) sponsors the Banner Medical Plan, Prescription Drug Plan and Dental Plan (collectively the Health Plans or Plan) under the Banner Health Master Health and Welfare Benefits Plan for its eligible employees. The Health Plans are self-funded, which means the benefits are paid from the general assets of Banner Health.

The benefits referred to in this Summary Plan Description (SPD) are those in effect January 1, 2011. This SPD summarizes the benefits and important provisions of the Health Plans. If there is a conflict between a statement in this SPD and in the Master Health and Welfare Benefits Plan, the terms of the Master Health and Welfare Benefit Plan shall control.

If, after referring to the information in this document, you still have a question concerning a Health Plan benefit, call the Plan Administrator at the Service Center at Banner Plan Administration at 1-800-827-2464 or 480-684-7070 in the Phoenix-metropolitan area.

Asistencia para Miembros de Habla Hispana

Este folleto contiene un resumen en Ingles acerca de los derechos y beneficios de los empleados bajo el Plan de Beneficios de Salud Banner Health /Laboratory Sciences of Arizona. Si tiene dificultad entendiendo alguna parte de este folleto, por favor comuniquese con el Administrator del Plan durante las horas de trabajo:

BPA Operations Compliance
525 W. Brown Road
Mesa, AZ 85201
800-827-2464
480-684-7070 (in the Phoenix-metropolitan area)

Table of Contents

To avoid paging up and down through this document you can:

- Click on the title or page number in this Table of Contents and be brought directly to that page.

INTRODUCTION	6
ELIGIBILITY	8
Yourself.....	8
Your Dependents	8
Domestic Partners	11
Important Information about Domestic Partner Coverage.....	11
Enrolling a Domestic Partner.....	11
Tax Implications of Enrolling a Domestic Partner	12
ENROLLMENT	14
When Coverage Is Effective	14
If You Do Not Enroll	15
Changing Your Elections – Eligible Change Events	15
Special Enrollment/Notice of Employee Rights	15
Change in Status	16
Significant Cost or Coverage Change.....	17
Medicare or Medicaid Entitlement	17
Qualified Medical Child Support Orders.....	18
Contributions for Coverage	18
Non-Tobacco User Discount.....	18
Termination of Coverage	19
BANNER HEALTH EMPLOYEE MEDICAL PLANS	20
Medical Plan Options	20
Banner Choice Plus	20
Banner Option.....	20
PPO Option	22
Indemnity Option	23
2011 Benefit Chart - Banner Choice Plus	25
Banner Health Employee Select Medical Plans	28
In-Network Option.....	28
Non-Network Option	29
2011 Benefit Chart – Banner Select \$500	31
2011 Benefit Chart – Banner Select \$250	35
Medical Benefits Provisions	38
General.....	38
Deductibles	38
Copayment Provision:.....	38
Emergency Room Copayment:.....	38
Surgery for Morbid Obesity Copayment	38
Unpaid Copayments, Deductibles and Coinsurance.....	38
Childbirth:.....	38
Surgical Services for Breast Reconstruction (WHCRA):.....	38
Travel Reimbursement Policy.....	39
Alternative Benefits Management	39
Covered Medical Services	40
Non-Covered Medical Services	44

Hospital and Outpatient Review/Pre-Certification	48
Services Requiring Pre-Certification under PPO Option and Indemnity Option:	48
When & Where to Call	48
BANNER PRESCRIPTION DRUG BENEFIT	49
Prescription Drug Benefit Options.....	49
Basic Plan.....	49
Standard Plan:	49
Expanded Plan:	49
2011 Benefit Chart – Banner Prescription Drug Benefits.....	50
Choose a Drug in the “Formulary” and Save.....	51
Generic Drugs Cheaper.....	51
Mail Order Option for “Maintenance” Drugs Offers Convenience and Savings	51
Formulary Questions and Answers.....	53
General Prescription Drug Provisions	54
Security and Privacy of your Information	54
Specific Requirements	54
Prior Authorization Policies*	54
Step Therapy Program	54
Exclusions and Limitations.....	54
Quantity Limitations	55
Identification Card	55
Still have questions?	55
BANNER DENTAL PLANS	56
2011 Benefit Chart – Preventive Dental Plan.....	56
2011 Benefit Chart - Comprehensive Dental Plan.....	57
2011 Benefit Chart – Enhanced Dental Plan.....	58
Non-Covered Dental Services	59
2011 Dental Plans Class of Service Definitions Comparison Chart	61
Class A Services: Preventive and Diagnostic Dental Procedures.....	61
Class B Services: Basic Dental Procedures	61
Class C Services: Major Dental Procedures	62
Class D Services: Orthodontic Treatment and Appliances.....	63
FILING A CLAIM.....	64
Claims Administrator.....	64
Appeals Procedure	65
Appeals Administrator.....	66
Exhaustion of Administrative Remedies	67
Limitations Period on Legal Actions and Choice of Venue	67
GENERAL PROVISIONS	68
Governing Documents	68
Plan Administration.....	68
No Participant Vested Rights to Benefits	69
Privacy of Personal Health Information	69
Pre-Existing Conditions	69
Waiver of Right.....	69
COORDINATION OF BENEFITS PROVISIONS.....	70
Coordination of Benefits.....	70
Order of Benefit Determination	70

Coordination with Medicare	71
SUBROGATION AND REIMBURSEMENT.....	71
Recovery of Benefits Paid or Payable	71
Subrogation.....	71
Reimbursement.....	73
HEALTH CARE REFORM (AFFORDABLE CARE ACT 2010)	75
Grandfathered Plans.....	75
COBRA - CONTINUATION OF COVERAGE OPTION	76
What is COBRA Coverage?	76
Who is Entitled to Elect COBRA Coverage?	76
When is COBRA Coverage Available?.....	77
Electing COBRA Coverage	78
Deadline for COBRA Election	78
Length of COBRA Coverage.....	79
Disability Extension of COBRA Coverage	79
Cost of COBRA Coverage.....	81
Payment for COBRA Coverage.....	81
Military Leave.....	82
YOUR RIGHTS UNDER ERISA	83
Receive Information About Your Plan and Benefits	83
Continue Group Health Plan Coverage.....	83
Prudent Actions by Plan Fiduciaries.....	83
Enforce Your Rights	83
Assistance with Your Questions	84
GENERAL PLAN INFORMATION	85
Plan Sponsor	85
Employer Identification Number	85
Plan Identification Number:.....	85
Plan Funding	85
Plan Administrator	85
Claims Administrator.....	85
Claims Decisions (other than Mental Health Substance Abuse)	85
Appeals Administrator	86
COBRA Administrator	86
GLOSSARY/DEFINITIONS	87

Introduction

Banner is pleased to provide you and your covered dependents this Summary Plan Description (“SPD”) that describes and explains the coverage options available to you under the :

- Medical Plan,
- Prescription Drug Plan, and
- Dental Plan.

Please take time to read your SPD and become familiar with your benefit coverage. By reading each section carefully, you will understand your benefits and know how to use them wisely. You will also be informed about any out-of-pocket expenses that are your responsibility.

This SPD provides descriptions of the health care benefits available under the Health Plans. This includes your Medical Plan, Prescription Drug Plan, and Dental Plan. Please refer to the appropriate sections of this SPD for the benefits **you have elected**.

Throughout this SPD, you will see references to the Plan Administrator, Claims Administrator, Appeals Administrator, and COBRA Administrator.

Plan Administrator

The Plan Administrator operates the Health Plans, other than deciding benefit claims and appeals, and administering COBRA. The Plan Administrator is Banner Plan Administration (BPA). You can contact BPA at 1-888-827-2464 or 480-684-7070 in the Phoenix-metropolitan area.

Claims Administrator

The Claims Administrator decides your initial claim for benefits under the Plan. BPA is also the Claims Administrator under the Health Plans and you can contact the Claims Administrator with respect to your initial claim for benefits at:

Claims Decisions (other than Mental Health Substance Abuse)

Banner Plan Administration
P.O. Box 16423
Mesa, AZ 85211-6423
1- 800-827-2464
480-684-7070 (in the Phoenix Metro area)

Mental Health Substance Abuse Decisions

CIGNA Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344
1-800-633-5354

Appeals Administrator

If your initial claim for benefits under the Plan is denied, the Appeals Administrator decides the appeal for benefits under the Plan. The Appeals Administrator is the Appeals and Grievance Committee and you can contact the Appeals Administrator with respect to your appeal of a denied claim for benefits at:

Appeals and Grievance Committee
P.O. Box 16423 6th Floor
Mesa, AZ 85211-6423
480-684-7070

The Plan Administrator's, Claims Administrator's and Appeals Administrator's authority is described in the *Plan Administration* Section.

COBRA Administrator

The COBRA Administrator administers COBRA under the Health Plans. The COBRA Administrator is:

Discovery Benefits
3216 13th Ave South
PO Box 869 Fargo, ND 58107
1-866-451-3399 or 701-451-3399

Eligibility

If you meet the eligibility requirements described below, you may elect coverage under the Health Plans for yourself, your spouse or domestic partner and your eligible dependents. To be covered under a Health Plan, you must enroll for coverage in order to enroll a dependent.

Yourself

You are eligible to enroll for coverage under the Health Plans if you are scheduled to work 32 hours or more a pay period and are classified as a benefit eligible full-time or part-time employee excluding Pay In-Lieu, Per-Diem, Registry, Weekend Staffing, Leased Employees and all other non-benefit eligible positions

If Your Employment Status Changes

Your coverage will cease at the end of the month your status changes to an employment classification that is no longer eligible to participate in coverage. You may, however, be eligible for coverage under COBRA (see the Section **COBRA – Continuation of Coverage Option**). You will again be eligible for coverage on the date you move to a benefit eligible employment status, after the applicable waiting period. You must enroll within 31 days of this event.

If You Are Rehired

If you terminate employment with Banner and are rehired within 31 days of your date of termination, without any other intervening event that would permit a midyear change in election, the Plan Administrator will automatically re-enroll you in the Health Plans using the same elections that were in effect prior to your termination of employment. Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion, permit you to change your elections based on the facts and circumstances surrounding your reemployment. Depending on the nature of the election change, you may be required to pay your premiums on an after-tax basis until the next Plan Year

If you are rehired more than 31 days after your date of termination, you may make benefit elections as if you were a new hire. If you resign and return to Banner within 12 months, your length of service will be bridged for designated benefits and years of service back to your previous hire date.

Your Dependents

If you are eligible to elect coverage under the Health Plans for yourself, you also may elect coverage for your eligible dependents or domestic partner. Your dependents and domestic partner become eligible for coverage when you do, provided you enrolled for coverage and have supplied the appropriate documents validating dependency.

If both you and your spouse, domestic partner, or other dependent are employed by Banner neither you nor they may cover the other as a dependent at the same time they are enrolled for coverage. Either you or your domestic partner may enroll your eligible children as dependents.

Your eligible dependents include:

- **Your legally married spouse.** For the purpose of coverage under the Health Plans, a spouse is a person of the opposite sex to whom you are married if the marriage is recognized in the state in which you reside and in accordance with federal law. Legally married spouse includes such an individual separated from you under a legal separation decree. See the provisions related to domestic partners for details regarding eligibility for a partner of the same gender.

Legally married spouse does not include a divorced spouse, even if you are required by a court order to provide health care coverage.

- **Your common-law spouse** if you live in a state that recognizes common-law marriages. Proof is required.
- **Your domestic partner.** (same or opposite gender) (The domestic partner packet must be completed and turned in to the Service Center at Banner Plan Administration by either contacting the Service Center or obtaining a copy online at www.BannerBenefits.com.)
- **Your children** described below who are not eligible to enroll in coverage under another employer-sponsored medical, prescription drug or dental plan (other than a parent's plan):
 - *Your-children through age 25* (whether born to you, legally adopted or a step-child through marriage).
 - *Unmarried children for whom you or your spouse has legal custody/guardianship through age 25.* To be eligible under the Health Plans, a child for whom you have legal custody/guardianship must meet the definition of a tax dependent for health plan coverage purposes under Section 152 of the Internal Revenue Code. Children of an eligible dependent are excluded unless you or your spouse has legal custody/guardianship. You will need to provide a copy of any court decree or legal documentation in the case of legal custody or guardianship. The Health Plan may verify eligibility at any time.
 - *Your unmarried incapacitated children* who are 26 or older and who are incapable of self-support due to continuously disabling mental or physical handicap. To be eligible under the Health Plans, an incapacitated child must meet the definition of a tax dependent for health plan coverage purposes under Section 152 of the Internal Revenue Code. You must provide proof of the disability within one year of the following, whichever is later:
 - The child's 26th birthday, or
 - The date the incapacity began if the child is over age 26.
 - If your child was covered under another employer's plan but loses coverage because of your divorce, death of your spouse, loss of eligibility under your spouse's employer's plan, or the employer discontinues the plan, your child may be covered under the Health Plans as long as your child was incapable of self-support because of a mental or physical handicap incurred before your child reaches age 26 and you notify the Health Plans within 31 days of when your child's coverage would end.

Special Rules for Guardianship and Incapacitated Children. For purposes of Health Plans coverage, a child for whom you or your spouse has custody/guardianship, or an incapacitated child meets the definition of a tax dependent if you can claim an exemption for the child on your federal income tax return. Even if you cannot claim an exemption for the child, your child may still meet be tax-qualified for health coverage purposes. Most commonly, your child will be claimable as a "Qualifying Child" under Section 152 of the Code, as follows:

Qualifying Child. A child (including, for this purpose, your child, sibling, and stepsibling, or a descendant of any such relative) is considered your "Qualifying Child" under IRS rules if he or she meets all of these requirements:

- The child is under age 19, or under age 24 and a full-time student, or is a child of any age

- who is totally and permanently disabled;
- The child has the same principal place of residence as you for more than 50% of the year. Temporary absences due to special circumstances, such as illness; and education, business, vacation or military service, are not treated as absences; and
- The child does not provide over 50% of the child's own financial support for the year.

Qualifying Relative. If child who is not your Qualifying Child is your tax-qualified “qualifying relative” if the child meets all of the requirements of a “Qualifying Relative,” as follows:

- Is either your child (including, generally for this purpose, your child, descendant of a child, sibling or stepsibling, and your niece or nephew, although other relations may qualify) or a child who has the same principal place of residence as you and is a member of your household;
- You provide more than 50% of the child's financial support for the year; and
- The child is not a Qualifying Child of another taxpayer for the year.

Special Rule for Children of Parents who are Divorced or Separated. A special exception applies in the case of a child of parents who are divorced or legally separated, or who live apart at all times during the last 6 months of the calendar year. In the case of such a child, you may cover the child under the Health Plans on a tax-free basis even if the child is not your “qualifying child” or “qualifying relative” as defined above if the child:

- receives over 50% of his or her support during the year from his or her parents;
- is in the custody of one or both parents for more than 50% of the year; and
- qualifies under Section 152(c) or 152(d) as a qualifying child or qualifying relative of one of the child's parents

The Health Plans may request documentation to support continued coverage no less than annually. **In addition, you are required to submit Certification of Tax Dependent Status for a child for whom you have legal custody or are legal guardian, and for an incapacitated child age 26 or over.**

- **Unmarried children of your domestic partner** through age 25 for whom you and your domestic partner provide at least 50% financial support. **You are required to submit Certification of Tax Dependent Status for your domestic partner and his or her children. See the Section Tax Consequences if Your Domestic Partner and/or His or Her Child is a “Qualified Dependent.”**
- **Children under QMCSO.** Your children through age 25 for whom you are legally responsible to provide health coverage under a qualified medical child support court order (QMCSO).

QMCSO - A QMCSO is a court's judgment, decree, or order (including approval of a settlement agreement) that states that you are legally responsible to provide coverage under a Health Plan(s) for that child.

It is your responsibility to immediately advise the Service Center at Banner Plan Administration to remove a domestic partner or dependent who for any reason is no longer eligible for coverage.

Domestic Partners

The Definition of a Domestic Partner

If you are eligible for coverage under the Health Plans, you have the option of enrolling a domestic partner. Domestic partner relationships must meet the criteria listed below.

- Both the employee and the domestic partner are at least age 18 or older, and mentally competent to consent to a declaration of domestic partnership.
- The individual being declared as the employee's domestic partner is under the age of 65.
- The employee and the domestic partner have lived together in a common household for at least six months and will continue to do so throughout the entire period of benefits coverage.
- The employee and the domestic partner are in a serious and committed relationship.
- The employee and the domestic partner are not related in any way that would prohibit legal marriage if they could otherwise be married under applicable law.
- The employee and the domestic partner are not legally married to, legally separated from or domestic partner to, any other persons.
- The individual being declared as the employee's domestic partner is not otherwise eligible for coverage under the Banner Health Plans.

Important Information about Domestic Partner Coverage

Banner will recognize a same-sex or opposite-sex domestic partnership, as long as the employee and the domestic partner meet the criteria listed above (see the Section **The Definition of a Domestic Partner**) and follow the enrollment process (see **Enrolling a Domestic Partner**).

If the employee and the domestic partner terminate their relationship, the employee must immediately contact the Plan Administrator to remove the domestic partner, and any children of the domestic partner, from the employee's benefits coverage.

The domestic partner, and children of the domestic partner, will be eligible for COBRA coverage under the same conditions as all other covered members (see the Section **COBRA – Continuation of Coverage Option**).

Enrolling a Domestic Partner

An employee who wishes to enroll a domestic partner (and eligible children of a domestic partner) must submit the following information to the Service Center at Banner Plan Administration during the designated enrollment period (either when first eligible to enroll, during the annual enrollment period or within 31 days of an eligible change event).

- A ***Declaration of Domestic Partnership*** completed and signed by both the employee and the domestic partner. Proof required includes:
 - Copies of a current driver's license or other state-issued identification cards, showing dates of birth and current addresses, for both the employee and the domestic partner.
- A completed ***Domestic Partner Enrollment Form***.
- A completed ***Certification of Tax Dependent Status***, if applicable. Proof required includes:

- At least three proofs of financial interdependence (for example, joint checking or savings accounts, joint credit card accounts, joint ownership of property, joint filing of income tax returns).
- Copies of the most recent W-2 forms, or copies of the most recent federal or state income tax returns for both the employee and the domestic partner.

The employee will be notified of the status of the enrollment after the information has been received and reviewed by the Plan Administrator.

While the required information is being submitted and reviewed, you should proceed with your own enrollment, and enrollment of your own dependent children. Any needed changes in your enrollment, (such as from Employee Only to Employee Plus Family level of coverage), will be completed by the Plan Administrator after receipt of your Domestic Partner Enrollment Form.

Tax Implications of Enrolling a Domestic Partner

If you enroll your domestic partner and/or your domestic partner's eligible children, you must complete and submit a Certification of Tax Dependent Status of Domestic Partner and Domestic Partner's Eligible Children with your domestic partner packet. If you do not return the Certification, your domestic partner and his or her children will be treated as your non-qualified tax dependents and you will be taxed on the cost of the Health Plans coverage for which you have enrolled them as detailed below.

Post-Tax Elections Only

Due to the tax issues under the current Internal Revenue Code, married employees pay premiums for spouses with pre-tax dollars. However, if your domestic partner or any of his/her eligible children are not your "qualified dependents" for health coverage purposes under the IRS definition, then you will only be allowed to enroll them in Banner benefits using post-tax dollars.

Tax Consequences if Your Domestic Partner and/or His or Her Child is a "Qualified Dependent"

If your domestic partner or any of his/her eligible children meet the IRS definition of "qualified dependent," then you will not be taxed on the value of the dependent coverage under the Health Plans (*i.e.*, you are not taxed on the contribution that Banner pays for your tax-qualified dependents and you may pay your portion of the contribution for their coverage on a pre-tax basis). To be a qualified dependent for health coverage purposes, your domestic partner and/or his or her eligible child or children must meet the following requirements:

- the individual has the same principal place of residence as you and is a member of your household;
- the individual receives more than 50% of his or her financial support from you; and
- in the case of an eligible child, the child is not a Qualifying Child of another taxpayer for the year.

Tax Consequences if Your Domestic Partner and/or His or Her Child is NOT a "Qualified Dependent"

If your domestic partner or any of his/her eligible children do not meet the IRS definition of a "qualified dependent," then you will be taxed on the value of the dependent coverage (*i.e.*, you are taxed on the contribution that Banner pays for your non-qualified dependents and you must pay your portion of the contribution for their coverage on an after-tax basis). The value of the coverage that Banner provides will be considered imputed income to you. Your imputed income will equal the cost of COBRA continuation coverage (not including the 2% COBRA administrative fee) for your domestic partner (and

the cost of coverage for his or her children, if applicable) reduced by the amount of your contribution for their coverage. If you have imputed income associated with your domestic partner coverage, it will be added to the taxable earnings on your paycheck (and W-2 form) and payroll taxes will be withheld from it.

As long as you pay taxes on the cost of the coverage for your non-qualified domestic partner and any of his/her eligible dependents who are not your qualified dependents, then neither you nor your domestic partner will be taxed on the benefits (i.e., paid claims) that your domestic partner and his/her dependents receive from the Health Plans.

An Example - Chris is a Banner employee who wishes to enroll Kelly as a domestic partner. Kelly is not Chris' tax dependent for health coverage purposes. Chris will elect coverage using post-tax premiums for any Health Plan in which Kelly is enrolled. The amount Banner contributes towards coverage for Kelly will be considered as imputed income for Chris and reported for tax purposes.

For further information about the tax implications of enrolling a domestic partner in Banner benefits, please contact the Service Center at Banner Plan Administration at 800-827-2464 or 480-684-7070 in the Phoenix Metro area.

Enrollment

There are three different circumstances under which you may enroll yourself and your eligible dependents in the Health Plans. You may enroll:

- When you are first hired or first become eligible,
- During annual open enrollment, or
- When you experience a qualified change event. (See **Changing Your Elections – Eligible Change Events**).

When you enroll in the Health Plans, you choose your coverage options under each of the Medical Plan, Prescription Drug Plan, and Dental Plan. You begin by selecting your benefit option from each of the three programs. Then you select the dependents you wish to cover (if any) under each of the Health Plans. The number and types of dependents you choose to cover will determine your coverage category in each program. The coverage categories are:

- Single
- **Single plus Spouse**
- **Single plus Children**
- **Family**

There are two ways to enroll in Banner Health Plan benefits. During your eligibility period or during the annual enrollment period, you will receive an Enrollment Guide along with your cost of coverage. You will make your coverage choices:

- Through the internet on the Banner Benefit Administration System at www.buckhrsolutions.com/banner, or
- By calling The Service Center at Banner Plan Administration at 1-800 827-2464 or 480-684-7070 in the Phoenix-metropolitan area, where a Banner Benefits Service representative will assist you with enrolling for coverage.

After enrollment, you will receive a confirmation of your Health Plans elections from The Service Center at Banner Plan Administration.

Once you enroll, you cannot make changes during the year unless you experience an eligible change event (see **Changing Your Elections – Eligible Change Events**).

When Coverage Is Effective

Current Employees: Changes made during the Annual Enrollment Period are effective for January 1st of the following year. If you do not re-enroll in the Health Plans during the annual enrollment period, you will continue to have the same level of coverage and benefit options under the Health Plans that you chose the year before. There is an exception to this rule if you have a health care or dependent care Flexible Spending Account (see the separate SPD for the Banner Health Pre-Tax Plan for more information), for which you must re-enroll each year.

New Employees: Enrollment must be completed no later than 31 days from your date of hire. Your coverage begins the first day of the month following your hire date, unless your date of hire is on the

first day of the month, then your coverage will begin that same day. If you do not enroll within your 31 day enrollment period, you must wait until the next annual enrollment period unless you experience an eligible change event. Coverage for a newborn eligible dependent begins at birth for the first 31 days as long as you are enrolled in the Medical Plan and Prescription Drug Plan. To maintain coverage for your newborn, you must enroll the newborn within 31 days of birth; otherwise the coverage for your newborn will be discontinued after 31 days. This rule also applies for children who are legally adopted by you or placed for adoption with you. Coverage is not available to children of a dependent, unless you have legal custody/guardianship.

If You Do Not Enroll

If you do not elect coverage when you become eligible, you must wait until the Annual Enrollment Period to elect coverage, unless you experience an eligible change event or you qualify for special enrollment (see **Changing Your Elections – Eligible Change Events**).

Changing Your Elections – Eligible Change Events

Once you elect to receive or decline coverage, you generally cannot change your elections until the following annual enrollment period. However, there are certain circumstances when you may be eligible to change your elections earlier due to an eligible change event. You must make your new elections within 31 days of the event causing the change (60 days in the case of an election due to an event related to changes in Medicaid or state child health care coverage), and the change must be consistent with the event. The circumstances that may cause your eligibility to change are:

- Situations governed by HIPAA special enrollment rules.
- Change in status event (described below) when the change is consistent with the change in status event.
- In the case of Medical Plan coverage, you, your domestic partner, or dependent children become entitled to Medicare, Medicaid (CMS). (You may cancel coverage for the individual who becomes eligible for Medicare or Medicaid)
- A significant cost or coverage change in the health care provided to you or your dependents.
- Qualified Medical Child Support Order (QMCSO)

Any change must be consistent with the reason the change was permitted. A change in your election under these circumstances will be effective the first day of the month following the later of the date the election change is completed or the date the triggering event occurs. If the change is as the result of the birth or adoption of a child, including placement of a child for adoption, the election change shall take effect on the date of the birth or adoption (or placement for adoption).

Special Enrollment/Notice of Employee Rights

A special enrollment period is a time other than the annual enrollment period when you and your eligible dependents can enroll in the Health Plans. Special enrollments are allowed if one of the following events occurs:

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption
- You declined coverage under a Banner Health Plan (either initially or during a subsequent open enrollment period) because you were covered under another group health care plan or health insurance coverage, and you then lose that coverage for any of the following reasons:

- You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause)
- Employer contributions toward the other group health plan coverage terminate, or
- You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
 - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment
 - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area
 - In the case of an group HMO, loss of coverage because you no longer reside or work in the service area; provided that no other benefit package is available to you
 - When you or your dependent incurs a claim that meets or exceeds a lifetime limit on all benefits (Dental Plan only), or
 - When a plan no longer offers any benefits to your class of similarly situated individuals.
- You or your dependent becomes:
 - Ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated, or
 - Eligible for a premium assistance subsidy for the Medical Plan under Medicaid or the state child health plan.

If you acquire a new dependent, you, your spouse/domestic partner and your new and current dependent child or children can **all** enroll as a result of the addition of the new dependent. In other words, if you adopt a child, that child is entitled to the special enrollment period because he or she is a new dependent. Additionally, your other dependent child or children who were eligible but were not previously enrolled also may enroll during this special enrollment period.

The request for a change in coverage must be made within 31 days of the special enrollment event, subject to the following exceptions:

- If the event is reaching a lifetime limit on benefits under another group dental plan, then the request must be made within 31 days of the date a claim is denied under the other group dental plan due to the operation of a lifetime limit on all benefits, or
- If the event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premium assistance subsidy for the Medical Plan under Medicaid or the state child health plan, then the request for a change in coverage must be made within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Generally, your new coverage takes effect on the first day of the month following the later of the date the election change is completed or the date the triggering event occurs. If the event is the birth or adoption of a child (including placement of a child for adoption), however, the election change shall take effect on the date of the birth or adoption (or placement for adoption).

Change in Status

Any change in coverage must be consistent with the qualifying event. An eligible qualifying event involves the following:

- Legal marital status – any event that changes your legal marital status, including marriage, death of a spouse, divorce, or annulment.

- Number of dependents – any event that changes the number of your dependents, including birth, legal guardianship, adoption, placement for adoption, divorce or death of a dependent.
- Employment status and work schedule – any event in which employment begins or ends for you or your eligible dependent; the gain or loss of eligibility due to a change in full-time to part-time status or vice versa.
- Dependent status – any event that causes your eligible dependent to satisfy or cease to satisfy eligibility requirements due to age, student status, or similar circumstances.
- Residence or worksite – any event that where you or your eligible dependent transfer place of residence or work site that creates a change in your health plan coverage. (Example – Banner Choice Plus is not offered in all Banner Communities.)

Enrollment must be completed no later than 31 days from the date of the qualifying event. Your election will take effect on the first day of the month following the later of the date the election change is completed or the date the triggering event occurs.

Any change in your elections due to a qualifying event must be consistent with your qualifying event effective date. A change in your elections is necessary if the qualifying event causes a loss of eligibility under another plan. For example, if your spouse loses his or her job, you may add your spouse to your coverage.

Significant Cost or Coverage Change

You may also change your coverage election under the Health Plans midyear if:

- The cost of your current coverage option significantly increases or significantly decreases
- An event occurs that significantly curtails coverage or causes you to lose coverage under your current coverage option
- A coverage option is added or is significantly improved under the Health Plan during the year, and you are eligible for such option
- You, your spouse/domestic partner, or your eligible dependent loses coverage under any group medical coverage sponsored by a governmental or educational institution, or
- The change corresponds with a change made by you or your dependent under another employer's plan in the following circumstances:
 - If the annual enrollment period under the other plan occurs at a different time of year than annual enrollment under the plan, or
 - If the other employer's plan allows you or your dependent to change elections due to the reasons described in this section (special enrollment, change in status, significant cost or coverage changes, and QMCSO).

The request for a change in coverage must be made within 31 days of the significant cost or coverage change. Your election will take effect on the first day of the month following the later of the date the election change is completed or the date the triggering event occurs.

Medicare or Medicaid Entitlement

If you or your spouse, domestic partner or dependent enroll in or lose coverage under Medicare (Part A or B) or Medicaid, you may change your medical coverage election under the Medical Plan accordingly. The request for a change in coverage must be made within 31 days of the change in your Medicare or Medicaid coverage. Your election takes effect on the first day of the month following the date your Medicare or Medicaid coverage change takes effect.

Qualified Medical Child Support Orders

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders from a state court or state administrative agency requiring a partner to provide medical support to a child, for example, in cases of legal separation or divorce.

A QMCSO may require a Health Plan to make coverage available for your child even though, for income tax or plan purposes, the child is not your dependent due to divorce or legal separation. In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your last known name and address, and the child's name and last known address,
- Provides a reasonable description of the type of coverage to be provided by the plan, or the manner in which the type of coverage is to be determined,
- States the period to which it applies, and
- Specifies each plan to which it applies.

A QMCSO may not require the Health Plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Health Plan. Upon approval of a QMCSO the Health Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order, to the extent it is consistent with the terms of the Health Plan. A child's coverage under a QMCSO will take effect on the later of the date provided in the QMCSO, or the first day of the month following the date the Plan Administrator approves the QMCSO.

You and the affected child will be notified if an order is received and will be provided with a copy of Banner Health's QMCSO procedures. A child covered under the Health Plan pursuant to a QMCSO will be treated as an eligible dependent under the Health Plan. You may request a free copy of Banner Health's QMCSO procedures from the Service Center at Banner Plan Administration.

Contributions for Coverage

You and Banner share the cost for the Health Plans. The cost for coverage depends on the Medical Plan, Prescription Drug Plan and/or Dental Plan coverage options you choose under the Health Plans and the eligible dependents you choose to cover. The price sheets show the costs for coverage. Your coverage cost is collected over the calendar year through regular deductions from your paycheck. The deductions are collected on a pre-tax basis, unless coverage is elected for a domestic partner or other non-tax qualified dependent child. The cost of coverage is subject to change from year to year. The amount of participant contributions required for each plan year is determined in advance by Banner and communicated to participants. The amount of participant contributions remain set for the plan year and any additional costs necessary to support benefits under the Health Plans are paid by Banner from its general assets. Benefits under the Health Plans are paid first from the aggregate contributions of participants, and Banner pays the remaining cost of benefits provided under the Health Plans.

<p>Non-Tobacco User Discount: A discounted rate is available to employees who certify that they and their covered dependents do not use tobacco products in any form. You may change the selection any time during the year. The change will be effective the first of the following month. You may contact The Service Center at BPA to apply for a waiver to comply with HIPAA nondiscrimination rules.</p>
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Termination of Coverage

Your coverage shall automatically terminate on the earliest of the following dates:

- the last day of the month in which you terminate employment,
- the last day of the month in which employment classification changes to an ineligible position,
- the last day of the month you elect to be terminated from the Health Plan,
- the last day of the month required contributions cease,
- the date of your death,
- the effective date of a Health Plan amendment that eliminates your coverage, or
- the date the Health Plan is terminated.

Your spouse/domestic partner and dependent coverage shall terminate on the earliest of the following dates:

- the same date your coverage terminates,
- the last day of the month your dependent or spouse/domestic partner ceases to meet the eligibility requirements of the Health Plan,
- the last day of the month in which any required contributions cease to be paid, or
- the effective date of a Health Plan amendment that eliminates their coverage.

Any member, who repeatedly fails to follow his or her medical treatment regimen/medical recommendations (medically non-compliant) or commits fraud, may be terminated from the Health Plans with no rights under COBRA. Each occurrence of member non-compliance will be documented. A warning letter regarding the potential for termination, along with appeal rights will be sent to the member via certified mail with a copy placed in the member's record.

Banner Health Employee Medical Plans

Medical Plan Options

The Banner Medical Plan offers you a number of options from which to choose:

- Banner Choice Plus
- Banner Select \$500
- Banner Select \$250

A detailed list of providers in each of the networks described can be located on www.bannerhealthplans.com and select “I am a member.” The “Find a Medical Provider” is in the menu selection on the left-hand of the window.

You can also call the Service Center at Banner Plan Administration at 1-888-827-2464 or 480-684-7070 in the Phoenix-metropolitan area who can assist with finding a contracted provider. The features of each Medical Plan option are described separately below.

Banner Choice Plus

Your enrollment in Banner Choice Plus allows you access to all three provider networks at any time. Each provider network, however, has a different arrangement for sharing costs. Your choice will determine the amount of out-of-pocket expenses you pay, if any.

Choice Plus Networks:

- **Banner Option** – is an innovative way to deliver health care. Selected health care providers are available to meet your medical needs on the most cost-effective basis. Many services are provided at no cost to you or require only a small copayment.
- **PPO Option** - is a network of selected healthcare providers to meet your medical needs on a cost-effective basis. You may see healthcare providers participating in the PPO Option on a cost-sharing basis. Copayments, deductibles and co-insurance apply.
- **Indemnity Option** - allows you to see any health care provider and share a larger portion of the costs, as you would under a traditional health plan. Copayments, deductibles and co-insurance apply and are higher than those in the PPO Option.

Remember, you choose from the three provider networks each time you receive health care services. You may have your care provided by or arranged through your Primary Care Physician (PCP), whom you select from our list of qualified professionals at enrollment, to minimize your out-of-pocket costs, or you may wish to see other providers for treatment. You can use whichever option you feel is appropriate at any time.

Banner Option

The Banner Option has several important features:

- You have a continuing relationship with the physician of your choice for most of your health care needs.
- Your medical expenses are automatically paid – there are no claims to file.
- There are minimal out-of-pocket costs after you make your payroll contributions. There is no deductible to meet, only copayments.
- Many preventive benefits are covered under the Banner Option.

The Banner Option is staffed by a carefully selected group of providers who are committed to providing quality care at an affordable price. The providers have agreed to be paid directly by Banner Choice Plus at a special rate. As a result, both your costs and Banner Health's costs are lower than they would be under a traditional health care plan.

Using the Banner Option

To use the Banner Option:

- You must select a Primary Care Physician (PCP) from our list of family practitioners, internists, and pediatricians. Each family member may select a different PCP. If you do not select a PCP at the time of enrollment, the Medical Plan will select a PCP for you and each one of your covered dependents.
- Call your PCP whenever you need medical care.
- Let your PCP handle all your routine medical needs and coordinate any services you may need. Some services require prior authorization.

You may change your PCP within the physician network you have chosen at any time by contacting The Service Center at Banner Plan Administration at 800-827-2464 or 480-684-7070 in the Phoenix Metro area. The change is effective the date you contact the Service Center. Within a short period of time, you will receive verification of the change and a new identification card.

Preventive Care

Many preventive care services are covered in the Banner Option. So, if you and your dependents go to your PCP for routine physicals, well baby care, and routine injections and immunizations, you will receive these services for only \$15 per office visit. An annual Well Woman examination is covered with a \$15 copayment and includes a breast examination, Pap smear and an order for a screening mammogram if appropriate for your age and/or medical history. Routine lab tests such as hemoglobin, cholesterol, or any other ancillary services such as x-rays or follow-up visits are only covered as routine preventive care and not as a part of the annual Well Woman examination.

By providing preventive care before you get sick, Banner Choice Plus will help you stay in good health. That way, you decrease your chances of developing a serious and debilitating illness.

Hospital Care

If you or a covered dependent needs hospital care, your Banner Option provider will arrange for your hospital admission. When appropriate, you will be admitted to a Banner Choice Plus healthcare facility. If the hospitalization is for a special procedure or condition not treatable at a Banner Choice Plus facility, the Plan Administrator will determine the most appropriate facility, and you will still receive Banner Option benefits.

Emergencies

You are covered for medical emergencies wherever they occur, even if you are away from Banner Option providers. The term "medical emergency" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) and in the absence of immediate medical attention could result in:

- placing the health of the member in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or body part.

For medical emergencies, the Medical Plan will pay 100% of eligible expenses after a \$140 copayment at any Banner Option hospital facility, \$345 copayment at all other facilities. (Waived if admitted as inpatient.)

The Cost of Services

In addition to your payroll contribution, you will usually only need to pay a copayment for services in the Banner Option. There is no deductible to meet, and there is no out-of-pocket maximum limit.

Filing Claims for Benefits

There are no claims to file when you use the Banner Option.

PPO Option

PPO Option includes selected healthcare providers to meet your medical needs on a cost-effective basis.

Using the PPO

You will be eligible for PPO Option benefits for covered expenses when you receive treatment from a PPO Option provider without a referral from your PCP.

Preventive Care

Preventive care benefits are not covered under the PPO Option benefit except for an annual Well Woman examination including a breast examination, Pap smear and an order for a screening mammogram if appropriate for your age and/or medical history for a \$15 copayment. Screening lab tests such as hemoglobin or cholesterol are covered as routine preventive care under the Banner Option of your Medical Plan only and are not a part of the annual Well Woman examination.

Hospital Care

If you are planning a non-emergent, elective hospital stay under the care of a PPO Option provider, you must pre-certify your stay with the Claims Administrator. To do so, call 800-827-2464 or 480-684-7070 in the Phoenix-metropolitan area at least seven days in advance of your intended admission date. If your stay is properly pre-certified, the Medical Plan will pay 80% of eligible expenses after your medical deductible has been met. There are no deductibles for Mental Health/Substance Abuse benefits under the PPO Option. **If you don't get pre-certification, you will be responsible for a \$250 penalty and 100% of any charges not authorized on a retrospective review by the Claims Administrator.** This is in addition to your deductible and copayments. You or your physician will need to pre-certify elective inpatient admissions and some outpatient surgeries and procedures. Services that require pre-certification are listed in the "Hospital and Outpatient Review/Pre-Certification" section of this document.

Emergencies

You are covered for medical emergencies wherever they occur. The term "medical emergency" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) and in the absence of immediate medical attention could result in:

- placing the health of the member in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or body part.

For medical emergencies, the Medical Plan will pay 100% of eligible expenses after a \$140 copayment at any Banner Option facility, \$345 copayment at all other facilities. (Waived if admitted as inpatient.) If you use the emergency room for non-emergency care you will be responsible for 100% of any charges.

The Cost of Services

In addition to your payroll deduction premium contributions, you are responsible for sharing the cost of services through a deductible and copayments. After you pay the medical deductible (\$250 for

employee only and \$500 for employee plus spouse, employee plus child (ren) or employee plus family) and the \$30 office visit copay, if applicable, the Medical Plan pays 80% of allowable expenses.

Filing Claims for Benefits

You may have to file your own claims. To file a claim, see instructions on the claim form available at www.BannerBenefits.com. Reimbursement for allowable expenses will be sent to the Member only if they do not sign it over to the provider. See **Filing a Claim**.

Indemnity Option

As mentioned earlier, you are free to see any provider with Banner Choice Plus. However, Indemnity Option benefits are subject to deductibles and copayments that are higher than those under the PPO Option. The Indemnity Option works like a traditional health care plan. You select your providers, you pay your providers, and you are reimbursed for any allowable expenses after filing a claim, unless your provider submits the claim on your behalf.

Using the Indemnity Option

You are eligible for Indemnity Option benefits for covered expenses when you receive treatment from any provider not included in the Banner Option and the PPO Option provider networks.

Preventive Care

Preventive care benefits are not covered under Indemnity Option except for an annual Well Woman examination including a breast examination, Pap smear and an order for a screening mammogram if appropriate for your age and/or medical history for a \$15 copayment. Screening lab tests such as hemoglobin or cholesterol are covered as routine preventive care under the Banner Option of your Medical Plan only and are not a part of the annual Well Woman Examination.

Hospital Care

If you are planning a non-emergent elective hospitalization in a facility outside of the Banner Option or PPO Option provider networks, you must pre-certify your stay with the Claims Administrator. To do so, call 800-827-2464 or 480-684-7070 in the Phoenix Metro area at least seven days in advance of your intended admission date. If your stay is properly pre-certified, the Medical Plan will pay 60% of eligible expenses after your deductible has been met. **If you don't get pre-certification, you will be responsible for a \$250 penalty in addition to the deductible and 100% of any charges not authorized on a retrospective review by the Claims Administrator.** This is in addition to your deductible and copayments. You or your physician will need to pre-certify elective inpatient admissions, some outpatient surgeries procedures. Services that require pre-certification are listed in the "Hospital and Outpatient Review/Pre-Certification" section of this document.

Emergencies

You are covered for medical emergencies wherever they occur. The term "medical emergency" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) and in the absence of immediate medical attention could result in:

- placing the health of the member in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or body part.

For medical emergencies, the Medical Plan will pay 100% of eligible expenses after a \$140 copayment at any Banner Option facility, \$345 copayment at all other facilities. (Waived if admitted as inpatient.) If you use the emergency room for non-emergency care you will be responsible for 100% of any charges.

The Cost of Services

In addition to your payroll deduction premium contributions, after you pay the deductible (\$750 for employee only and \$1,500 for employee plus spouse, employee plus child (ren) or employee plus family, the Medical Plan pays 60% of allowable expenses.

Filing Claims for Benefits

You may have to file your own claims. To file a claim, see instructions on the claim form available at www.BannerBenefits.com. See **Filing a Claim**.

2011 Benefit Chart - Banner Choice Plus

	BANNER OPTION	PPO OPTION	INDEMNITY OPTION*
Use of Providers	You select a Primary Care Physician (PCP), who coordinates all care within this option.	You select a provider from the list of participating PPO Option providers. Your PCP is not involved.	Benefits are paid when you see a provider not in the Banner Option or the PPO Option provider networks.
Annual Deductible	No deductible.	\$250 Employee Only \$500 Family (2 or more)	\$750 Employee Only \$1,500 Family (2 or more)
Out-of-Pocket Maximums	None.	\$2000 Single \$5000 Family (2 or more)	\$5000 Single \$10,000 Family (2 or more)
Allergy Injections and Serum	Plan pays 100% for injections; serum covered with 50% copay.	After deductible is met, Plan pays 80% for injections; 50% for serum.	After deductible is met, Plan pays 60% of allowed charge for injections; 50% of allowed charge for serum.
Complementary Medicine Includes ECHO nutrition counseling, acupuncture, chiropractic and naturopathic services	\$30 copay up to \$750 annual maximum.	<i>(Deductible waived)</i> \$30 copay up to \$750 annual maximum.	<i>(Deductible waived)</i> \$30 copay up to \$750 annual maximum.
Diabetic Education	Plan pays 100% at Banner Option facility.	After deductible is met, Plan pays 80% up to \$500.	After deductible is met, Plan pays 60% of allowed charge up to \$500.
Emergency Room Visits (Including professional fees.)	<i>(Deductible waived)</i> Plan pays 100% after \$140 copay at a Banner facility, \$345 at all other facilities. If admitted to hospital, copay is waived.	<i>(Deductible waived)</i> Plan pays 100% after \$345 copay. If admitted to hospital, copay is waived.	<i>(Deductible waived)</i> Plan pays 100% after \$345 copay. If admitted to hospital, copay is waived.
Home Health Care Visits or Durable Medical Equipment (See the Section Covered Medical Expenses)	Plan pays 100% at Banner participating providers.	<i>Not Covered.</i>	<i>Not Covered.</i>
Hospice	Plan pays 100%.	After deductible is met, Plan pays 80%.	After deductible is met, Plan pays 60% of allowed charge.
Hospitalization (Applies to outpatient surgery at a hospital or surgi-center) Pre-Certification required for certain outpatient procedures or surgeries.	Plan pays 100% after \$125 copay per admission at a Banner hospital facility or \$300 at all other facilities.	After deductible is met; ~ Plan pays 80% at Banner Hospitals; 70% at a designated hospital.	After deductible is met, Plan pays 60% of allowed charge. (pre-certification is required)
Infertility Coverage	Infertility diagnostic work-up and treatments covered at 50% of allowed charges*. Banner pays up to \$5000 lifetime maximum at designated Banner providers. No coverage allowed for services provided by non-designated providers.	<i>Not Covered</i>	<i>Not Covered</i>

	BANNER OPTION	PPO OPTION	INDEMNITY OPTION*
In-Hospital Physician Visits	Plan pays 100%.	After deductible is met, Plan pays 80%.	After deductible is met, Plan pays 60% of allowed charge.
IV Infusion	Plan pays 100% at Banner participating providers.	<i>Not Covered.</i>	<i>Not Covered.</i>
Lab and X-Ray	Plan pays 100% after \$15/visit copay at Banner Option participating providers. \$50 copay for CT, MRI, or PET Scan. Pre-certification is not required.	After deductible is met, Plan pays 80% at a participating facility. Some procedures require pre-certification.	After deductible is met, Plan pays 60% of allowed charge. Some procedures require pre-certification.
Maternity Care ~ Prenatal Care ~ Provider Delivery ~ Room and Board for Mother and Baby	~ In office prenatal care; Plan pays 100% ~ Plan pays 100%. ~ Plan pays 100% after \$125 copay.	<i>(Deductible Waived)</i> ~ In office prenatal care; Plan pays 80% ~ Plan Pays 80% After deductible is met; ~ Plan pays 80% at Banner Hospitals; 70% at a designated hospital.	After deductible is met, Plan pays: ~ In office prenatal care; Plan pays 60% of allowed charge ~ 60% of allowed charge. ~ 60% of allowed charge.
Mental Health – Inpatient Services and Substance Abuse Treatment	Plan pays 100% after \$125 copay per admission at a Banner hospital facility or CIGNA network providers.	<i>(Deductible Waived).</i> Plan pays 100% after \$125 copay per admission at a Banner hospital facility or CIGNA network providers.	After deductible is met, Plan pays 60% of allowed charge.
Substance Abuse Treatment-Intensive Outpatient Program	Plan pays 100% after \$10 copay per visit at CIGNA network providers.	<i>(Deductible Waived).</i> Plan pays 100% after \$10 copay per visit at CIGNA network providers.	After deductible is met Plan pays 60% of allowed charge.
Mental Health – Outpatient Services	Plan pays 100% after \$15 office visit copay at CIGNA network providers.	<i>(Deductible Waived).</i> Plan pays 100% after \$15 copay per visit at CIGNA network providers.	After deductible is met, Plan pays 60% of allowed charge.
Surgery for Morbid Obesity – 24 month waiting period	Plan pays 100% after \$5000 copay at a Banner facility. Copay applied to hospital services only. Must be pre-certified by Plan.	<i>Not Covered.</i>	<i>Not Covered.</i>
Office Visits	Plan pays 100% after \$15 office visit copay for PCP visit; \$30/visit copay for specialist visit. Referral to specialist must be arranged by your PCP.	After deductible is met, \$30/visit copay.	After deductible is met, Plan pays 60% of allowed charge.
Outpatient Therapy - Physical, Occupational and Speech Therapy (No copay, deductible or coinsurance for inpatient therapy services)	Covered in full after \$10/visit copay for up to 30 visits per therapy type per calendar year.	After deductible is met, Plan pays 80% for up to 30 visits per therapy type per calendar year.	After deductible is met, Plan pays 60% of allowed charge for up to 30 per therapy type per calendar year.
Pre-Certifying Your Hospital Stay (Without pre-	Your Banner Option provider will pre-certify your stay.	Pre-certification is required.	Pre-certification is required.

	BANNER OPTION	PPO OPTION	INDEMNITY OPTION*
certification, a \$250 penalty will be applied)			
Preventive & Routine Care (Includes Well Woman Exam)	Well Woman examination Plan pays 100% after \$15 copay. Other preventive & routine care covered with appropriate copay.	<i>Not covered</i> , except for Well Woman examination. Well woman exam covered after \$15 copay.	<i>Not covered</i> , except for Well Woman examination. Well woman exam covered after \$15 copay.
Skilled Nursing Facility	Plan pays 100% for 90 days per calendar year. Custodial care not covered.	After deductible is met, Plan pays 80% for up to 90 days per calendar year after hospitalization. Custodial care not covered.	After deductible is met, Plan pays 60% of allowed charge for up to 90-days per calendar year after hospitalization. Custodial care not covered.
Surgical Services ~ Surgeon ~ Assistant Surgeon ~ Anesthesiologist ~ Tubal Ligation ~ Vasectomy	~ Plan pays 100%. ~ Plan pays 100%. ~ Plan pays 100%. ~ Plan pays 100% after \$200 copay. ~ Plan pays 100% after \$100 copay.	After deductible is met: ~ Plan pays 80%. ~ Plan pays 80%. ~ Plan pays 80%. ~ Plan pays 80% after \$200 copay. ~ Plan pays 80% after \$100 copay.	After deductible is met , ~ Plan pays 60% of allowed charge. ~ Plan pays 60 of allowed charge. ~ Plan pays 60% of allowed charge. ~ Plan pays 60% of allowed charge after \$200 copay. ~ Plan pays 60% of allowed charge after \$100 copay.
Urgent Care	Plan pays 100% after \$40 copay at a Banner Option provider.	<i>(Deductible waived)</i> Plan pays 100% after \$80 copay.	<i>(Deductible waived)</i> Plan pays 100% of allowed charge after \$80 copay.
Transplant Coverage	See Managed Transplant Services Certificate of Coverage at www.BannerBenefit.com		

*The Medical Plan provides coverage up to the “allowed charge” for eligible expenses, based on the Claims Administrator’s Allowed Charge Schedule. The member is responsible for the applicable coinsurance plus any amount above the allowed charge when care is received from a non-participating provider.

Banner Health Employee Select Medical Plans

With the Banner Select Plans, you can choose the Medical Plan option that best meets your and your family's needs:

- Banner Select \$ 500; or
- Banner Select \$ 250

You choose the Medical Plan option by the amount of first dollar coverage and Out-of-Pocket maximum that best works for you.

You have the option of selecting providers from The In-Network Option or Non-Network Option. Your enrollment in the Banner Select Plans allows you access to both options at any time. Each, however, has a different arrangement for sharing costs. Your choice will determine the amount of out-of-pocket expenses you pay.

In-Network Option

In-Network Option includes Banner facilities and selected healthcare providers to meet your medical needs on a cost-effective basis.

First Dollar Coverage

First dollar coverage is when you receive coverage up front and you only have a small copayment for certain services. With first dollar coverage, Banner Select Plans will pay up to \$250 or \$500 for each covered individual before you have to meet any deductible under the Medical Plan. After your first dollar coverage is met, services are applied to your annual deductible and co-insurance amounts. Basically, Banner Select Plans will pay the first \$250 or \$500 of your medical claims for each covered individual, before services are applied to your deductible.

When the first dollar coverage has been reached, and you meet your individual or family deductible all additional expenses will be applied to the regular Schedule of Benefits.

Hospital Care

If you are planning non-emergency, elective hospitalization, you must pre-certify your stay with the Claims Administrator. To do so, call 800-827-2464 at least seven days in advance of your intended admission date. If your stay is properly pre-certified, the Medical Plan will pay 90% of eligible expenses after your first dollar coverage and deductible have been met if you are hospitalized at a Banner facility. If you are hospitalized at a non-Banner facility, the Medical Plan will pay 80% of eligible expenses after your first dollar coverage and deductible have been met.

If you don't get pre-certification, the Medical Plan will pay 50% of eligible expenses after your deductible has been met. You or your physician will need to pre-certify elective inpatient admissions, and some outpatient surgeries procedures. Services that require pre-certification are listed in the **"Hospital and Outpatient Review/Pre-Certification"** section of this document.

Emergencies

You are covered for medical emergencies wherever they occur. The term "medical emergency" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) and the absence of immediate medical attention could result in:

- placing the health of the member in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

For medical emergencies, the Medical Plan will pay 100% of eligible emergency room expenses after a \$140 copayment at any Banner facility, \$345 copayment at all other facilities (waived if admitted). If you use the emergency room for non-emergency care you will be responsible for 100% of any charges.

If you are hospitalized as a result of an emergency, the Medical Plan will pay 90% at a Banner facility or 80% at all other facilities of eligible expenses after your first dollar coverage and deductible have been met.

The Cost of Services

In addition to your payroll deduction premium contributions, after you pay the deductible (\$250 for employee only and \$500 for employee plus spouse, employee plus child (ren) or employee plus family), the Medical Plan pays 80% of allowable expenses, 90% of allowable expenses if services are performed at a Banner facility.

Filing Claims for Benefits

You may have to file your own claims. To file a claim, see instructions on the claim form available at www.BannerBenefits.com. See **Filing a Claim**.

Non-Network Option

In the Non-Network Option, you are free to see any provider at all with Banner Select \$500/\$250. However, services at the Non-Network Option are subject to deductibles and copayments that are higher than those in the In-Network Option. The Non-Network Option works like a traditional health care plan. You select your providers, you pay your providers, and you are reimbursed for any allowable expenses after filing a claim. First Dollar Coverage is not available under the Non-Network Option.

Using the Non-Network Option

You are eligible for Non-Network Option benefits for covered expenses when you receive treatment from any provider not included in the In-Network Option of Banner Select Medical Plans.

Hospital Care

If you are planning non-emergency hospitalization outside of a Banner facility or a Banner participating provider, you must pre-certify your stay with the Claims Administrator. To do so, call 800-827-2464 at least seven days in advance of your intended admission date. If your stay is properly pre-certified, the Medical Plan will pay 50% of eligible expenses after your deductible has been met. If you don't get pre-certification, you will be responsible for a \$250 penalty in addition to the deductible and 100% of any charges not authorized on a retroactive review by the Claims Administrator. This is in addition to your deductible and copayments. You or your physician will need to pre-certify elective inpatient admissions, outpatient surgeries and certain outpatient procedures. Services that require pre-certification are listed in the "Hospital and Outpatient Review/Pre-Certification" section of this document.

Emergencies

You are covered for medical emergencies wherever they occur. The term "medical emergency" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) and the absence of immediate medical attention could result in:

- placing the health of the member in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or body part.

For medical emergencies, the Medical Plan will pay 100% of eligible expenses after a \$345 copayment at any non-Banner facility. If you are admitted to a hospital for a medical emergency, the Medical Plan will waive the copayment. If you use the emergency room for non-emergency care you will be responsible for 100% of any charges.

The Cost of Services

In addition to your payroll deduction premium contributions, after you pay the deductible (\$500 for employee only and \$1000 for employee plus spouse, employee plus child or children or employee plus family, the Medical Plan pays 50% of allowable expenses.

Filing Claims for Benefits

To file a claim for Non-Network Option benefits, see instructions on the claim form available at www.BannerBenefits.com. Reimbursement for allowable expenses will be sent to the Member only if they do not sign it over to the provider. See **Filing a Claim**.

2011 Benefit Chart – Banner Select \$500

*The Medical Plan provides coverage up to the “allowed charge” for eligible expenses, based on the Claims Administrator’s Allowed Charge Schedule. The member is responsible for the applicable co-insurance plus any amount above the allowed charge when care is received from a non-participating provider

	IN NETWORK COVERAGE*	NON-NETWORK COVERAGE*
How the Plan Works	Once Plan pays \$500, deductible and co-insurance apply.	Annual deductible and co-insurance apply.
Choice of Providers	Your choice of any participating provider	Your choice of any provider
First Dollar Coverage	Plan pays first \$500 of allowable medical expenses for each covered individual	Not available
Annual Deductible	\$500 Individual Only \$1000 Family	\$1000 Individual Only \$2000 Family
Out-of-Pocket Maximums	\$1,500 Individual Only \$3000 Family	\$7,500 Individual Only \$15,000 Family
Allergy Injections and Serum	After Plan pays \$500, and deductible is met, Plan pays 70% for injections; 50% for serum.	After deductible is met, Plan pays 50% of allowed charge.
Complementary Medicine Includes ECHO nutrition counseling, acupuncture, chiropractic and naturopathic services.	<i>(Deductible Waived)</i> \$30 Copay per visit up to \$750 maximum.	<i>(Deductible Waived)</i> \$30 Copay per visit up to \$750 maximum.
Diabetic Education	After Plan pays \$500, and deductible is met, Plan pays 70%.	After deductible is met, Plan pays 50% of allowed charge.
Emergency Care (Including professional fees)	<i>(Deductible Waived)</i> Plan pays 100% after \$140 copay at a Banner facility (\$345 at all other facilities). If admitted to hospital, copay is waived. <i>First-dollar does not apply.</i>	<i>(Deductible Waived)</i> Plan pays 100% after \$345 copay. If admitted to hospital, copay is waived.
Home Health Care Visits, Durable Medical Equipment (See the Section Covered Medical Expenses)	After Plan pays \$500, and deductible is met, ~ Plan pays 90% at a Banner provider ~ Plan pays 70% at a participating provider	<i>Not Covered</i>
Hospice	After Plan pays \$500, and deductible is met, Plan pays 70%.	After deductible is met, Plan pays 50% of allowed charge.

	IN NETWORK COVERAGE*	NON-NETWORK COVERAGE*
Hospitalization (Also applies to outpatient surgery at a hospital or surgical center.) Certain outpatient procedures and surgeries require pre-certification.	After deductible, Plan pays: ~ 90% at a Banner facility, 50% without pre-certification. ~ 70% at a Banner participating provider, 50% without pre-certification.	After deductible, Plan pays: ~ 50% of allowed charge.
Infertility Coverage	After Plan pays \$500, and deductible is met, infertility diagnostic work up and treatments covered at 50% of allowed charges. Banner pays up to a \$ 5000 lifetime maximum at designated Banner providers. No coverage allowed for services provided by non-designated providers.	<i>Not Covered</i>
In-Hospital Physician Visits	After Plan pays \$500, and deductible is met, Plan pays 70%.	After deductible, Plan pays at 50% of allowed charge.
IV Infusion	After Plan pays \$500, and deductible is met, ~ Plan pays 90% at a Banner facility; ~ Plan pays 70% at a Banner participating provider	<i>Not Covered</i>
Lab and X-ray (Some procedures require pre-certification.)	After Plan pays \$500, and deductible is met, ~ Plan pays 90% at a Banner facility ~ Plan pay 70% at a Banner participating provider	After deductible, Plan pays ~ 50 % of allowed charge
Maternity Care ~ Prenatal Care ~ Provider Delivery ~ Room and Board for Mother and Baby	<i>(Deductible Waived for prenatal and provider delivery)</i> ~ In office prenatal care covered at 100% ~ Provider delivery covered at 100% After Plan pays \$500 and deductible is met, ~ Room and board for mother and baby paid at; ~ 90% at a Banner Hospitals ~ 70% at all other facilities	After deductible, Plan pays 50% of allowed charge.
Mental Health – Inpatient Services and Substance Abuse Treatment	After Plan pays \$500 and deductible is met, Plan pays: ~ 90% at a Banner facility ~ 70% at CIGNA network facilities	After deductible is met, Plan pays 50% of allowed charge.

	IN NETWORK COVERAGE*	NON-NETWORK COVERAGE*
Mental Health – Outpatient Services and Substance Abuse Treatment	After Plan pays \$500 and deductible is met, Plan pays at 70% at CIGNA network providers.	After deductible is met, Plan pays 50% of allowed charge.
Office Visits	After Plan pays \$500, and deductible is met, Plan pays at 70%.	After deductible, Plan pays 50% of allowed charge.
Outpatient Therapy - Physical, Occupational and Speech Therapy (No deductible or co-insurance for inpatient therapy services)	After Plan pays \$500, and deductible is met, Plan pays 70% up to 30 visits per therapy type per calendar year at a Banner participating provider.	After deductible is met, Plan pays 50% of allowed charge up to 30 visits per therapy type per calendar year.
Preventive and Routine Care – (Includes Well Woman Exam)	After Plan pays \$500, and deductible is met, covered at 70%.	After deductible, Plan pays 50% of allowed charge.
Skilled Nursing Facility	After Plan pays \$500, and deductible is met, Plan pays: ~ 90% at a Banner facility for up to 90-days per calendar year. ~ 70% at a Banner participating provider for up to 90-days per calendar year. Custodial care not covered.	After deductible is met, Plan pays: 50% of allowed charge for up to 90-days per calendar year. Custodial care not covered.
Surgery for Morbid Obesity (First Dollar Coverage will not be applied.)	Covered at 100% after \$5000 copay at a Banner facility. Copay applied to hospital services only. Must be pre-approved by Plan.	<i>Not covered.</i>
Surgical Services Surgeon Assistant Surgeon Anesthesiologist Tubal Ligation Vasectomy	After Plan pays \$500 and deductible is met, Plan pays: ~ 70% ~ 70% ~ 70% ~ 70% ~ 70%	After deductible is met, Plan pays 50% of allowed charge.
Urgent Care	<i>(Deductible Waived)</i> Plan pays 100% after \$40 copay. <i>First-dollar does not apply</i>	<i>(Deductible Waived)</i> Plan pays 100% of allowed charge after \$80 copay
Transplant Coverage	See Managed Transplant Services Certificate of Coverage at www.BannerBenefit.com	

*The Medical Plan provides coverage up to the “allowed charge” for eligible expenses, based on the Claims Administrator’s Allowed Charge Schedule. The member is responsible for the applicable co-insurance plus any amount above the allowed charge when care is received from a non-participating provider.

2011 Benefit Chart – Banner Select \$250

	IN NETWORK COVERAGE*	NON-NETWORK COVERAGE*
How the Plan Works	Once Plan pays \$250, deductible and co-insurance apply.	Annual deductible and co-insurance apply.
Choice of Providers	Your choice of any participating provider	Your choice of any provider
First Dollar Coverage	Plan pays first \$250 of allowable medical expenses for each covered individual	Not available
Annual Deductible	\$250 Individual Only \$750 Family	\$ 500 Individual Only \$1500 Family
Out-of-Pocket Maximums	\$2,000 Individual Only \$6,000 Family	\$10,000 Individual Only \$30,000 Family
Allergy Injections and Serum	After Plan pays \$250, and deductible is met, Plan pays 75% for injections; 50% for serum.	After deductible is met, Plan pays 50% of allowed charge.
Complementary Medicine Includes ECHO nutrition counseling, acupuncture, chiropractic and naturopathic services.	<i>(Deductible Waived)</i> \$30 Copay per visit up to \$750 maximum.	<i>(Deductible Waived)</i> \$30 Copay per visit up to \$750 maximum.
Diabetic Education	After Plan pays \$250, and deductible is met, Plan pays 75%.	After deductible is met, Plan pays 50% of allowed charge.
Emergency Care (Including professional fees)	<i>(Deductible Waived)</i> Plan pays 100% after \$140 copay at a Banner facility (\$345 at all other facilities). If admitted to hospital, copay is waived. <i>First-dollar does not apply.</i>	<i>(Deductible Waived)</i> Plan pays 100% after \$345 copay. If admitted to hospital, copay is waived.
Home Health Care Visits, Durable Medical Equipment (See the Section Covered Medical Expenses)	After Plan pays \$250, and deductible is met, ~ Plan pays 90% at a Banner provider ~ Plan pays 75% at a participating provider	<i>Not Covered</i>
Hospice	After Plan pays \$250, and deductible is met, Plan pays 75%.	After deductible is met, Plan pays 50% of allowed charge.
Hospitalization (Also applies to outpatient surgery at a hospital or surgi-center.)	After deductible, Plan pays: ~ 90% at a Banner facility, 50% without pre-certification. ~ 75% at a Banner participating provider, 50% without pre-certification.	After deductible, Plan pays: ~ 50% of allowed charge.
Certain outpatient		

procedures and surgeries require pre-certification.		
Infertility Coverage	After Plan pays \$250, and deductible is met, infertility diagnostic work up and treatments covered at 50% of allowed charges. Banner pays up to a \$ 5,000 lifetime maximum at designated Banner providers. No coverage allowed for services provided by non-designated providers.	<i>Not Covered</i>
In-Hospital Physician Visits	After Plan pays \$250, and deductible is met, Plan pays 75%.	After deductible, Plan pays at 50% of allowed charge.
IV Infusion	After Plan pays \$250, and deductible is met, ~ Plan pays 90% at a Banner facility; ~ Plan pays 75% at a Banner participating provider	<i>Not Covered</i>
Lab and X-ray (Some procedures require pre-certification.)	After Plan pays \$250, and deductible is met, ~ Plan pays 90% at a Banner facility ~ Plan pay 75% at a Banner participating provider	After deductible, Plan pays ~ 50 % of allowed charge
Maternity Care ~ Prenatal Care ~ Provider Delivery ~ Room and Board for Mother and Baby	<i>(Deductible Waived for prenatal and provider delivery)</i> ~ In office prenatal care covered at 100% ~ Provider delivery covered at 100% After Plan pays \$250 and deductible is met, ~ Room and board for mother and baby paid at; ~ 90% at a Banner Hospitals ~ 75% at all other facilities	After deductible, Plan pays 50% of allowed charge.
Mental Health – Inpatient Services and Substance Abuse Treatment	After Plan pays \$250 and deductible is met, Plan pays: ~ 90% at a Banner facility ~ 75% at CIGNA network facilities	After deductible is met, Plan pays 50% of allowed charge.
Mental Health – Outpatient Services and Substance Abuse Treatment	After Plan pays \$250 and deductible is met, Plan pays at 75% at CIGNA network providers.	After deductible is met, Plan pays 50% of allowed charge.

Office Visits	After Plan pays \$250, and deductible is met, Plan pays at 75%.	After deductible, Plan pays 50% of allowed charge.
Outpatient Therapy - Physical, Occupational and Speech Therapy (No deductible or co-insurance for inpatient therapy services)	After Plan pays \$250, and deductible is met, Plan pays 75% up to 30 visits per therapy type per calendar year at a Banner participating provider.	After deductible is met, Plan pays 50% of allowed charge up to 30 visits per therapy type per calendar year.
Preventive and Routine Care – (Includes Well Woman Exam)	After Plan pays \$250, and deductible is met, covered at 75%.	After deductible, Plan pays 50% of allowed charge.
Skilled Nursing Facility	After Plan pays \$250, and deductible is met, Plan pays: ~ 90% at a Banner facility for up to 90-days per calendar year. ~ 70% at a Banner participating provider for up to 90-days per calendar year. Custodial care not covered.	After deductible is met, Plan pays: 50% of allowed charge for up to 90-days per calendar year. Custodial care not covered.
Surgery for Morbid Obesity – 24 month waiting period (First Dollar Coverage will not be applied.)	Covered at 100% after \$5,000 copay at a Banner facility. Copay applied to hospital services only. Must be pre-approved by Plan.	<i>Not covered.</i>
Surgical Services ~ Surgeon ~ Assistant Surgeon ~ Anesthesiologist ~ Tubal Ligation ~ Vasectomy	After Plan pays \$250 and deductible is met, Plan pays: ~ 75% ~ 75% ~ 75% ~ 75% ~ 75%	After deductible is met, Plan pays 50% of allowed charge. ~ 50% ~ 50% ~ 50% ~ 50% ~ 50%
Urgent Care	<i>(Deductible Waived)</i> Plan pays 100% after \$40 copay. <i>First-dollar does not apply</i>	<i>(Deductible Waived)</i> Plan pays 100% of allowed charge after \$80 copay
Transplant Coverage	See Managed Transplant Services Certificate of Coverage at www.BannerBenefit.com	

*The Medical Plan provides coverage up to the “allowed charge” for eligible expenses, based on the Claims Administrator’s Allowed Charge Schedule. The member is responsible for the applicable co-insurance plus any amount above the allowed charge when care is received from a non-participating provider.

Medical Benefits Provisions

The following Medical Plan features apply to each of the options, Choice Plus, Select \$500, and Select \$250.

General

Once the Claims Administrator receives satisfactory proof that you or your dependent has incurred an expense for treatment of a covered illness or injury, the Medical Plan will pay the amounts as indicated in the 2011 Benefits Chart only for Medically Necessary services and supplies not exceeding the Usual, Reasonable and Customary charges.

The benefits payable shall not exceed the Maximum Annual or Lifetime Benefits and are subject to the Deductible and copayment provisions unless specifically stated.

Deductibles: Refer to the 2011 Benefits Chart

Copayment Provision: Refer to the 2011 Benefits Chart.

Emergency Room Copayment: The copayment for Emergency Room services is \$140 per visit at a Banner facility, \$345 at all other facilities and does not apply to the plan year deductible. The copayment will be waived if the patient is admitted as an inpatient to the hospital as a result of the ER visit. However, the inpatient copay or deductible will still apply.

Surgery for Morbid Obesity Copayment: The copayment for surgery for morbid obesity is \$5000 and will be applied to hospital services only and will not be applied to the plan year deductible, coinsurance or out-of-pocket maximum. You must have been eligible and participated in a Banner health plan for 24 months to qualify for this benefit.

Unpaid Copayments, Deductibles and Coinsurance: The Plan Administrator has the right to automatically deduct from your paycheck amounts to cover copayments, deductibles, and coinsurance for certain benefits. This right applies to benefits that are provided at a Banner facility and for which the related charges have not been paid by you within 120 days of the provision of such services. Such deductions will be established by the Plan Administrator.

Childbirth: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans may not, under Federal law, require that a provider obtain authorization from the Medical Plan for prescribing a length of stay less than 48 hours or 96 hours as applicable.

Surgical Services for Breast Reconstruction (WHCRA): In case of a participant or dependent who is receiving benefits under a participating medical program in connection with a mastectomy and elects breast reconstruction, coverage under the participating medical program will be provided in a manner determined in consultation with the attending physician and the patient for the following:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Copayments and deductible may still apply, as described in the applicable benefit booklet, but such copayments and deductibles must be consistent with those established for other medical benefits under the participating medical program.

Travel Reimbursement Policy

Travel expenses incurred while seeking specialty medical or behavioral healthcare at a Banner participating facility are reimbursable in certain circumstances. Members can be reimbursed for “reasonable travel expenses” when they are required to travel more than 100 miles from their primary place of residence to a Banner participating provider or facility for referred specialty medical care. This benefit also allows companion to accompany the patient. Some specifics must be met for reimbursement:

- The health care provider must refer the patient for the specialty care.
- The travel distance for specialty care must be at least 100 miles from the member’s primary residence.
- To qualify for reimbursement for companion expenses, the companion must be a parent, guardian, or other family friend aged 18 or older.

All travel expenses must be pre-approved by the Medical Plan. Actual expenses for lodging and meals will be reimbursed up to a per diem rate of \$150.00 per person per day (excludes tobacco and alcohol), up to a maximum of 90-days. Other transportation expenses such as airfare and mileage must be pre-approved by the Medical Plan. Receipts are required for amounts more than the per diem rate Medical Services Reimbursement Claim Form are available from the Service Center at Banner Plan Administration or at www.BannerBenefits.com

Alternative Benefits Management

Alternative Benefits Management is a process whereby cases are reviewed in terms of cost of care required and the availability of alternate health care for the treatment of you or an Eligible Dependent. The ultimate goal of Alternative Benefits Management is to provide quality care as cost-effectively as possible.

During the Alternative Benefits Management process, the Claims Administrator will discuss with you, your physician and Hospital, the development and assessment of an appropriate treatment plan, explore alternatives for care and treatment and determine Health Plan benefits available to you or an Eligible Dependent.

Cases on which Alternative Benefits Management will be conducted are identified by:

- Admissions that exceed the recommended or approved length of stay;
- Diagnoses that are generating ongoing and excessively high costs;
- Conditions that are known to require extensive follow-up care and treatment.

If the Health Plan elects to provide alternative benefits for you or an Eligible Dependent in one instance, it does not obligate the Health Plan to provide the same or similar benefits for any member in any other instance where the alternative treatment is not determined to be Medically Necessary, cost-effective or feasible. Nor will it be construed as a waiver of the Health Plan’s right to administer the Health Plan thereafter in strict accordance with its provisions and terms.

Covered Medical Services

The following are covered medical services under each of the options: Choice Plus, Select \$500, and Select \$250. The Medical Plans provide for eligible charges incurred by a covered person, subject to coinsurance, copayments and deductibles as stated in the 2011 Benefits Chart. Such charges will be subject to the Usual, Reasonable and Customary criteria. Only those services and supplies listed below that are Medically Necessary will be considered under the Medical Plan.

1. Inpatient Hospital care for room and board not to exceed the cost of a Semi-Private room or other accommodations deemed Medically Necessary by the attending Physician. If the Hospital only has private rooms, coverage will be provided.
2. Miscellaneous Hospital services required for purposes of treatment while confined as an Inpatient.
3. Coverage for a newborn eligible dependent begins at birth for the first 31 days as long as you are enrolled in the Medical Plan. To maintain coverage for your newborn, you must enroll the newborn through the Benefit Enrollment within 31 days of birth; otherwise the coverage for your newborn will be discontinued after 31 days. This rule also applies for children who are legally adopted by you or placed for adoption with you. Coverage is not available to children of a dependent, unless you have legal custody/guardianship.
4. Confinement in an acute inpatient rehabilitation facility is covered at 100% for 60 days per illness/injury and will be considered if:
 - a. The admission to the acute inpatient rehabilitation facility is Medically Necessary and may include care for non-custodial conditions as an alternative to acute care in a general hospital.
 - b. The admission is temporary in nature and must be supported by a physician's treatment plan with a goal leading to rehabilitation and increased ability to function.
5. Confinement in a Skilled Nursing Facility is covered at 100% for 90 days per calendar year, and will be considered if:
 - a. The admission to a skilled nursing facility is Medically Necessary and may include care for non-custodial conditions as an alternative to acute care in a general hospital.
 - b. The admission is temporary in nature and must be supported by a physician's treatment plan with a goal leading to rehabilitation and increased ability to function.
6. Eligible charges incurred in an Ambulatory Surgical Facility.
7. Eligible charges incurred in a Birthing Center.
8. Supplies and non-custodial nursing care received from a skilled Home Health Care Agency. The covered person must be admitted to a skilled home health care for treatment of the same illness or injury, or in lieu of hospitalization for treatment of an acute or chronic illness, which requires skilled nursing observation and/or management.
9. Anesthetic services rendered by a licensed anesthesiologist or Certified Registered Nurse Anesthetist in connection with a surgical operation or obstetrical delivery.
10. Surgical expenses incurred for the Services of:
 - a. A surgeon, and
 - b. An approved assistant surgeon, and
 - c. Administration of anesthesia.
11. Non-experimental solid organ or bone marrow transplants are covered under a separately insured benefit. See the Managed Transplant Program Certificate of Coverage for the details of this program at www.BannerBenefits.com.
12. Surgical reproductive sterilization, but not surgical reversal. Applicable coinsurance applies.
13. Pre-admission testing.

14. Diagnostic evaluation and treatment for crisis intervention or chronic mental and nervous conditions are covered under your Mental Health benefit when Medically Necessary and Appropriate. Outpatient Mental Health services for marital, family, codependency, sex, interpersonal, eating disorders and gambling counseling are covered.
15. Treatment for Inpatient care for mental illness, substance abuse or detoxification is covered when Medically Necessary
16. Diagnostic evaluation and medical treatment for learning disorders or developmental disabilities, attention deficit or mentally disabled.
17. Dental services received after an accidental injury to sound natural teeth, which occurred while covered under the Medical Plan. This includes replacement of such teeth, any related X-rays, inpatient and outpatient services. Treatment must be rendered within 12 months of the Injury unless a delay is Medically Necessary. In reference to injury to a tooth, the tooth must be a natural tooth free from decay and otherwise functionally sound at the time of the injury.
18. Pregnancy and related care and/or services rendered to a Covered Employee or spouse shall be allowable as any other illness under the Medical Plan. One routine ultrasound per pregnancy unless, based on Member's condition and history, additional services are determined to be Medically Appropriate and Necessary.
19. Interruptions of pregnancy limited solely to miscarriage or such Medically Appropriate and Necessary therapeutic abortion for an eligible Member, within such time frames as permitted by applicable state laws and regulations.
20. Initial contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace a human lens lost while covered under the Medical Plan either through ocular injury or intraocular surgery excluding intraocular Toric lens following cataract surgery.
21. Inpatient visits by the attending Physician.
22. Cosmetic surgery for correction of damage caused by an accidental injury, or for correction of a congenital abnormality, which results in a malformation, or absence of a body part. Surgical services for breast reconstruction following mastectomy due to breast cancer, on which the mastectomy has been performed and surgical reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas is also a covered expense when related to a breast cancer diagnosis. This coverage complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA)
23. Consultation performed by a Physician when directly related to the primary reason for hospitalization. Staff consultations required by the medical staff or by the rules or regulations of the Hospital are not covered.
24. The following medical services or supplies that are ordered and/or prescribed by the attending Physician:
 - a. services of a licensed registered physiotherapist when rendered under the direct supervision of the attending Physician,
 - b. allergy testing and injections; serum covered with 50% copayment;
 - c. oxygen and/or rental of equipment required for its administration;
 - d. home Medical Equipment as allowed by CMS is covered for rental or purchase, based on the judgment of the by the Claims Administrator. Supplies used in conjunction with Home Medical Equipment including rehabilitation kits, supplies and educational materials when Medically Necessary.
 - e. pre-certification is required for motorized wheelchairs and power operated vehicles. Maximum coverage is \$5000 maximum benefit allowance per chair. Covered Services include repairs, replacements, adjustments and duplicates when Medically Necessary;
 - f. radiotherapy;
 - g. chemotherapy;

- h. diagnostic X-ray and laboratory services;
 - i. charges for original fitting, adjustment and placement of braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired, including replacements or repairs when Medically Appropriate and Necessary. Coverage will include equipment that restores function to perform activities of daily living. Upgraded components, devices and/or equipment are not covered. Benefits will not be provided for appliances required for employment, leisure or recreational activity and for multiple devices for the convenience of the covered person.
 - j. blood and/or blood plasma, if not replaced, and equipment for its administration;
 - k. emergency transportation of the covered person by a professional ambulance to the nearest Hospital or other medical institution equipped and staffed to treat the illness or injury. Other ambulance transports will be covered only in instances when Medically Necessary. Benefits for air transportation are available only in instances when ground transportation is not medically appropriate. Claims for air ambulance service will be reviewed for medical necessity;
 - l. occupational therapy services performed by an Occupational Therapist to increase ability to function following disease, injury or loss of body part are limited to 30 visits per calendar year. Services must be provided in accordance with a prescribed plan of treatment. Benefits are not available for Maintenance Care;
 - m. speech therapy services performed by a Speech Therapist to increase ability to function following disease or injury are limited to 30 visits per calendar year. Services must be provided in accordance with a prescribed plan of treatment. Benefits are not available for Maintenance Care;
 - n. physical therapy services performed by a Physical Therapist or a Physical Therapy Assistant to increase ability to function following disease, injury or loss of body part. Benefits are limited to 30 visits per calendar year. Services must be provided in accordance with a prescribed plan of treatment. Benefits are not available for Maintenance Care.
 - o. therapy services rendered within the home or outpatient facility apply towards the 30 visit annual maximum, i.e. home health, in home therapy or outpatient therapy. There is no copay for therapy services provided in home.
 - p. biofeedback services for urinary or fecal incontinence.
25. Consultation and testing necessary to determine treatment options for infertility.
 26. Infertility diagnostic work-up and treatments covered at 50% of allowed charges. Banner pays up to \$5000 lifetime maximum at Banner designated providers.
 27. Wigs or artificial hairpieces due to loss of hair from chemotherapy. Limit up to \$250 per calendar year.
 28. Well Woman examination one time per calendar year includes a breast examination, Pap smear and an order for a screening mammogram if appropriate for your age and/or medical history with the appropriate fees. Routine lab tests such as hemoglobin, cholesterol, or any other ancillary services such as x-rays or follow-up visits are not part of the Well Woman benefit and will be covered after appropriate fees.
 29. Genetic testing when medically indicated and documented by the physician.
 30. Hospice Services.
 31. Visual training services, including orthoptics and pleoptic training provided to Members under the age of ten years. Benefits are limited to a Lifetime Maximum of 16 visits per Member.
 32. Diabetic education.
 33. Benefits are available for Medically Necessary Orthotic Devices for the feet (up to \$250 maximum per benefit period) when ordered by a Physician or Podiatrist. Benefits will not be

provided for Orthotic Services required for employment, leisure or recreational activity or to allow a member to participate in a sports activity, or for multiple orthotic devices for the convenience of the covered person.

34. Hearing aid examinations, hearing aids and related supplies, related to the loss of hearing was due to an accidental injury, illness, or congenital permanent childhood hearing impairment. Benefit is limited to \$3000 allowance every three (3) years.
35. Cardiac and pulmonary rehabilitation services when medically indicated, limited to 90 calendar days (not 90 visits) per episode.
36. Outpatient prescription drugs are covered under a separate benefit. See **Banner Prescription Drug Benefit**.
37. Take home prescription drugs received upon discharge from a hospital or urgent care center are covered for up to a three day supply under your medical benefits.
38. Surgery for morbid obesity, including the treatment of complications resulting from any or all types of surgical morbid obesity procedures and services in preparation for the surgery. If approved, services must be received at a Banner facility, and covered individual must be covered under a Banner Medical Plan for a minimum of 24 months. A \$5000 copayment will apply to hospital services. Services in preparation of the surgery will be paid according to the 2011 Benefits Chart.
39. Chiropractic services for examinations and/or treatments for conditions related to neuromusculoskeletal disorders unless otherwise excluded under Medical Benefits Exclusions.
40. Acupuncture services and supplies include:
 - a. Services for examinations and/or treatments for conditions related to neuromusculoskeletal disorders, nausea, or pain syndromes
 - b. Hypnotherapy, behavior training sleep, therapy and weight programs
41. Naturopathic services, unless otherwise excluded under Medical Benefits Exclusions.
42. Nutritional counseling services through ECHO otherwise excluded under Medical Benefits Exclusion.
43. 30 months of Dialysis coverage. Medicare covers Dialysis after 30 months. Banner Health Plans will assist members in obtaining Medicare coverage prior to 30 months coverage. Dialysis requires Pre-Certification.
44. Manipulation under anesthesia as medical indicated unless otherwise excluded under Medical Benefits Exclusions.

Non-Covered Medical Services

No benefits shall be payable under any part of the Medical Plan for the following list of exclusions:

1. Any portion of a charge that exceeds the Usual, Reasonable and Customary guidelines of the Medical Plan.
2. Any charges not incidental to or necessary for diagnosis of any injury or illness except as specified herein.
3. A service, supply or treatment not Medically Necessary, including experimental procedures.
4. Services or supplies for which there is no legal obligation to pay or charges which would not be made except for the availability of the benefits under this Medical Plan.
5. Any Experimental, Unproven, or Investigational procedures, drugs, devices, treatments or pharmacological regimens. This includes those procedures, drugs, devices, treatments and pharmacological regimens that are:
 - a. delivered within the context of a phase one, two, or three clinical trial; or
 - b. delivered pursuant to the approval or supervision of an institutional review board or human subjects committee; or
 - c. those which employ drugs or devices which have not received approval for marketing by the United States Food and Drug Administration (FDA) or the Center for Medicare and Medicaid Services (CMS); or
 - d. those which are provided pursuant to consent documents which describe the procedure as investigational or experimental research which utilizes other working of that nature.
6. All associated expenses and complications arising from such Experimental, Unproven or Investigational procedures, drugs, devices, treatments, or pharmacological regimens are also excluded.
7. The Medical Plan reserves the right to change coverage with respect to Experimental, Unproven or Investigational standards or to add or delete certain procedures as medical standards change.
8. Specific sources of information will be reviewed by the Medical Plan in its determination of whether a procedure, drug or device is Experimental, Unproven, or Investigational. The following are some but not all of the sources the Medical Plan will include as part of its review process:
 - a. This booklet;
 - b. Any and all consent documents you sign;
 - c. Any protocols pursuant to which the treatment, procedure, drug, or device is to be delivered;
 - d. Medical records; and
 - e. Authoritative medical literature.
9. Services furnished by or for U.S. Government or any other government, unless payment is legally required.
10. Any condition or disability:
 - a. Resulting from being engaged in any activity primarily for wage, profit or gain; and
 - b. Entitling the covered person to any benefit under a Workers' Compensation act or similar legislation.
11. Non-medical expenses such as training, education instructions or educational materials, except for Diabetic Education.
12. Expenses for preparing medical reports, itemized bills or claim forms.
13. Expenses for mailing and/or shipping and handling charges.
14. Software or other computer applications or devices for the use of tracking medical information.
15. Charges for missed appointments.
16. Travel expenses of Physicians attending to a covered person or travel expenses of the covered person.
17. Massage therapy or rolfing (massage of tissues surrounding muscles).

18. Custodial care, sanitarium care or rest care.
19. Professional services performed by a person who ordinarily resides in the covered person's household or who is related to the covered person, such as a spouse, parent, child, brother or sister, whether such relationship is by blood or exists by law.
20. Cosmetic surgery or any complications arising from cosmetic surgery unless the complications affect medical health or activities of daily living
21. Wigs or artificial hairpieces with the exception of those needed due to loss of hair from chemotherapy.
22. Reversal of sterilization procedures, non-medically indicated abortions, surrogate motherhood, and sex transformations.
23. All charges related to sex change surgery or any related complications.
24. Orthopedic or corrective shoes, except when Medically Necessary, using CMS criteria.
25. Hospital or outpatient surgical services for dental treatment, unless Medically Necessary due to a serious medical condition. In these instances, the Hospital services must be pre-authorized by the Medical Plan.
26. Personal comfort or service items while confined in a Hospital. This includes, but is not limited to, radio, television, telephone, guest meals and the like.
27. Air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other equipment or clothing which could be used in the absence of an illness or injury.
28. Special education and counseling related to behavioral problems associated with a manifest mental disorder or other disturbance.
29. Eye refraction surgery, Lasik procedures and radial keratotomy.
30. Hearing aid examinations, hearing aids or related supplies, unless related to the Accidental Injury, or Illness, or congenital permanent childhood hearing impairment. Benefit is limited to \$3000 allowance every three (3) years.
31. Any expenses incurred in the course of or arising out of an adoption.
32. Any expenses incurred by a surrogate mother.
33. Any expenses including medication, retrieval and storage for egg donation.
34. Infertility diagnostic work-up and/or treatment by non-designated provider, including reconstructive surgery to restore bodily function.
35. Infertility treatment for dependent children.
36. Experimental human organ and tissue transplants. If the first and second designated facility determines for any reason, that a transplant recipient is not an acceptable transplant candidate, no coverage will be provided for further transplant-related services or supplies, regardless of a third designated facility's or a non-designated facility's acceptance of the recipient.
37. No benefits or services for Orthotic Services for the feet required for employment, leisure or recreational activity or to allow a member to participate in a sports activity, or for multiple orthotic devices for the convenience of the covered person.
38. No benefits for electronic speech aids, robotization devices, robotic prosthetics, myoelectronic prosthetics, computer processor type components, customized cutaneous dermal protective covers, endolite prosthetics, dental appliances, artificial organs, and upgraded components, devices and/or equipment for prosthetic appliances, braces, casts, splints, crutches, cervical collars, head halters, and traction apparatus
39. Employment, FFA and DOT physicals, or any physicals for sports, school or any other physicals which are required by any entity for purposes other than Medically Necessary.
40. Vaccinations or inoculations required for foreign travel or employment purposes.
41. Temporomandibular (TMJ), craniomandibular joint (CMJ) treatment, and orthognathic surgery including surgical and non-surgical services related to malocclusion, malposition of the teeth or

jaw dysfunction unless directly related to accidental injury, including instances in which treatment was initiated prior to January 1, 2002.

42. No benefits will be provided for a tinnitus masker, XOMED audient conductor, or batteries for hearing aids.
43. Services performed by a vocational residential rehabilitation center or a community re-entry program of learning services.
44. Behavioral health treatment that is:
 - a. Educational or vocational testing and services, including treatments for personal growth or development.
 - b. Testing and the associated interventions for learning disabilities, learning style, information processing, academic planning and/or academic placement.
45. Non-Medically Necessary treatment that is not reasonably expected to improve an individual's condition or level of functioning. This includes (but is not limited to) treatment for the following conditions or diagnoses:
 - a. Mentally disabled (except initial diagnosis)
 - b. Autism (except for behavioral therapy provided by an eligible provider)
 - c. Learning disabilities
46. Applied behavioral analysis is considered experimental or investigative.
47. Wilderness Program and Halfway Houses.
48. Expenses from a child of an enrolled dependent child.
49. Bariatric surgery or any procedure for morbid obesity is not covered at a non Banner facility.
50. Chiropractic services and supplies not covered:
 - a. Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from participating chiropractors
 - b. Hypnotherapies, behavior training, sleep therapy, and weight programs
 - c. Thermography
 - d. Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage
 - e. Services and/or treatments that are not documented as Medically Necessary services
 - f. Magnetic resonance imaging (MRI), CAT scans, and any type of diagnostic radiology
 - g. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing
 - h. Manipulation under anesthesia or other related services
 - i. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids
 - j. Adjunctive therapy not associated with spinal, muscle or joint manipulation
 - k. Vitamins, minerals, or other similar products
 - l. Orthotics or supplies related to orthotics
51. Acupuncture services and supplies not covered:
 - a. Thermography
 - b. Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage
 - c. Services and/or treatments that are not documented as Medically Necessary services
 - d. Magnetic resonance imaging (MRI), CAT scans, and any type of diagnostic radiology
 - e. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing
 - f. Acupuncture under anesthesia or other related services

- g. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids
 - h. Adjunctive therapy not associated with acupuncture
 - i. Vitamins, minerals, or other similar products, including, but not limited to nutritional supplements that are Native American, South American, European, or of any other origin
 - j. Nutritional supplements obtained by the Member through an acupuncturist, health food store, grocery store, or by any other means.
52. Naturopathic services and supplies not covered:
- a. Hypnotherapies, behavior training, sleep therapy, and weight programs
 - b. Thermography
 - c. Services, lab tests, x-rays, and other treatments not documented as clinically necessary, appropriate or classified as experimental, investigational, or as being in the research stage
 - d. Services and/or treatments that are not documented as Medically Necessary services
 - e. Radiological imaging including but not limited to, magnetic resonance imaging (MRI), CAT scans, and any types of therapeutic radiology
 - f. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing
 - g. Homeopathic remedies provided or prescribed by the naturopath
 - h. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids
 - i. Vitamins, minerals, or other similar products
53. Nutrition counseling services and supplies not covered:
- a. Services, lab test, x-rays, and other treatments not documented as clinically necessary, appropriate, or classified as experimental, investigational, or as being the research stage
 - b. Services and/or treatments that are not documented as Medically Necessary services
 - c. Vitamins, minerals, or other similar products
54. The Medical Plan may not be obligated to pay for expenses due to a sickness or injury for which a third party is liable or legally responsible. See the **Subrogation** section of this booklet.
55. Dialysis coverage is limited to 30 months under Banner Medical Plans. Medicare covers Dialysis after 30 months. Banner Medical Plans will assist members in obtaining Medicare coverage prior to 30 months coverage. Dialysis requires Pre-Certification.
56. Manipulation under anesthesia services and supplies not covered:
- a. When performed by a provider who is not certified or trained
 - b. When does not meet medical indicated
57. Services under this Plan are not covered when provided by a member of the member's immediate family.

Hospital and Outpatient Review/Pre-Certification

When you seek medical care through your Primary Care Physician (PCP), he/she will arrange for your hospital admission, outpatient surgery or diagnostic testing, and the services will be covered under the Banner Option benefit. When you seek medical care without any direction from your Primary Care Physician under the PPO or Indemnity Option, you or your provider are responsible for making the Medical Plan aware of any of the following hospitalizations and/or medical procedures being requested.

Services Requiring Pre-Certification under PPO Option and Indemnity Option:

- At any non-designated facility
- Elective surgeries and certain outpatient procedures
- Prosthetics/Orthotics/DME over \$1000
- Any Transplant (Only covered under the Managed Transplant Program (MTP))
- Total Obstetrical Care
- Dialysis

The Claims Administrator reviews the reasons for the hospitalization, outpatient surgery or diagnostic procedure and the estimated length of the proposed hospital stay. The Claims Administrator will make recommendations on whether the hospital admission, outpatient surgery or diagnostic procedure proposed by the physician can be pre-certified as Medically Necessary under the terms of this Medical Plan.

These recommendations provide another opinion for you and the Physician before hospitalization. The Claims Administrator will encourage Physicians to avoid hospitalization when safe and equally effective alternatives are available.

If the patient is admitted to the hospital, the Claims Administrator will review the stay and continue to make recommendations on medical necessity and appropriateness, so the patient can be discharged as soon as medically safe and acceptable. The Claims Administrator must be contacted at any time during the pregnancy and will follow up periodically once a due date is determined.

When the pre-admission hospital/outpatient review procedures are followed and have been certified, the Medical Plan will pay the regularly scheduled PPO Option or Indemnity Option benefits based on the provider of the service. If this is not done, and the services were Medically Necessary, you will be responsible for the first \$250 of charges, in addition to any applicable deductible. You will also be responsible for 100% of any additional charges that are not approved for that service.

When & Where to Call

You or your designated representative must call the Claims Administrator at least fourteen (14) days prior to any procedures:

800-827-2464

480-684-7070 (in the Phoenix Metro area)

Banner Prescription Drug Benefit

Prescription Drug Benefit Options

You must elect Medical Plan coverage to have Prescription Drug Plan coverage. If you elect coverage under the Medical Plan, you may choose your Prescription Drug Plan coverage as follows:

Basic Plan: The Basic Plan is best suited for those who:

1. Currently take no prescription medications regularly. –OR–
2. Are taking some medications, all of which are listed on the Basic & Banner Select 250 Formulary.
3. Request generics instead of brand-name medications whenever possible.
4. The Basic Plan is the only prescription drug option available if you choose the Banner Select \$250 prescription plan. See **Select \$250 Plan** in the chart below for the cost-sharing that applies to the Banner Select \$250 prescription plan.

Standard Plan: The Standard Plan is best suited for those who:

1. Regularly take medications that are not listed on the Basic & Banner Select 250 Formulary.
2. Have all/most of their medications listed on the Standard Prime Formulary.
3. Take some brand-name/non-formulary medications regularly.

Expanded Plan: The Expanded Plan is best suited for those who:

1. Regularly take medications that are not listed on the Basic & Banner Select 250 Formulary.
2. Have all/most of their medications listed on the Expanded Formulary.
3. Take several brand-name/non-formulary medications regularly.

NOTE: If you elect the Banner Select \$250 Medical Plan option, you will automatically be enrolled in the Basic Plan for prescription drug coverage. If you elect coverage under the Choice Plus or Select \$500 Medical Plan options and do not choose a prescription drug benefit, you will automatically receive the Standard Plan option.

Within each of these three options you can save money in three ways:

- by selecting generic drugs over name brand drugs (save up to 75% or more);
- by ordering long term “maintenance” drugs by mail (save over 15%); and
- by choosing generic or name brand drugs that are on the formulary (save up to 75% or more).

2011 Benefit Chart – Banner Prescription Drug Benefits

Prescription Drug Plan	Select \$250 Plan	Basic Prescription Drug Plan	Standard Prescription Drug Plan	Expanded Prescription Drug Plan
Best suited for those who:	- Banner Select \$250 Medical Plan follows this Prescription Drug plan and cannot be changed for any other option.	- Require fewer prescriptions - request generics instead of name - brand medications - choose drugs listed in the formulary	- Regularly take prescriptions that are not listed on the Basic/High Performance formulary - Take some brand-name/non-formulary medications regularly - request generics instead of name brand medications - choose drugs listed on the formulary	- Regularly take medications that are not listed on the Basic/High Performance formulary - Take several brand-name/non-formulary medications regularly
Retail Copay (up to a 31 day supply) (Mandatory generics)	Formulary \$ 10 generic \$40 brand Non formulary brand: 100% of cost. Not covered*	Formulary: \$ 8 generic \$40 brand Non formulary brand: 100% of cost. Not covered*	Formulary: \$7 generic \$35 brand name Non formulary brand: \$70 Copay	Formulary: \$6 generic \$30 brand name Non formulary brand: \$60 Copay
Mail Order Copay (93-day supply) (Mandatory generics)	Formulary: \$25 generic \$100 brand Non formulary brand: 100% of cost. Not covered*	Formulary: \$ 20 generic \$100 brand Non formulary brand: 100% of cost. Not covered*	Formulary: \$16 generic \$85 brand name Non formulary brand: \$175 Copay	Formulary: \$14 generic \$75 brand name Non formulary brand: \$150 Copay
Annual Maximum Out-of-Pocket (per member)	\$2,500	\$2,500	\$2,500	\$2,500
Formulary	Basic & Banner Select 250 High Performance	Basic & Banner Select 250 High Performance	Standard Prime National Formulary	Expanded National Formulary

* Benefits not covered by the Prescription Drug Plan are not included in Annual Out of Pocket Maximums.

Choose a Drug in the “Formulary” and Save

“Formulary” is a term used to describe a select list of drugs that Express Scripts and Banner has determined to be safe, high quality and cost-effective choices for a wide variety of therapeutic categories. The formulary includes lower cost generic as well as higher cost name brand medications. Cost becomes the determining factor in a drug’s inclusion in the formulary only after all other considerations such as safety and effectiveness are met. Within both the standard drug benefit and the expanded drug benefit, you will save money by choosing generic drugs when available for your particular prescription.

You can determine if the prescriptions you use are included in the formulary and whether or not they are available as generics by contacting Express Scripts at 800-900-6337 or visiting the [Express Scripts web site](#). Formularies are available at www.BannerBenefits.com

Generic Drugs Cheaper

Generic drugs are chemically equivalent to name brand drugs and provide the same therapeutic effects. Generic drugs are tested by the Food and Drug Administration to guarantee their effectiveness. The reason drug companies come up with different brand names for the same drug is to differentiate and market themselves to consumers. These marketing efforts are costly and that’s why drug companies charge more for name brand medications.

You can save up to 75 % on Banner Prescription Drug copays by choosing generic drugs over formulary name- brand drugs or non-formulary drugs. (see copay section on above chart).

Mail Order Option for “Maintenance” Drugs Offers Convenience and Savings

After your first fill or refill in 2011 for a maintenance medication, you’ll receive a letter from Express Scripts asking you to contact them via their website or by phone to discuss having your prescriptions filled by Express Scripts Prescription Drug and sent directly to your home. You will have the option of choosing to pick up your prescription at a local Prescription Drug with no penalty, or to save money by using the Express Scripts Prescription Drug. You will need to let Express Scripts know of your preferences before you can pick up your third monthly refill of maintenance medication.

When you are prescribed a medication that will need to be filled on a monthly basis (for example birth control, hormones, blood pressure, etc), you have two options for ordering them:

- Mail Order/Home Delivery- is not only convenient—the prescriptions are delivered right to your door —your copay is up to 25% lower than the copays would be for buying the same drugs in 31-day supply increments from a local Prescription Drug. Each mail order prescription is checked by two registered pharmacists, and delivered in a plain, weather-resistant pouch (cold pack for heat sensitive medications) designed to ensure safety, protection and privacy. There is no postage charged for standard delivery (shipped from Tempe, Arizona usually arriving in a few days).
- 90 Day Retail Supply- You can receive up to 93 day supply of your medication at your local retail Prescription Drug. Although there is no copay discount, you will gain the convenience of picking up a 3 month supply instead of visiting your Prescription Drug once a month. (See Prescription Drug network list to determine participating pharmacies at www.BannerBenefits.com or call Express Scripts Member Services at 800-900-6337).

To Help You Choose the Best Prescription Drug Plan Option, visit the secure Express Preview Web site.

<https://member.express-scripts.com/preview/banner2011>

Demo User Name: **previewtest**

Password: **password**

Express Preview allows you to identify:

- A cost effective benefit plan by estimating your out of pocket costs by comparing each Prescription Drug Plan.
- The nearest network pharmacies under each Prescription Drug Plan option.
- Drugs including in the formulary.

Formulary Questions and Answers

Are only low-cost drugs on the formulary?

The formulary is made up of lower cost generics as well as higher cost name-brand medications. Cost becomes the determining factor in a drug's selection only after all other considerations such as safety and effectiveness are met.

Does the formulary change?

The formulary is updated as new products are released on the market and evaluated by the Prescription Drug and Therapeutics Committee, which is made up of clinical pharmacists and physicians. Express Scripts will then pass these evaluations onto Banner Health. Occasionally, a drug may be removed from the formulary, but this happens infrequently.

If there is a generic available for a medication I am on, do I have to take the generic?

No, but you may pay a higher copay for choosing a non-generic drug. If your doctor indicates that substitution is permissible and you still request the brand name, you will be charged the cost difference between the brand and the generic drug, plus the applicable copay up to the cost of the drug. Say, for example, you have the expanded benefit and choose a formulary brand drug that costs \$120 when the equivalent generic drug is \$40. You would pay \$80 (cost difference between the brand and generic drug) plus the applicable copay, in this case \$30, for a total of \$110.

How do I find out which drugs are included in the formulary?

You can find the list of drugs included in the formulary at the following website www.express-scripts.com. The list also tells you if the drug you're considering is available as a generic and whether or not it is available through mail order. You can also call the Express Scripts customer service number at 800-900-6337.

Will my Prescription Drug know what copays to charge?

Once your pharmacist enters a prescription into the computer, a message will appear indicating the copay amount associated with that drug.

I am currently taking a drug not on the formulary. How do I switch to a formulary drug?

You can call your doctor to ask him/her to write a prescription for a formulary alternative product.

My doctor has prescribed a drug not on the formulary. What should I do?

If you arrive at your Prescription Drug with a prescription for a drug that is not on the formulary, ask your pharmacist to contact your doctor to suggest an alternative that is on the formulary since that would result in a lower copay amount for you. If your doctor decides you need to continue to take the prescribed medication, you will have to pay the higher copay. Non-formulary drugs are covered at higher copay under the Standard Prime and Expanded National Formulary, but they are excluded under the Basic and Select \$250 formulary.

How can I take advantage of the savings I would get from using Mail Order?

Call your doctor and ask him/her for a mail order prescription for your maintenance drugs dispensing a "93 day supply". (Example – if you are using an inhaler, your physician should specify the number of inhalers you need for 3 months.) Your doctor can then either fax the prescription to Express Scripts Mail Service at 800-396-2171 or you can mail it in. Mail Order forms are available through Express Scripts at 800-900-6337 or www.express-scripts.com.

What if the cost of the medication is less than the copay amount?

You will pay the lower of the two costs, either the retail cost of the drug or your copay. For example, if your copay is \$25 and the retail cost of the drug is \$8, you would pay \$8.

General Prescription Drug Provisions

Security and Privacy of your Information

Express Scripts is firmly committed to protecting the confidentiality of your Prescription Drug information. To ensure the security of your personal and health-related information, Express' web sites support web browsers that use 128-bit encryption. 128-bit encryption is not required, but is recommended on your browser when viewing or entering information on their site. All Banner PCs are loaded with 128-bit encryption so there is no problem using the site from work.

Specific Requirements

The following provisions apply to this Prescription Drug Benefit:

- All prescription drugs must be obtained from a Participating Prescription Drug.
- Participating Pharmacies will dispense prescriptions for up to a 31-day or 93-day supply (see participating pharmacies).
- Mail Order prescriptions are dispensed for up to a 93-day supply.
- You will be financially liable for the cost of medications obtained after you are no longer eligible for Coverage under this Prescription Drug Plan.

Prior Authorization Policies*

Express Scripts and Banner have put together a variety of programs that review clinical application and appropriateness. Certain drugs require Prior Authorization before your prescription will be covered. Your physician must request Prior Authorization through Express Scripts, fax requests to 1-800-396-2171. If it is after normal business hours, weekends or holidays, your pharmacist may contact Express Scripts and request a 72-hour or one unit Prior Authorization. We understand the importance of your involvement in decisions affecting your health care.

Step Therapy Program

Step therapy is a program under which certain medications (second-line drugs) are not covered until one or more equivalent drugs (that is, drugs that act in a similar way to treat your condition with similar safety, efficacy, and side effects) have been tried first. These drugs are called "first-line" drugs. Until the first-line drugs have been tried and determined ineffective, the second-line drugs will not be covered.

Step therapy programs are designed to help patients and Physicians appropriately manage the use of medications. These programs follow certain guidelines to ensure that the appropriate drugs are prescribed:

- If a patient has taken a second-line drug within the last 130 days, then the second-line drug is covered.
- If the patient is prescribed a second-line drug but has never taken the second-line drug within the last 130 days, a message goes to the pharmacist informing him/her that this is a "step therapy" or second-line drug and informing him/her which first-line drug should be tried.

If you are a new patient and have taken either of these second-line drugs within the last 130 days or you have already tried the first-line drugs, and your claim for a second-line drug is not being processed, your doctor can request an override from Express Scripts. If you have not yet used the first-line drug, then your doctor should give you a prescription for the first-line drug before trying the second-line therapy product. First-line drugs are usually less expensive for the patient and employer.

Exclusions and Limitations

The following are not covered under this Outpatient Prescription Drug Benefit:

- Drugs obtained at a Non-Participating Prescription Drug
- Any drug labeled "Caution – Limited by Federal Law to investigational Use"

- Drugs deemed Experimental, not FDA approved or considered Investigational by the FDA
- Over-the-counter drugs
- Drugs used for other than FDA approved indications
- Vitamins, nutritional replacements and dietary supplements
- Anorexiant, appetite suppressants, diet aids, weight loss medications, and drugs used to treat obesity.
- Drugs prescribed for non-Covered Services.
- Take home drugs. Drugs prescribed for use after discharge from a Hospital, Nursing Home, Skilled Nursing Facility or other Inpatient or Outpatient Facility must be obtained from a Participating Prescription Drug, not from the Inpatient or Outpatient Facility.
- Drugs purchased before a member's effective date of Coverage under this benefit, or after the member's coverage terminates.
- Off label use of medications, except for certain drugs used for the treatment of cancer in accordance with state law.
- The Prescription Drug Plan may not be obligated to pay for expenses due to a sickness or injury for which a third party is liable or legally responsible.
- Replacement will be allowed 1 time per year, which includes vacation and business travel refill too soon.

Quantity Limitations

Some drugs have quantity limitations per 31-day prescription. These limitations are based on FDA recommended indications and dosing. To determine if quantity limitations apply to your medication, please contact Express Scripts at 800-900-6337, 24 hours a day, seven days a week.

Identification Card

Members must present their Banner Choice Plus/Select identification card to the pharmacist when prescriptions are filled or refilled. If your identification card is used after Coverage under the Prescription Drug Plan terminates, you will be held responsible for all drug claims made after the date of termination, including drug claims paid on behalf of your covered Dependents.

Still have questions?

For benefit questions, contact the Service Center at Banner Plan Administration at 480-684-7070 in the Phoenix-metropolitan area or 800-827-2464 in all other areas.

Direct your Prescription Drug coverage questions to the Express Scripts Customer Service number at 800-900-6337, 24 hours a day, seven days a week.

Banner Dental Plans

The Banner Dental Plans offer you three choices of Coverage that best meet your and your family’s needs. Banner believes the best way to assure mouth and teeth health is to periodically see your dentist for regular cleaning and x-rays. This is why under all three Dental Plans the Preventive coverage is covered at 100%.

To assure optimum payment for all covered dental services, you should consider seeing a dentist who participates with our contracted provider Total Dental Associates (TDA). See the charts below for Dental Plan coverage and benefits.

Members in the Comprehensive and Enhanced Dental Plans who have not been covered by one of the three Banner Dental Plans for at least 12 months are limited to a maximum of 50% coverage for other than preventive services (Class A).

2011 Benefit Chart – Preventive Dental Plan

<i>Note: All reimbursements are subject to Usual and Reasonable Charge.</i>		
Covered Services		Percentage and/or Dollar Amount
Calendar Year Deductible		
Per person		\$50
Per family		\$150
The deductible applies to these Classes of Service: Class B Services – Basic		
Dental Percentage Payable	TDA Providers*	Any Dental Provider
Class A Services – Preventive	100%	100%
Class B Services – Basic	95%*	75%
<i>(Click Here for Definitions of Class of Service)</i>		
Maximum Benefit Amount per person per calendar year		\$500
*TDA=Total Dental Administrator, Banner’s National Dental Network		

2011 Benefit Chart - Comprehensive Dental Plan

<i>Note: All reimbursements are subject to Usual and Reasonable Charge.</i>		
Covered Services		Percentage and/or Dollar Amount
Calendar Year Deductible		
Per person		\$50
Per family		\$150
The deductible applies to these Classes of Service:		
Class B Services – Basic		
Class C Services – Major		
Class D Services – Orthodontia		
Dental Percentage Payable	TDA Providers*	Any Dental Provider
Class A Services – Preventive	100%	100%
Class B Services – Basic	95%*	75%
Class C Services – Major	95%*	75%
Class D Services – Orthodontia	50%*	50%
<i>(Click Here for Definitions of Class of Service)</i>		
<i>Note: The payment rate will be 50% for members with less than one year of participation in one of the Banner Dental Plans</i>		
Maximum Benefit Amount		
Classes A, B and C – per person per Calendar Year		\$1,500
Class D – Orthodontia, per person per Lifetime		\$2,500
*TDA=Total Dental Administrator, Banner’s National Dental Network		

2011 Benefit Chart – Enhanced Dental Plan

<i>Note: All reimbursements are subject to Usual and Reasonable Charge.</i>		
Covered Services		Percentage and/or Dollar Amount
Calendar Year Deductible		
Per person		\$100
Per family		\$300
The deductible applies to these Classes of Service:		
Class B Services – Basic		
Class C Services – Major		
Class D Services – Orthodontia		
Dental Percentage Payable	TDA Providers*	Any Dental Provider
Class A Services – Preventive	100%	100%
Class B Services – Basic	95%*	75%
Class C Services – Major	95%*	75%
Class D Services – Orthodontia	50%*	50%
<i>(Click Here for Definitions of Class of Service)</i>		
<i>Note: The payment rate will be 50% for members with less than one year of participation in one of the Banner Dental Plans.</i>		
Maximum Benefit Amount		
Classes A, B and C – per person per Calendar Year		\$2,500
Class D – Orthodontia, per person per Lifetime		\$5,000
*TDA=Total Dental Administrator, Banner’s National Dental Network		

Non-Covered Dental Services

The Dental Plans do not coverage charges for:

1. **charges before coverage begins**- care, treatment or supplies for which a charge was incurred before a person was covered under the Dental Plan,
2. **cosmetic dentistry** - charges for cosmetic dentistry such as teeth whitening,
3. **crowns** - for teeth that are restorable by other means or for the purpose of periodontal splinting,
4. **excess charge** - the part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge,
5. **general anesthesia** - for routine procedures,
6. **government** - care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law,
7. **hygiene** - oral hygiene, plaque control programs or dietary instructions,
8. **no charge** - care and treatment for which there would not have been a charge if no coverage had been in force,
9. **no listing** - services which are not included in the list of covered dental services,
10. **no obligation to pay** - charges incurred for which the Dental Plan has no legal obligation to pay,
11. **not Medically Necessary** – charges incurred for which the Dental Plan has determined are not Medically Necessary,
12. **occupational** - care and treatment of an injury or sickness that, in either case, is occupational - that is, arises from work for wage or profit, including self-employment,
13. **orthodontia** - orthodontic treatment, except as specified,
14. **orthognathic surgery** - surgery to correct a receding or protruding jaw,
15. **personalization** - personalization of dentures,
16. **plan exclusions or limitations** – charges excluded or limited by the plan design as stated in this document,
17. **relative** - professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law,
18. **replacement** - replacement of lost or stolen appliances,
19. **splinting** - crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic,

20. **Temporomandibular Joint (TMJ) Syndrome** - all diagnostic and treatment services related to the treatment of jaw joint problems including TMJ Syndrome.
21. **war** - any loss that is due to a declared or undeclared act or war.

2011 Dental Plans Class of Service Definitions Comparison Chart

Preventive Dental Plan	Comprehensive Dental Plan	Enhanced Dental Plan
Class A Services: Preventive and Diagnostic Dental Procedures		
<p>The limits on Class A Services are for routine services:</p> <ol style="list-style-type: none"> 1. routine oral exams (This includes the scaling and polishing procedure to remove coronal plaque, calculus and stains. It does not include periodontal scaling and root planning. Limit of two exams every Calendar Year.), 2. two bitewing x-ray series per Calendar Year, 3. one full mouth x-ray or one panoramic x-ray every 36 months, 4. two fluoride treatments for covered dependent children under age 19 every 12 months, 5. space maintainers for covered dependent children under age 14 to replace primary teeth, 6. sealants for covered dependent children under age 14, 7. emergency palliative treatment for pain, 8. other dental x-rays if required for diagnosis and treatment of specific conditions, or 9. consultations for preventive and basic dental procedures. 	<p>The limits on Class A Services are for routine services:</p> <ol style="list-style-type: none"> 1. routine oral exams (This includes the scaling and polishing procedure to remove coronal plaque, calculus and stains. It does not include periodontal scaling and root planning. Limit of two exams per Calendar Year.), 2. two bitewing x-ray series per Calendar Year, 3. one full mouth x-ray or one panoramic x-ray every 36 months, 4. two fluoride treatments for covered dependent children under age 19 every 12 months, 5. space maintainers for covered dependent children under age 14 to replace primary teeth, 6. sealants for covered dependent children under age 14, 7. emergency palliative treatment for pain, 8. other dental x-rays if required for diagnosis and treatment of specific conditions, or 9. consultations for preventive, basic, major and orthodontic dental procedures. 	<p>The limits on Class A Services are for the following routine services:</p> <ol style="list-style-type: none"> 1. routine oral exams (This includes the scaling and polishing procedure to remove coronal plaque, calculus and stains. It does not include periodontal scaling and root planning. Limit of two exams per Calendar Year), 2. two bitewing x-ray series per Calendar Year, 3. one full mouth x-ray or one panoramic x-ray every 36 months, 4. two fluoride treatments for covered dependent children under age 19 every 12 months, 5. space maintainers for covered dependent children under age 14 to replace primary teeth, 6. sealants for covered dependent children under age 14, 7. emergency palliative treatment for pain, 8. other dental x-rays if required for diagnosis and treatment of specific conditions, or 9. consultations for preventive, basic, major and orthodontic dental procedures.
Class B Services: Basic Dental Procedures		
<p>The limits on Class A Services are for routine services:</p> <ol style="list-style-type: none"> 1. oral surgery is limited to removal of teeth, preparation of the mouth for dentures and 	<p>The limits on Class B Services are for routine services:</p> <ol style="list-style-type: none"> 1. oral surgery is limited to removal of teeth, preparation of the mouth for dentures and 	<p>The limits on Class B Services are for the following routine services:</p> <ol style="list-style-type: none"> 1. oral surgery is limited to removal of teeth, preparation of the mouth for dentures and

<p>removal of tooth-generated cysts of less than 1/4 inch,</p> <ol style="list-style-type: none"> 2. extractions This service includes local anesthesia and routine post-operative care. (Coverage excludes the extraction of wisdom teeth); 3. recementing bridges, crowns or inlays, 4. fillings, other than gold, 5. general anesthetics upon demonstration of Medical Necessity 6. antibiotic drugs. 	<p>removal of tooth-generated cysts of less than 1/4 inch,</p> <ol style="list-style-type: none"> 2. extractions This service includes local anesthesia and routine post-operative care., 3. recementing bridges, crowns or inlays, 4. fillings, other than gold, 5. general anesthetics upon demonstration of Medical Necessity, 6. antibiotic drugs, 7. periodontics (gum treatments), 8. endodontics (root canals), 9. rebasing or relining of removable dentures, 10. mouth guards for bruxism (allowed once every 3 years). 	<p>removal of tooth-generated cysts of less than 1/4 inch,</p> <ol style="list-style-type: none"> 2. extractions. This service includes local anesthesia and routine post-operative care.), 3. recementing bridges, crowns or inlays, 4. fillings, other than gold, 5. general anesthetics upon demonstration of Medical Necessity, 6. antibiotic drugs, 7. periodontics (gum treatments), 8. endodontics (root canals), 9. rebasing or relining of removable dentures, 10. mouth guards for bruxism (allowed once every 3 years).
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Class C Services: Major Dental Procedures

<p>There are no Class C Services provided under the Preventive Plan</p>	<p>The limits on Class C Services are for routine services:</p> <ol style="list-style-type: none"> 1. gold restorations, including inlays, onlays and foil fillings (The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.), 2. installing precision attachments for removable dentures, 3. installing partial, full or removable dentures to replace one or more natural teeth. (This service also includes all adjustments made during a six-month period following the installation.), 4. addition of clasp or rest to existing partial removable dentures, 5. initial installation of fixed bridgework to replace one or more natural teeth which were extracted, 6. repair of crowns, bridgework and removable dentures, 7. Implants 	<p>The limits on Class C Services are for the following routine services:</p> <ol style="list-style-type: none"> 1. gold restorations, including inlays, onlays and foil fillings (The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.), 2. installing precision attachments for removable dentures, 3. installing partial, full or removable dentures to replace one or more natural teeth. (This service also includes all adjustments made during a six-month period following the installation.), 4. addition of clasp or rest to existing partial removable dentures, 5. initial installation of fixed bridgework to replace one or more natural teeth which were extracted, 6. repair of crowns, bridgework and removable dentures, 7. Implants
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	<p>8. replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth.; however, this item will apply only if one of these tests is met:</p> <ul style="list-style-type: none"> a. The replacement or addition of teeth is required because of one or more natural teeth being extracted. b. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable. c. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed. 	<p>8. replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth.; however, this item will apply only if one of these tests is met:</p> <ul style="list-style-type: none"> a. The replacement or addition of teeth is required because of one or more natural teeth being extracted. b. The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable. c. The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.
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Class D Services: Orthodontic Treatment and Appliances

<p>There are no Class D Services provided under the Preventive Plan</p>	<p>This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.</p> <p>These services include: preliminary study (x-rays, diagnostic casts and treatment plan), active treatments and retention appliance.</p> <p>Payments for comprehensive full-banded orthodontic treatments are made in installments. Benefits are paid at a percent of the total allowance after deductible is met, not to exceed the dental orthodontic maximum.</p>	<p>This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.</p> <p>These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.</p> <p>Payments for comprehensive full-banded orthodontic treatments are made in installments. Benefits are paid at a percent of the total allowance after deductible is met not to exceed the dental orthodontic maximum.</p>
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Filing a Claim

Eligibility Claim - Claims that relate solely to whether you are eligible to participate in the Health Plans, and that do not involve a claim for benefits under the Health Plans should be filed with, and are determined by the Plan Administrator. (File Eligibility Claims in writing to the [Claims Administrator's address](#).) The Plan Administrator's decisions regarding eligibility under the Health Plans are final, and are not subject to the Health Plan's appeals process.

Benefits Claim - Physicians and hospitals in the Banner Option and the PPO Option provider networks will automatically submit your claim for services to the Claims Administrator. The Claims Administrator will pay the network provider as agreed in their contract. You do not need to submit a claim.

If you did not use a network provider, **you** will have to keep the itemized bills (paid or unpaid), complete a medical claim form or prescription claim form, as appropriate, and send the form with the bills to the Claims Administrator for payment. Claims must be submitted within one hundred eighty (180) days from the date you received the medical service. See instructions on the claim form, available at www.BannerBenefits.com. Send your claim to:

Claims Administrator

Banner Plan Administration
P.O. Box 16423
Mesa, AZ 85211-6423
1- 800-827-2464
480-684-7070 (in the Phoenix Metro area)

All claims for services already received must be filed with the Claims Administrator no later than one hundred eighty (180) days following the date of the service. Claims submitted after that time will not be paid.

The Claims Administrator will process the claim and send you an Explanation of Benefits (EOB), which will detail the amounts covered and paid to the appropriate providers. If you have paid the provider and are to be reimbursed from the Claims Administrator, your claim must include proof of payment. You will be responsible for paying to the provider any amounts not covered under the Health Plan.

Claims Administrator will provide reimbursement forms and identification cards. You must complete and sign the "Employee Statement" of the reimbursement form. A separate reimbursement form must be filed for each covered person's claim. Itemized, original bills should be attached to the reimbursement form; unless all necessary information is included in the Physician's billing form.

Timelines Applicable to Appeals Decisions

- If your claim for urgent medical care or treatment is denied, the Claims Administrator will notify you of the denial within seventy-two (72) hours of receipt of the claim. In that case, the notification will be oral and a written confirmation will be furnished within the subsequent three (3) days. Urgent care claims are pre-service claims that require notification or approval prior to receiving medical care and a delay in the care:
 - could seriously jeopardize your life, health or your ability to regain maximum function, or
 - in the opinion of a physician with knowledge of your medical condition, could cause severe pain that could not be adequately managed without the care or treatment.

- If your claim for benefits for health care that has been received (post-service claim) is denied, the Claims Administrator will send you a written explanation of the reasons for denial within thirty (30) days of the receipt of your claim. The Claims Administrator may extend this time period for deciding the claim by fifteen (15) days if it finds the extension of time necessary and beyond its control, and if the Claims Administrator notifies you of the extension before the initial 30 day period expires.
- If your claim for services that require notification or approval prior to receiving health care (pre-service claim) is denied, the Claims Administrator will send you a written explanation of the reasons for denial within fifteen (15) days of receipt of your claim. The Claims Administrator may extend this time period for deciding the claim by fifteen (15) days if it finds the extension of time necessary and beyond its control, and if the Claims Administrator notifies you of the extension before the initial 30 day period expires.

If your claim is denied in whole or in part, including if the claim is denied because of incomplete information submitted by you, the Claims Administrator will notify you in writing or by electronic notification of the adverse benefit determination. The notification you receive will include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Health Plan provisions on which the determination is based;
- a description of any additional material or information that you must provide to complete your claim and an explanation of why the material or information is necessary;
- a description of the Health Plan's appeal procedures and time limits; and
- if an internal rule, guideline, protocol, or other criteria was used in making the adverse determination, the Claims Administrator will inform you of the specific rule, guideline, protocol, or other criteria and provide a copy of the rule, guideline, protocol, or other criteria free of charge to you upon request.

You have the right to access certain information and documents from the Claims Administrator used in making the initial determination. If your claim is denied, you may file an appeal. You must timely complete the claim and appeals procedures in order to exhaust your administrative remedies.

Appeals Procedure

If the your claim is denied, you have the right to file an Appeal by sending a written request for review by the Appeals Administrator within one hundred eighty (180) days of the notification that the original claim was denied. Your request for review is called an "appeal." Your appeal, and all supporting medical information and documentation, must be sent to the Appeals Administrator within one hundred eighty (180) days of your receipt of the notification that the original claim was denied. Receipt of the notification that the original claim was denied is presumed to occur three days after the date of the determination, unless the third day is a Sunday or federal holiday, in which case it is the first business day after. Your appeal is considered "complete" as of the earlier of (i) the date on which you inform us that you have submitted all supporting medical information and documentation for your appeal, or (ii) the last day of the 180 day period for submitting your appeal. For example:

- Claim was denied on Monday, October 3, 2011
- Receipt of the denial is presumed to occur Thursday, October 6, 2011
- You send a written appeal on January 3, 2012
- You cannot submit any information or documentation in support of your appeal after April 3, 2012

You can send your Appeal to:

Appeals Administrator

P.O. Box 16423 6th Floor

Mesa, AZ 85211-6423

480-684-7070

If you do not file your appeal within the allowed time frame, you will not be allowed to file an appeal. You must timely complete the claim and appeals procedures in order to exhaust your administrative remedies.

The Appeals Administrator will decide all appeals that are not overturned by the Claims Administrator's initial screening review. Prior to the Appeals and Grievance Committee's review of an appeal, the Claims Administrator will screen the appeal and pay the claim if it determines that payment is appropriate. The individual or Committee who screens the appeal on behalf of the Claims Administrator will not be the same individual or committee who decided your initial claim or be organizationally subordinate to those individual(s). The initial screening level of review of an appeal will not result in a denied appeal. Rather, any appeals that are not overturned in the screening process by the Claims Administrator will be reviewed by the Appeals Administrator for determination.

The Appeals Administrator does not include any individual(s) at the Claims Administrator who decided your original claim or anyone who is organizationally subordinate to such individual(s). If the adverse benefit determination is based in whole or in part on a medical judgment, the Appeals Administrator will consult with a physician or physicians who are not connected with your original claim and who are not subordinate to any physician consulted in connection with the claim decision.

Timelines Applicable to the Formal Appeal Process:

The Appeals Administrator will decide the appeal and send a notice of its decision to you as follows:

- If your claim was for urgent care, the Appeals Administrator will notify you of its decision within seventy two (72) hours of its receipt of your appeal. The Appeals Administrator will furnish a written determination within an additional three (3) days of the initial notification of its determination.
- If your claim was for a service that had not been received (a "pre-service" claim), the Appeals Administrator will notify you of its decision within fifteen (15) days of its receipt of your appeal.
- If your claim is for services that have already been received, the Appeals Administrator will notify you of its decision within thirty (30) days of its receipt of your appeal.

The written notice of decision will include:

- The specific reason or reasons for the adverse determination and reference to the specific Health Plan provisions on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or

similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Except as required by law, the decisions are final and binding on all parties.

Exhaustion of Administrative Remedies

You or your covered dependents must timely comply with and exhaust the Claims and Appeal Procedures described above for every issue deemed relevant by you or your covered dependent, prior to bringing an action for benefits under the Health Plan under Section 502(a) of ERISA. Exhaustion of the Appeal Procedure includes the requirement that you and your covered dependents timely raise all reasons for challenging a denial of benefits.

Limitations Period on Legal Actions and Choice of Venue

No legal action may be brought for benefits under the Health Plan after one (1) year from the date of the Appeals and Grievance Committee's final decision on appeal. Any legal action brought for benefits under the Health Plan must be filed in the United States District Court, District of Arizona - Phoenix.

General Provisions

Governing Documents

This booklet is incorporated into and part of the Master Health and Welfare Plan. Complete details of the Master Health and Welfare Plan, however, are not set forth in this booklet and the legal documents which constitute this document will govern. If there is any difference between this booklet and those of the Master Health and Welfare Plan Document,, the Plan Administrator, will apply the Master Health and Welfare Benefit Plan Document and this booklet in a consistent manner.

Plan Administration

The **Plan Administrator** has the sole and complete discretionary authority to control and manage the operation and administration of the Health Plans, and to construe the terms of the Health Plans, including the making of factual determinations. The Plan Administrator is Banner Plan Administration (BPA). You can contact BPA at 1-888-227-3688 or 480-684-7000 in the Phoenix-metropolitan area.

The **Claims Administrator** has the sole and complete discretionary authority to determine initial claims for Health Plan benefits and, in carrying out this function, to construe the terms of the Health Plans, including the making of factual determinations. The Claims Administrator is:

Banner Plan Administration
P.O. Box 16423
Mesa, AZ 85211-6423
800-827-2464
480-684-7070(in the Phoenix Metro area)

The **Appeals Administrator** has the sole and complete discretionary authority to determine participant appeals of denied claims for Health Plan benefits and, in carrying out this function, to construe the terms of the Health Plans, including the making of factual determinations. The Appeals Administrator is:

Appeals and Grievance Committee
P.O. Box 16423 6th Floor
Mesa, AZ 85211-6423
480-684-7070 (in the Phoenix Metro area)

The Claims Administrator (with respect to initial claims for benefits) and the Appeals Administrator (with respect to appeals of denied claims for benefits) shall have the discretionary authority to grant or deny benefits under the Health Plans. Benefits under the Health Plans will be paid only if the Claims Administrator, or Appeals Administrator, as applicable, decides in its sole and complete discretion that the applicant is entitled to them. The decisions of the Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, shall be final and conclusive with respect to all questions relating to the Health Plans.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Health Plans. The Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, may seek such expert advice as reasonably necessary with respect to the Health Plans. The Plan Administrator, Claims Administrator, and Appeals Administrator, as applicable, shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or

unlawful. The Plan Administrator may adopt uniform rules for the administration of the Health Plans from time to time, as it deems necessary or appropriate.

No Participant Vested Rights to Benefits

Banner reserves the right to change, modify, amend, suspend, or terminate any or all of the benefits provided here in whole or in part, at any time for any reason it determines to be appropriate, by a written instrument approved by the Health and Welfare Plan Committee, and executed by the Chief Executive Officer, Vice President Total Rewards, or Vice President Managed Care and Benefits Administration. No participant has a vested right to the continuation of any particular benefit provided by the Health Plans. Termination or amendment of a Health Plan will not affect any claim incurred while the Health Plan was in force, but Banner reserves the right to change prospectively the types of coverage it offers through the Health Plans.

Privacy of Personal Health Information

Banner Health, as Plan sponsor, is committed to protecting your private and personal health information. Banner has and will continue to enter into agreements with service providers, referred to as "business associates," that contractually protect your personal health information under the same guidelines as those used by Banner. Banner will not disclose your personal health information without your prior written consent or authorization, except as necessary for your treatment, payment for services rendered, healthcare operations or as otherwise permitted by law. Additionally, you have the right to access and review your own personal health information in accordance with procedures established by Banner and presented in the Notice of Privacy Practices issued separately.

Pre-Existing Conditions

No claim for health services will be denied on the grounds that a disease or physical condition existed prior to the effective date of you, your spouse/domestic partner or your covered dependent's coverage. However, no benefits are payable for services incurred prior to the effective date of coverage.

Waiver of Right

If the Plan Administrator fails to exercise any of its rights under the Health Plans, the failure to exercise any right, or the failure to require you to perform any obligations described in the Health Plans, will not be deemed a waiver of the right. The failure of the Plan Administrator to exercise its right will not prevent the Plan Administrator from exercising the right or requiring you to perform at any later time, and will not result in a waiver of its rights with respect to a subsequent event.

Coordination of Benefits Provisions

Coordination of Benefits

If you or your dependents are eligible under more than one Group Plan, the Group Plan assuming primary payor status shall determine benefits first without regard to coverage allowed under any other group plan. When a Banner Plan is the secondary payor, the benefits payable from the Banner Plan may be reduced so the total payment from all group plans does not exceed the normal liability of this Plan.

The coordination of Benefits provision does not apply under the Plan for outpatient prescription medications. Therefore this Plan will not coordinate benefits when a member has primary coverage under another plan for outpatient prescription medications.

For purposes of coordination, “Allowable Charge” shall mean any Usual, Reasonable and Customary charge considered in part or in full by at least one of the Plans. A claim determination period shall be a Plan Year. The allowable charges will be determined in accordance with National Association of Insurance Commissioners’ model rules. The term “Group Plan” includes Federal programs, i.e., CMS (Medicare, Medicaid), Tri-Care, as well as state-regulated automotive insurance medical coverage. The regulations governing such plans shall take precedence over the following Order of Benefit Determination of this Plan.

Order of Benefit Determination

Any group plan that does not contain a Coordination of Benefits provision shall be considered the primary payor. When all plans covering the covered person contain a Coordination of Benefits provision, order of payment will be as follows:

- The Plan covering the covered person as an employee shall be considered the primary payor over the plan covering that person as a dependent.
- When the covered person is a child of non-divorced or non-separated parents, the Plan of the parent who has the earliest birth date (month and day) in the year will be the primary payor. If both parents have the same date of birth, the Plan covering the child longer will be the primary payor.
- When the covered person is a child of divorced or separated, the order of payment shall be:
 - If a court has assigned the financial responsibility for health care expenses of the child, the terms of the court order shall take precedence over the Order of Benefit Determination of this Plan.
 - The Plan of the natural parent having legal custody of the child shall pay first.
 - The Plan of the spouse of the natural parent having legal custody of the child shall pay second.
 - The Plan of the parent not having legal custody of the child shall pay third.
 - The Plan of the spouse of the parent not having legal custody of the child shall pay fourth.
- The Plan covering the covered person as an active employee (or the employee’s dependent) shall be the primary payor over the Plan covering that person as either a retired or former employee (or the retiree or former employee’s dependent).
- If an individual is covered under COBRA coverage or state continuation coverage, the plan covering the individual as an employee or retiree (or as that person’s dependent) pays first, and the continuation coverage pays second. This rule applies only when both plans provide non-dependent coverage to the individual or both plans provide dependent coverage to the individual. If one plan provides dependent coverage and the other non-dependent coverage, rule #1 in this section applies.

- When the covered person is an employee under more than one plan, the plan covering such individual for the longer period of time shall be considered the primary payor.

Coordination with Medicare

If you or any of your dependents are eligible for Medicare, the coordination of your benefits works differently from the above rules. A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. In general, Medicare pays secondary to the following:

- The Banner Plan if you or any of your dependents is entitled to Medicare and entitled to Social Security disability benefits, but only while coverage under the Plan is due to your “current employment status” under Medicare rules (generally (i) while you are actively working, or (ii) during the first six months while you are not actively working and are receiving disability benefits from an employer). If coverage under the Banner Plan is other than because of your “current employment status” (after your employment terminates or after the sixth month that you receive disability benefits), Medicare is primary.
- The Banner Plan if you or any of your dependents is suffering from end-stage renal disease (ESRD) (*i.e.*, on kidney dialysis or needing a kidney transplant), but only for the first 30 months of ESRD treatment (the 30-month period begins with the month in which eligibility for Medicare benefits for ESRD begins). Thereafter, Medicare is primary. When this provision determines that Medicare is primary, the Banner Plan pays secondary regardless of whether you or your dependent (whoever is eligible) has enrolled in Medicare.

Subrogation and Reimbursement

Recovery of Benefits Paid or Payable

The Plan is designed to help meet the actual costs for which you (or your covered dependents) are responsible when you (or your covered dependent) have expenses due to sickness or injury. The Plan may not be obligated to pay for expenses due to a sickness or injury for which a third party is liable or legally responsible. The following rules apply to the payment of benefits under the Plan and are designed to avoid overpaying benefits, paying duplicate benefits, and paying benefits when sickness or injury benefits also are paid from another source or are otherwise determined not to be your responsibility. By accepting benefits under the Plan, you (and your covered dependent) agree to the following recovery terms and you agree to assist the Plan Administrator in the Plan’s recovery. All references in this “Recovery of Benefits Paid or Payable” section to “you” or “your” include your covered dependent(s), as well as the guardian, estate or other legal representative for you and your covered dependent.

Subrogation

If the Plan pays benefits for a sickness or injury that was caused by an act or omission of a third party, the Plan will be “subrogated” to all of your rights of recovery. “Subrogated” or “Subrogation” means the Plan may take your place (or “stand in your shoes”) in pursuing your legal rights or a legal claim against the third party or your right to any recovery pursued on your behalf by the Plan or anyone else. If you receive benefits under the Plan for a sickness or injury that was caused by an act or omission of a third party, you must immediately notify the Plan Administrator of the name of any third party against whom you might have a claim as a result of your sickness or injury.

If you are injured in an automobile accident and the person who hit you was at fault, the person who hit you (and his or her insurance company) is the third party whose act or omission caused your sickness or

injury. The following entities or forms of insurance are examples of third parties that may be responsible for making payment:

- Any no-fault insurance.
- Medical benefit coverage under any automobile liability plan. This includes your or any third party's policy under which you are entitled to benefits.
- Under-insured and insured motorist coverage.
- Any automobile medical payments and personal injury protection benefits.
- Any third party liability insurance.
- Any workers' compensation insurance.

By accepting benefits under the Plan, you agree to this subrogation provision (as well as the other provisions of the Plan), including that you:

- Automatically assign to the Plan (you "subrogate") any right to recover payments and any actual recovery from any third party.
- Agree to notify the Plan Administrator when a third party may be liable for a sickness or injury covered under the Plan. You further agree to notify the Plan Administrator within 30 days of making any claim relating to that third party's liability. Failure to notify the Plan Administrator will suspend benefit payments for the applicable sickness or injury. Such suspension will be lifted when you sign the agreement discussed below.
- Recognize the Plan's right to recover its payment for Plan expenses from the third party who caused and/or is liable for the sickness or injury related to the Plan's benefit payments.
- Agree to cooperate with the Plan to provide information about your sickness or injury and otherwise do whatever is necessary to secure the Plan's subrogation right, including signing any necessary documents for the Plan to fully subrogate your claim.
- Agree to cooperate fully with the Plan in collecting from the person who caused the sickness or injury. (If a claim is settled without protecting the Plan's interests, your rights to full compensation may be lost.)
- Agree that no settlement proceeds will be distributed unless and until the Plan's interest has been paid to the satisfaction of the Plan's fiduciaries.
- Agree to refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery from you or the third party.

After you notify the Plan Administrator that a third party may be liable for expenses, or if the Plan Administrator believes a third party may be completely or partially liable for your sickness or injury, the Plan will require you to sign a statement evidencing your agreement with these provisions and to cooperate with the Plan Administrator in pursuing its subrogation rights.

To exercise its subrogation rights, the Plan may: (1) place a lien against a third party to the extent benefits have been paid; (2) bring an action on its own behalf, or on your behalf, against the third party (even if you do not pursue a claim against a third party); and (3) join any action filed by or on your behalf in order to recover its benefit payments. The Plan may make a demand on you directly.

The Plan has a right of subrogation against recoveries from a third party, including a right to any property to which the original recovery is converted. The Plan is granted this right of subrogation against all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), however the recovery is designated (e.g., as payment for expenses). This right of recovery is primary, even if you are not made whole (i.e., compensated in full). The Plan's subrogation rights apply to any benefits paid or payable by the Plan on your behalf as a result of any sickness or injury that was caused by an act or omission of a third party and to the Plan's expenses to enforce its rights under this

section. This right of subrogation shall remain in effect until the Plan is repaid in full or until the claim is settled by the Plan fiduciary.

If you do not fully cooperate with the Plan in its efforts to enforce its subrogation rights, the Plan may reduce the amount payable to you or on your behalf for current or future expenses until the Plan has made a full recovery. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons where such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action against you.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right to subrogation. Also, the recovery rights of the Plan outlined in this provision will be reduced by an amount representing the Plan's agreed-upon share of any costs or attorney's fees you incurred in obtaining compensation.

Reimbursement

If the Plan pays benefits for a sickness or injury that was caused by an act or omission of a third party, the Plan has the right to be repaid (reimbursed) for such benefits from any settlement, judgment, or insurance proceeds you receive from (or on behalf of) that third party. You must repay the Plan on a first-dollar basis (meaning that the Plan has a right to be repaid first from any monies you receive). The Plan has a right to reimbursement whether or not the third party admitted liability for the payment and whether or not a portion of the settlement, judgment, or insurance proceeds was identified as a reimbursement of expenses or anything else. If you receive benefits under the Plan for a sickness or injury that was caused by an act or omission of a third party, you must immediately notify the Plan Administrator of the name of any third party against whom you might have a claim as a result of your sickness or injury.

A third party includes any person or organization (including an insurance company). For example, if you are injured in an automobile accident and the person who hit you was at fault, the person who hit you (and his or her insurance company) is the third party whose act or omission caused your sickness or injury. If appropriate under the circumstances, you or your insurer may be considered a third party if you are or may be responsible for your disability and/or you have insurance coverage for injury, illness, or disability. The following entities or forms of insurance are examples of third parties that may be responsible for making payment:

- Any no-fault insurance.
- Medical benefit coverage under any automobile liability plan. This includes your or any third party's policy under which you are entitled to benefits.
- Under-insured and insured motorist coverage.
- Any automobile medical payments and personal injury protection benefits.
- Any general liability insurance.
- Any worker's compensation insurance.

By accepting benefits under the Plan, you agree to this reimbursement provisions (as well as the other provisions of the Plan), including that you:

- Automatically assign to the Plan any right to recover payments and any actual recovery from any third party, including any payments the third party makes to you.
- Agree to notify the Plan Administrator when a third party may be liable for any sickness or injury covered under the Plan. You further agree to notify the Plan Administrator within 30 days of making any claim relating to that third party's claim. Failure to notify the Plan Administrator

will suspend benefit payments for the applicable sickness or injury. Such suspension will be lifted when you sign the agreement discussed below.

- Agree to repay to the Plan the benefits and/or expenses paid on your behalf out of any recovery made from the third party.
- Agree to hold any money received from a third party in trust for the benefit of the Plan and to distribute the proceeds to the Plan upon demand by the Plan.
- Recognize the Plan's right to recover its payment for expenses from the third party who caused and/or is liable for the sickness or injury related to the benefit payments.
- Agree to execute and deliver such instruments as may be required by the Plan and to do whatever is necessary to secure the Plan's right of reimbursement.
- Agree to cooperate fully with the Plan in collecting from the person who caused the sickness or injury. (If a claim is settled without protecting the Plan's interests, your rights to full compensation may be lost.)
- Agree that no settlement proceeds will be distributed unless and until the Plan's interest has been paid to the satisfaction of the Plan's fiduciaries.
- Agree to refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery.

After you notify the Plan Administrator that a third party may be liable for expenses, or if the Plan Administrator believes a third party may be completely or partially liable for your sickness or injury, the Plan will require you to sign statement evidencing your agreement with these provisions and to cooperate with the Plan Administrator in pursuing its reimbursement rights.

The Plan has a first-priority lien on any amount you recover from a third party, including a right to any property to which the original recovery is converted. The Plan is granted this right of first reimbursement from all recoveries from a third party (whether by litigation, arbitration, settlement of a claim, or otherwise), however the recovery is designated (e.g., as payment for expenses). This right of recovery is primary, even if you are not made whole (i.e., compensated in full). The Plan's reimbursement rights apply to any benefits paid or payable by the Plan on your behalf as a result of any sickness or injury that was caused by an act or omission of a third party and to the Plan's expenses to enforce its rights under this section. This first-priority lien and right of reimbursement shall remain in effect until the Plan is repaid in full or until the claim is settled by the Plan fiduciary.

If you do not reimburse the Plan from any settlement, judgment, or insurance proceeds, or otherwise do not fully cooperate with the Plan's attempts to make a recovery, the Plan may reduce the amount payable to or on your behalf for current or future benefits until the Plan has been fully reimbursed. If you recover amounts from the third party that exceed the benefit payments already made by the Plan, the Plan may reduce its payment of future expenses for the applicable sickness or injury by the excess. In the event the Plan makes total payments that exceed the maximum amount to which you are entitled, the Plan shall have the right to recover the excess amount from persons to, or for, or with respect to whom, such excess payments were made, including, but not limited to, withholding payments otherwise available under the Plan. The Plan also reserves the right to bring legal action to obtain such reimbursement.

The Plan has a right to reimbursement for any legal fees it expends in exercising its right to reimbursement. Also, the recovery rights of the Plan outlined in this provision will be reduced by an amount representing the Plan's agreed-upon share of any costs or attorney's fees you incurred in obtaining compensation.

Health Care Reform (Affordable Care Act 2010)

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act) were enacted in March 2010 and are commonly referred to as “Health Care Reform”. They provide for a number of changes for group health plans. The Departments of Labor, Health and Human Services and the Treasury have been issuing regulations in several phases to implement the new law.

Grandfathered Plans

Banner has determined that the Medical Plans (including Prescription Drug) offered to its employees are considered to be “grandfathered” under the requirements of the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply immediately with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the Plan Administrator (480-684-7070 or 1-800-827-2464). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

COBRA - Continuation of Coverage Option

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage is a temporary extension of group health coverage under the Plan. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage under the Plan.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive COBRA coverage.

COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

For additional information about your COBRA rights and obligations under the Plan, you should contact the COBRA administrator. Contact information is provided below.

What is COBRA Coverage?

COBRA coverage is a continuation of group health coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the COBRA administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the components of the Plan is available in other portions of this SPD.

Who is Entitled to Elect COBRA Coverage?

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse's or domestic partner's hours of employment are reduced;
- Your spouse's or domestic partner employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes enrolled in CMS (Part A, Part B, or both); or

- You become divorced or legally separated from your spouse or domestic partner .

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in CMS (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

COBRA After a Leave under the Family and Medical Leave Act (FMLA)

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee’s spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee’s failure to return to work at the end of the leave. This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (section below entitled “**Length of COBRA Coverage**”).

Employees Eligible for Federal Trade Adjustment Assistance

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual’s group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, promptly contact the COBRA administrator or you will lose the right to elect COBRA during a special second election period.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in CMS (Part A, Part B, or both), the employer will notify the COBRA Administrator of the qualifying event.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. If the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the COBRA Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify your COBRA Administrator**. The Plan requires you to notify your COBRA administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the form entitled "Employee/Spouse/Dependent Notice of Qualifying Event Form and Procedures" and you must follow the procedures specified on the form. If these procedures are not followed, or if the notice is not provided in writing to the COBRA administrator during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA**. You may obtain a copy of the Employee/Spouse/Dependent Notice of Qualifying Event Form and Procedures from the COBRA Administrator.

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit to the COBRA administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the COBRA administrator. Under federal law, you have 60 days from the date you receive the COBRA election notice, provided to you at the time of your qualifying event, to decide whether you want to elect COBRA under the Plan.

The Election Form must be completed, in writing, and mailed or hand delivered to the COBRA Administrator. Oral Communication regarding COBRA coverage is not acceptable as COBRA elections and will not preserve COBRA rights.

Deadline for COBRA Election

If mailed, your election must be postmarked and if hand-delivered, your election must be received by the COBRA Administrator no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

If you reject COBRA before the due date, you may change your mind as long as you furnish a complete Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. Any qualified beneficiary for which COBRA is not elected within the 60-day election period (specified in the Plan's COBRA election notice) **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You can lose the right to avoid pre-existing condition exclusions applied to you by other group plans if you have more than a 63 day gap in health coverage. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not continue COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. COBRA coverage can end before the end of the maximum coverage period for several reasons which are described in the section below entitled “Termination of COBRA Coverage before the End of the Maximum Coverage Period.”

When Plan coverage is lost due to the death of the employee, the covered employee’s divorce or legal separation, or a dependent child’s loses eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of employee’s hours of employment, and the employee became entitled to CMS benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last for up to 36 months after the date of CMS entitlement. For example, if a covered employee becomes entitled to CMS eight months before the date on which his employment terminates, COBRA coverage under the Plan’s Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of CMS entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to CMS within 18 months BEFORE the termination or reduction of hours. Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee’s hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee’s termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must provide notice to the COBRA Administrator, of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to do so will eliminate the right to extend the period of COBRA coverage.

Disability Extension of COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee’s termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee’s termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the COBRA administrator, in writing, of the Social Security Administration’s determination of disability within 60 days after the latest of:

- The date of the Social Security Administration’s disability determination
- The date of the covered employee’s termination of employment or reduction of hours
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee’s termination of employment or reduction of hours

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

You must provide a copy of the Social Security Administration's determination letter to the COBRA administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours. Failure to do so will result in a loss of entitlement for the disability extension of COBRA coverage.

Second Qualifying Event Extension of COBRA Coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the COBRA administrator, in writing, of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the form entitled "(Employee/Spouse or Dependent Notice of a Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified on the form. Failure to follow the procedures or failure to provide the notice in writing to the COBRA administrator during the 60-day notice period will result in a loss of entitlement for the second qualifying event extension.

Temporary Extension for PBGC Recipients and TAA-Eligible Individuals

The American Recovery and Reinvestment Act of 2009 ("ARRA") provides for temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a non-forfeitable right to a benefit any portion of which is to be paid by the PBGC) until their death (and their covered spouse and dependents for an additional 24 months after the covered employee's death), and TAA-eligible individuals while receiving TAA benefits. Both of these temporary extensions expire on December 31, 2010. Please contact the COBRA Administrator if you think you may fall into one of these classifications.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan have been exhausted or satisfied)
- A qualified beneficiary becomes entitled to CMS benefits (under Part A, Part B or both) after electing COBRA
- The employer ceases to provide any group health plan for its employees

- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of participants or beneficiaries not receiving COBRA coverage (such as fraud).

You must notify the COBRA administrator, in writing, within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to CMS or becomes covered under other group health plan coverage.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan for a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage. You will be notified of COBRA premium changes by the COBRA Administrator.

If you were involuntarily terminated between September 1, 2008 and May 31, 2010, you may be receiving a COBRA premium subsidy under ARRA. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health coverage, including COBRA coverage. If you have questions about these new tax provisions. You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

Payment for COBRA Coverage

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the COBRA Administrator. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. This is the date your Election Form is postmarked, if mailed or the date your Election Form is received by the individual at the address specified above if hand-delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure the amount of your first payment is correct. You may contact the COBRA administrator to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Additional Questions

Questions concerning your Plan or your COBRA rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Address Changes

In order to protect your family COBRA rights, you should keep the COBRA administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the COBRA administrator.

COBRA Administrator Contact Information

Discovery Benefits
203 10th Street North
PO Box 869
Fargo, ND 58107
866-451-3399 or 701-451-3399

Conversion Privilege

There is no conversion privilege after COBRA coverage ends.

Military Leave

If you are absent from employment due to your service in the Uniformed Services, you may drop your coverage as soon as you begin service. If you are called for military duty for up to 31 days, your coverage may be continued as long as you pay the required premium contributions. If you are on military duty for 31 days or more, coverage for you and your dependents may be continued for up to 24 months at employee rates, or, if earlier, until the date on which you fail to return from service or apply for a position of employment in accordance with the rules under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Extended coverage under USERRA runs concurrently with COBRA continuation coverage (see the **COBRA – Continuation of Coverage Option** for further information

“Uniformed Services” means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commission corps of the Public Health Service and any other category of persons designated by the President in time of war or emergency.

Your Rights Under ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes certain duties on the people responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For example:

- If you request copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may

require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials – unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If your claim for benefits is denied or ignored in whole or in part after a final review, you may file suit in a state or federal court.
- If the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor or file suit in federal court.
- If you file a suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the court costs and legal fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Plan Information

The name of the Plan:

Banner Medical, Prescription Drug and Dental Plans under the Banner Health Master Health and Welfare Benefits Plan

Plan Sponsor

Banner
c/o BPA Operations Compliance
525 W. Brown Road
Mesa, AZ 85201
800-827-2464
480-684-7070 (in the Phoenix-metropolitan area)

Employer Identification Number

45-0233470

Plan Identification Number:

500

The fiscal year-end:

December 31

(For purposes of maintaining the Banner Health Master Health and Welfare Benefits Plan's financial records.)

Plan Funding

Self-funded, with benefits paid from the general assets of Banner. The benefits under the Plan are supported by the contributions of Banner and Plan participants, in accordance with the contribution requirements established by Banner each year.

Plan Administrator

Banner Plan Administration
c/o BPA Operations Compliance
525 W Brown Road
Mesa, AZ 85201
800-827-2464
480-684-7070 (in the Phoenix Metro area)

(Legal process may be served upon the Plan Administrator at the above address.)

Claims Administrator

Claims Decisions (other than Mental Health Substance Abuse)

Banner Plan Administration
P.O. Box 16423
Mesa, AZ 85211-6423
1- 800-827-2464
480-684-7070 (in the Phoenix Metro area)

Mental Health Substance Abuse Decisions

CIGNA Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344
1-800-633-5354

Appeals Administrator

Appeals and Grievance Committee
P.O. Box 16423 6th Floor
Mesa, AZ 85211-6423
480-684-7070

COBRA Administrator

Discovery Benefits
3216 13th Ave South
PO Box 869 Fargo, ND 58107
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Glossary/Definitions

The following terms define specific wording used throughout this booklet.

“Allowed Charge” means the maximum amount payable under the Plan for a Covered Service. The payment of professional services shall be based on the Claims Administrator’s Allowed Charge Schedule.

“Ambulatory Surgical Facility” refers to a public or private licensed facility that has all of the following:

- CMS approved facility
- an organized medical staff of Physicians,
- permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures,
- continuous Physician services and supervision,
- registered nursing services whenever a patient is in the facility, and
- do not provide services or accommodations for a patient to stay overnight.

“Birthing Center” refers to a public or private licensed facility used to provide Medically Necessary services and/or supplies associated with childbirth.

“Change in Status” defined as marriage, divorce, birth or adoption of a child, death of a dependent, change in employment status (full-time to part-time or vice versa), or loss of coverage by you, your domestic partner or a dependent under this or another group plan. Also, any change in benefit options must be consistent with the change in family status.

“CHIP or SCHIP” refers to the Children’s Health Insurance Program Reauthorization Act of 2009. The law provides health care to millions of children across the country and went into effect on April 1, 2009. The programs are administered by each state that refer to this program as the State Child Health Insurance Program.

“CMS” is the Centers for Medicare and Medicaid Services.

“Coinsurance Amount” is the percent or portion of the allowed Charge (example: 20%) paid by you after the Deductible has been satisfied. Most coinsurance counts toward your annual out of pocket maximum.

“Common-law Marriage” shall be recognized for purposes of dependent eligibility if such marriage is recognized by the state in which you reside. Proof is required. Contact your local Human Resources office or The Service Center at Banner Plan Administration for more information.

“Complementary Medicine” refers to therapies that are generally used to maintain or improve wellness, prevent disease or to treat health problems using non-conventional techniques. Includes acupuncture, chiropractic and naturopathic services

“Congenital Defect” refers to birth defects or physical abnormalities that are present at birth.

“COBRA - Continuation of Coverage” refers to extended coverage for Qualifying Individuals under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

“Coordination of Benefits (COB)” refers to someone being eligible under more than one group plan, the group plan assuming primary payer status shall determine benefits first without regard to coverage allowed under any other group plan. When a Banner Plan is the secondary payer, the benefits payable

from the Banner Plan may be reduced so that the benefits paid by all plans do not exceed the maximum allowable benefits under the Banner Plan.

“Copayment” is the fixed dollar amount of cost sharing (example: \$140 emergency room copayment). Copays are the flat dollar amount you pay each time you need care. Copays do not count toward meeting the annual deductible or out-of-pocket maximum.

“Cosmetic Surgery” means a procedure performed primarily to preserve or improve appearance rather than to restore anatomy and/or functions of the body, which are lost or impaired due to an illness or injury.

“Covered Person” is a Covered Dependent, Covered Domestic Partner or Covered Employee.

“Custodial Care” means any skilled or non-skilled health services, or personal comfort or convenience related services, which provides general maintenance, supportive, preventative and/or protective care.

Custodial Care:

- Does not seek a cure
- Can be provided in any setting
- May be provided between periods of acute health care needs
- Is care provided to an individual whose health services requirements are stabilized and whose current medical condition is not expected to significantly and objectively improve or progress over a specified period of time

Custodial Care may include the supervision or participation of Providers, licensed nurse, or registered therapist as necessary or desirable services. The mere participation of these professionals does not preclude the services as being custodial in nature. If a trained non-medical person can safely and effectively perform the nature of the services, the services are custodial. Further, Custodial Care and the nature of those services are not altered by the availability of the non-medical person. Custodial Care may also be referred to as maintenance, domiciliary, respite, and/or convalescent care.

“Deductible” is an amount of Allowable Expenses for which the Covered Employee is responsible before the Plan pays.

“Diagnostic Service” is a test or procedure performed to detect or monitor specific symptoms of a disease or condition. A Physician must order it. Diagnostic services include, but are not limited to X-ray and other radiology services needed for the diagnosis of illness or injury, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

“Dialysis” is primarily used to provide an artificial replacement for lost [kidney](#) function ([renal replacement therapy](#)) due to [renal failure](#). Dialysis may be used for very sick patients who have suddenly but temporarily, lost their kidney function ([acute renal failure](#)) or for quite stable patients who have permanently lost their kidney function.

“ECHO” (Employees Choosing Healthy Options) is designed to provide you with an assessment of your health habits and rewards you for practicing healthy lifestyles. In order to support you in your journey throughout the year, Echo provides a number of opportunities and activities designed to help you be successful in reaching your destination.

“Eligible Dependent” is a domestic partner or dependent of yours who qualifies for membership under the Plan in accordance with the requirements as specified in the Eligibility and Effective Date of Employee Coverage Section.

“Eligible Employee” is a person entitled to become a member, as specified in the Eligibility Section, and who makes any required contribution to the Plan.

“Eligibility Period” begins 31 days from your date of hire or qualifying event. Enrollment must be completed no later than 31 days from your date of hire or from the date of the qualifying event. Your coverage begins the first of the month following date of hire or qualifying event. Enrollment may also occur during the annual enrollment period for an effective date of January 1st of the following year.

“ERISA” Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants are entitled to certain rights.

“Experimental and Investigative” refers to the use of any treatment, procedure, facility, equipment, drug, device, pharmacological regimens or supply determined by the Claims Administrator, with appropriate professional consultation, to be experimental, of unproved value, redundant in connection with other services or not accepted practice.

A drug, device, medical service, treatment or procedure is Experimental or Investigative:

- If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure was reviewed and approved by the treatment facility’s Institutional Review Board or other body serving a similar function, or a federal law requires such review and approval; or
- If the Claims Administrator in its sole discretion determines that there exists reliable evidence that the drug, device, medical treatment or procedure is the subject of ongoing phase 1 or phase 2 clinical trials, is the research, experimental study or investigational arm of an ongoing phase 3 clinical trial, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If the Claims Administrator in its sole discretion determines that there exists reliable evidence with respect to the drug, device, medical treatment or procedure that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of reliable treatment or diagnosis;
- If the Claims Administrator in its sole discretion determines that based on prevailing medical evidence the drug, device, medical treatment or procedure is Experimental or Investigative.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols use by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedures: or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

“Global Surgical Package” refers to the CMS Fee Schedule Data Base (MFSDB) which provides the postoperative periods that apply to each surgical procedure. The CMS approved amount for these procedures includes payment for services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians' offices and may include preoperative visits, intra-operative services and complications following surgery.

- Preoperative Visits.--Preoperative visits *after the decision is made to operate* beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.
- Intra-operative Services.--Intra-operative services that are normally a usual and necessary part of a surgical procedure.

- **Complications Following Surgery.**--All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room.

“Halfway House” is a sober living facility which follows a social and educational model. The facility may or may not provide services that require state licensure and may or may not have 24 hour supervision by licensed staff.

“Home Health Care Agency” refers to a public or private agency or organization that specializes in providing medical care in the home. Such a provider of service must be primarily engaged in providing skilled nursing services and other therapeutic services,

- have policies established by a professional group associated with the agency including at least one Physician and at least one Registered Graduate Nurse to govern the services provided,
- have a full time administrator and provide full time supervision of services by a Physician or Registered Graduate Nurse,
- maintain a complete medical record on each individual,
- be duly licensed, constituted and operated pursuant to law by the state in which the facility is located.

“Home Medical Equipment” is equipment that is able to withstand repeated use and used by a covered person for the therapeutic treatment of an active illness or injury. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a Physician’s prescription.

“Hospice” refers to specialized services designed to care for the terminally ill.

“Hospital” is an institution, which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis.

It is an institution, which meets all of the following requirements:

- care and treatment of an illness or injury through medical, surgical and diagnostic facilities under its control;
- the hospital provides supervision of a Hospital Administrative staff; and
- 24-hour-a-day services by nurses.

“Illness” is bodily sickness or disease, psychiatric disorders and, in the case of a newborn child, congenital abnormalities.

“Immediate Family” means a member’s parent, sibling, child, spouse or domestic partner. Services under this Plan are not covered when provided by a member of the member’s immediate family.

“Incurred Date” means the date that services are rendered unless specifically defined otherwise.

“Infertility” the inability to conceive after one year of trying with unprotected intercourse for couples in which the female is under 35 and six months of trying for couples in which the female is over 35.

“IV Infusion” may include total parenteral nutrition (TPN), lipids, antibiotics, chemotherapy, or other types of fluid replacement received directly into a vein and administered in the home, physician office, ambulatory treatment unit, or outpatient setting.

“Injury” is a condition, which results independently of illness, and all other causes and is a result of an external force.

“Inpatient” means treatment in CMS approved facility during that period when charges are made for room and board.

“Lifetime Maximum” means the total dollar amount of Covered Services an eligible member may receive during a lifetime.

“Medical Emergency” means an illness and/or injury manifesting itself by acute symptoms of sufficient severity (including severe pain), the symptoms of which occur suddenly and unexpectedly, requiring immediate medical care from the most accessible Hospital to prevent death or serious health impairment of the Member.

The Claims Administrator makes the determination of what constitutes a Medical Emergency with advice from appropriate medical or surgical consultants.

“Medically Necessary” means care and treatment that is recommended or approved by a Provider; is consistent with the Plan Participant’s condition and accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the Plan Participant or Provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the Plan Participant.

Note: All of these criteria must be met; merely because a Provider recommends or approves certain care does not mean that it is Medically Necessary or that it is covered under the Plan.

“Medically Non-Compliant” means a member who repeatedly fails to follow medical treatment regimen/medical recommendations of health plan providers

“Member” means the employee and eligible dependents including spouse that are enrolled in one of the Banner Health Plans listed in this SPD.

“Medicare” refers to Title XVII (Health Insurance for the Aged) of the United States Social Security Act as amended, also referred to as Centers for Medicare and Medicaid Services (CMS).

“Mental/Nervous Disorders” refers to neurosis, psychoneurosis, psychopathy, psychosis, and mental or emotional diseases or disorders of any kind.

“Out-of-Pocket Expenses” means Deductible and Coinsurance amounts paid by the Covered Member.

“Outpatient” means treatment either outside of a Hospital setting or at a Hospital when room and board charges are not incurred.

“Partial Hospitalization” means the continuous treatment for at least three (3) hours, but not more than 12 hours, in any 24-hour period by an approved Health Care Provider for the treatment of mental illness or substance abuse.

“Physician” means a person acting within the scope of his or her license and holding the degree of:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Dental Medicine (D.M.D.)
- Doctor of Podiatry Medicine (D.P.M.)

“Plan Sponsor” means Banner.

“Plan Year” is the 12-month period beginning January 1 and ending December 31.

“Practitioner” means a Physician or a person acting within the scope of applicable state licensure/certification and holding the degree of:

- Audiologist
- Doctor of Chiropractic (D.C.)

- Doctor of Optometry (O.D.)
- Certified Nurse Anesthetist (C.R.N.A.)
- Registered Physical Therapist (R.P.T.)
- Psychologist (Ph.D.) (D.ED.) (E.E.D.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Professional Counselor
- Master of Social Welfare (M.S.W.)
- Speech Therapist
- Licensed Nurse Midwife
- Occupational Therapist
- Physiotherapist

And any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

“Prenatal Care” consists of pre and post delivery services rendered within the provider’s office.

“QMCSO” is a court’s judgment, decree, or order (including approval of a settlement agreement) that states that you are legally responsible to provide medical coverage for that child.

“Qualifying Event” refers to any event, which would allow an individual to continue group health coverage as mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

“Second Opinion of Surgery” means an opinion of a Surgeon to evaluate the medical advisability of a covered person undergoing elective surgical procedures based on that specialist’s examination of the covered person. A Physician not related to, or affiliated with the physician that made the initial recommendation must perform the examination

“Self-Funded” means that the benefits under the Plan are paid through the contributions of the employees and the general assets of the Plan Sponsor (Banner Health)

“Subrogation” means the Plan may take your place (or “stand in your shoes”) in pursuing your legal rights or a legal claim against the third party or your right to any recovery pursued on your behalf by the Plan or anyone else.

“Usual, Reasonable and Customary” or “Usual and Reasonable” as determined by the Claims Administrator is defined as:

- Usual – the charge the Provider most frequently makes to the majority of patients for the same service or procedures.
- Reasonable – the charge is reasonable when it meets the Usual and Customary criterion, or if, upon review, it merits special consideration based on the complexity of treatment of a particular case.
- Customary – the charge is within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other Providers.

“Wilderness Program” is a structured residential program with a social educational model that addresses attitude, self esteem and motivation rather than a medical model. May or may not have 24 hour supervision by licensed staff.

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