2027 Summary of Benefits

Banner Medicare Advantage Dual HMO D-SNP (H4931-007)

This is a summary of drug and health services covered January 1, 2027 - December 31, 2027.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.BannerHealth.com/MA or you can call our Customer Care Center for help.

Hours of Operation

You can call us from 8 a.m. to 8 p.m., seven days a week.

How to Contact Us

If you are a member of this plan, call toll-free 877-874-3930, TTY 711.

If you are not a member of this plan, call toll-free 877-874-3938, TTY 711.

Our website: www.BannerHealth.com/MA.

Who Can Join?

To join Banner Medicare Advantage Dual, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and the Arizona Health Care Cost Containment System (AHCCCS), or Medicaid, and live in our service area. Our service area includes the following counties in Arizona: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, and Yuma.

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and AHCCCS (Medicaid). How much AHCCCS (Medicaid) covers depends on your income, resources and other factors. You can enroll in this plan if you are in one of these AHCCCS (Medicaid) categories:

- **Full Benefits Dual Eligible (FBDE):** A member who is enrolled with an AHCCCS (Medicaid) Contractor for full Medicaid services (AHCCCS benefits) and who is receiving both Medicare Part A and Part B services. These individuals are considered to be Full Benefit Dual Eligible Members and includes Qualified Medicare Beneficiary Plus (QMB Plus), Specified Low-Income Medicare Beneficiary Plus (SLMB Plus), and Other Full Benefit Dual Eligible (Other FBDE Freedom to Work) populations. A Full Benefit Dual Eligible Member does not include those individuals enrolled with AHCCCS as Partial Dual Eligible in the following population categories: QMB Only, SLMB Only or QI-1.
- **Qualified Medicare Beneficiary with AHCCCS Benefits (QMB Plus):** An individual who is a Full Benefit Dual Eligible Member entitled to Medicare Part A, meets the Federal income standard of equal to or less than 100 percent of the Federal Poverty Level (FPL), and whose resources do not exceed three times the Supplemental Security Income (SSI) limit. AHCCCS (Medicaid) shall provide payment of the applicable Medicare Part A premium, the applicable Medicare Part B premium, deductibles coinsurance, and co-payments (except for Medicare Part D. Members who qualify as QMB Plus are individuals who are determined to be eligible for full AHCCCS (Medicaid) benefits. QMB Plus individuals are entitled to QMB AHCCCS (Medicaid) Benefits, plus all benefits under the State Plan for fully eligible AHCCCS (Medicaid) recipients.

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- **Specified Low-Income Medicare Beneficiary (SLMB Plus):** An individual who is entitled to Medicare Part A, has income that exceeds 100 percent of the FPL but less than 120 percent of the FPL, and resources do not exceed three times the SSI limit. Members who qualify as SLMB Plus are individuals who meet the standards for SLMB eligibility but who also meet the criteria for full AHCCCS (Medicaid) coverage. Such individuals are entitled to AHCCCS (Medicaid) payment of the Medicare Part B premium, Medicare premiums, deductibles, coinsurance, and copayments (except for Medicare Part D) as well as full state AHCCCS (Medicaid) benefits.
- **Other Full Benefits Dual Eligible (Freedom to Work):** An individual who is entitled to Medicare, does not meet either QMB Plus or SLMB Plus categorical income criteria, but is determined eligible for full AHCCCS (Medicaid) benefits (Freedom to Work Member). For an Other Full Benefit Dual Eligible Member, AHCCCS (Medicaid) does not provide payment for either Medicare Part A or Medicare Part B premiums.

If your category of AHCCCS (Medicaid) eligibility changes, your cost share may also increase or decrease. You must recertify your AHCCCS (Medicaid) enrollment to continue to receive your Medicare coverage.

Which Doctors, Hospitals, and Pharmacies Can I Use?

Banner Medicare Advantage Dual has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directories on our website: www.BannerHealth.com/MA. Or call us, and we will send you a copy of the provider directory and pharmacy directory.

What Do We Cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – however, we cover even more.

- Our plan members get all of the benefits covered by Original Medicare.
- Our plan members also get more than what is covered by Original Medicare.
- Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.BannerHealth.com/MA.
- Or call us, and we will send you a copy of the formulary.

Tips For Comparing Your Medicare Choices

This *Summary of Benefits* booklet gives you a summary of what Banner Medicare Advantage Dual covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklet, or use the Medicare Plan Finder on medicare.gov
- If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View it online at medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Legal Information

Banner Medicare Advantage Dual HMO D-SNP has contracts with Medicare and Medicaid. Enrollment depends on contract renewal.

Out-of-network / non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Care Center or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

Medicare Cost Sharing: If you are a Full Benefit Dual Eligible, Qualified Medicare Beneficiary Plus, Specified Low-Income Medicare Beneficiary Plus or other Full Benefit Dual Eligible (Freedom to Work), you will pay $0 for your Medicare-covered services as noted by the cost sharing in the chart.



Plan Premium, Deductible, and Maximum Out-of-Pocket (MOOP)

Out-of-Pocket Costs	
Monthly Plan Premium	**$0** per month. You are not responsible for paying because you are eligible for Medicare plan premium help under AHCCCS (Medicaid), you pay $0.
Part B Premium Reduction	**$2.00 per month.** If AHCCCS (Medicaid) isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A. If you are a non-QMB Freedom to Work individual, you are responsible for paying your Medicare Part B premium, we will reduce your monthly Medicare Part B premium by $2.00. Please refer to the Evidence of Coverage (EOC) for more information.
Medical Plan Deductible	**$0** You are not responsible for the deductible because you are eligible for Medicare cost-sharing help under AHCCCS (Medicaid).
Maximum Out-of-Pocket	**$9,850** This is the most you will pay out of pocket each year for Medicare-covered services and supplies received from network providers. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services because you are eligible for Medicare cost-sharing help under AHCCCS (Medicaid).

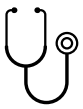
For AHCCCS (Medicaid)-covered services, refer to the "Arizona Health Care Cost Containment System (AHCCCS) Medicare Advantage Special Needs Plan for Dual Eligible Members 2027 Benefits" section in this document.

Medical and Hospital Benefits



Hospital Coverage and Ambulatory Surgery Center

Benefit	What you pay
Inpatient Hospital Stay	**$0 copayment** Our plan covers 90 days per benefit period for Medicare-covered inpatient hospital stays. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Prior authorization is required.
Outpatient Hospital Services	**0% coinsurance** per visit. **$0 copayment** per visit for diagnostic preventive colonoscopy. May require prior authorization.
Hospital Observation Services	**0% coinsurance**
Ambulatory Surgery Center	**0% coinsurance** per visit. **$0 copayment** per visit for diagnostic preventive colonoscopy. May require prior authorization.



Primary Care Provider (PCP) and Specialist Visits

Benefit	What you pay
PCP	**0% coinsurance**
Specialist	**0% coinsurance** May require prior authorization.



Preventive Care Screenings and Annual Physical Exam

Here's a list of the covered Medicare preventive services:

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings & counseling
- Bone mass measurements
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings:
  - Blood based biomarker tests
  - Colonoscopies
  - Computed tomography (CT) colonography
  - Fecal occult blood tests
  - Flexible sigmoidoscopies
  - Multi-target stool DNA tests
- Counseling to prevent tobacco use and tobacco-caused disease
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma screenings
- Hepatitis B (HBV) virus screenings
- Hepatitis C virus screenings
- Human immunodeficiency virus (HIV) services:
  - HIV screenings
  - Pre-exposure prophylaxis (PrEP) for HIV prevention
- Lung cancer screenings
- Mammograms (screening)
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program
- Obesity behavioral therapy
- Preventive visits:
  - "Welcome to Medicare" preventive visit
  - Yearly "Wellness" visit
- Prostate cancer screenings
- Sexually transmitted infections screenings and counseling
- Vaccines (or shots):
  - COVID-19 vaccines
  - Flu vaccines
  - Hepatitis B vaccines
  - Pneumococcal vaccines

Any additional preventive services approved by Medicare during the contract year will be covered. For more information on Medicare covered preventive services, please refer to the *Evidence of Coverage* online at www.BannerHealth.com/MA or call us.

Benefit	What you pay
Preventive Care (Medicare-covered)	**$0 copayment**
Annual Physical Exam	**$0 copayment**

Emergency and Urgent Care

Benefit	What you pay
Emergency Care	**0% coinsurance**
Urgent Care	**0% coinsurance**

Diagnostic Labs, Tests, and Radiological Services

Benefit	What you pay
Diagnostic Tests and Procedures	**0% coinsurance** May require prior authorization.
Lab Services	**0% coinsurance** May require prior authorization.
Diagnostic Radiology Services (e.g., MRIs, CT scan, Nuclear Medicine Services, etc.)	**0% coinsurance** May require prior authorization.
Outpatient X-rays	**0% coinsurance** May require prior authorization.
Therapeutic Radiology Services (e.g. Radiation Therapy for Cancer, etc.)	**0% coinsurance** Prior authorization is required.

Hearing Services

You must use Banner Medicare Advantage Dual's contracted network providers for these services.

Benefit	What you pay
Hearing Exam (Medicare-covered)	**0% coinsurance**
Routine Hearing Exam	**$0 copayment** Limit 1 exam every year.



Hearing Services (continued)

Benefit	What you pay
Fitting / Evaluation for Hearing Aids	**$0 copayment** Limit 1 visit every year. Prior authorization is required.
Hearing Aids	This plan includes up to a **$3,300** annual allowance for covered services. Covers hearing aids, repairs, and maintenance parts. Any cost above **$3,300** is your responsibility, additional hearing aids are not covered. **$0 copayment** Limit of 1 hearing aid every year per ear. Prior authorization is required.



Dental Services

You must use Banner Medicare Advantage Dual's contracted network providers for these services.

Benefit	What you pay
Dental Services (Medicare-covered)	**0% coinsurance**
Combined Preventive and Comprehensive Dental Services	This plan includes up to a **$3,000** annual benefit amount (allowance) for preventive and comprehensive dental services. Cost of all visits will be deducted from yearly coverage amount. Any cost above **$3,000** is your responsibility.
Preventive Dental Services	**$0 copayment** Preventive coverage includes: • Oral exam – 2 per calendar year • Cleaning – 2 per calendar year • Fluoride – 2 per calendar year • Bitewing X-ray – 1 per calendar year Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please refer to the plan's Evidence of Coverage for details.



Dental Services (continued)

Benefit	What you pay
Comprehensive Dental Services	**$0 copayment** Comprehensive coverage includes: • Restorative services • Endodontics • Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery • Adjunctive General Services Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please refer to the plan's Evidence of Coverage for details.



Vision Services

You must use a VSP Advantage network provider for non-Medicare vision services.

Benefit	What you pay
Eye Exam (Medicare-covered)	**0% coinsurance** Includes annual glaucoma screening.
Eyewear (Medicare-covered)	**0% coinsurance** for Medicare-covered eyeglasses or contact lenses after cataract surgery.
Routine Eye Exam	**$0 copayment** for annual routine eye (eye refraction) exam.



Vision Services (continued)

Benefit	What you pay
Routine Eyewear	This plan includes up to a **$200** annual allowance for frames or contact lenses (fitting and contacts). Eyeglasses (lenses and frames) or contacts (annual supply) are limited to one every year up to annual allowance. • Single vision, lined bifocal, lined trifocals covered every year. • Standard progressive lenses covered every year. • Additional savings of 20%-25% on additional lens upgrades. Discounts do not apply at Costco or Walmart / Sams Club. Any costs above annual allowances or additional lens upgrades are member responsibility. **$0 copayment** for routine eyeglasses (lenses and frames). **$0 copayment** for routine contact lenses (in lieu of glasses).



Mental Health Services

Benefit	What you pay
Outpatient Mental Health Services (Individual or Group Sessions)	**0% coinsurance** per individual or group session with a mental health professional (non-psychiatrist).
Psychiatric Services (Individual or Group Sessions)	**0% coinsurance** per individual or group session with a psychiatrist.
Intensive Outpatient Program Services	**0% coinsurance** May require prior authorization.
Partial Hospitalization Program	**0% coinsurance** May require prior authorization.



Skilled Nursing Facility and Rehabilitation Services

Benefit	What you pay
Skilled Nursing Facility (Medicare-covered)	**$0 copayment** Our plan covers 100 days per benefit period for Medicare-covered skilled nursing facility (SNF). A benefit period begins the day you go into a SNF. The benefit period ends when you haven't received any inpatient skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Prior authorization is required.
Occupational Therapy Visits	**0% coinsurance** Prior authorization is required.
Physical Therapy and Speech Therapy Visits	**0% coinsurance** Prior authorization is required.
Cardiac Rehabilitation Services	**0% coinsurance** Prior authorization is required.
Intensive Cardiac Rehabilitation Services	**0% coinsurance** Prior authorization is required.
Pulmonary Rehabilitation Services	**0% coinsurance**
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**0% coinsurance** Prior authorization is required.



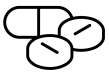
Ambulance and Transportation Services

Benefit	What you pay
Ambulance Services	**0% coinsurance** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip. Prior authorization is required for non-emergency Medicare-covered ambulance services.



Ambulance and Transportation Services (continued)

Benefit	What you pay
Routine Transportation (non-emergent)	**$0 copayment** for up to 36 one-way trips during current benefit year to plan-approved non-Medicare covered benefit locations using rideshare services, van and medical transport. Limited to plan-approved non-Medicare covered benefit locations not covered by Medicare or AHCCCS (Medicaid): • Routine chiropractic services, dental services, hearing / hearing aid services, podiatry, and eye exam / eyewear providers • OTC benefits • Food and Produce benefits • Silver&Fit® fitness facilities • Other plan approved locations. Each one-way trip must not exceed 50 miles. One trip is one-way transportation, a round trip is two trips. Transportation services must be requested 3 business days prior to a scheduled appointment or trip. Contact our Customer Care Center at 877-874-3930, TTY 711 to schedule a trip.



Medicare Part B Drugs

Medicare-covered Part B Drugs may be subject to step therapy requirements.

Benefit	What you pay
Medicare Part B Drugs	**0% coinsurance** for chemotherapy, radiation, and other Part B drugs. May require prior authorization.
Medicare Part B Insulin	**0% coinsurance**

Other Benefits



Chiropractic Care

Benefit	What you pay
Chiropractic Visit (Medicare-covered)	**0% coinsurance** Prior authorization is required.
Routine Chiropractic Visit	**$0 copayment** Limit 6 visits every year.



Dialysis and Kidney Disease Services

Benefit	What you pay
Dialysis Services (Medicare-covered)	**0% coinsurance**
Kidney Disease Education Services	**0% coinsurance** Referral is required.



Fitness Benefit

Benefit	What you pay
Physical Fitness Benefit	**$0 copayment** for access to fitness centers, classes and kits. Fitness classes/fitness kits provided by the Silver&Fit® program. The Silver&Fit program® is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on: • Fitness center membership • Digital fitness videos • Home fitness tools



Fitness Benefit (continued)

Benefit	What you pay
Physical Fitness Benefit (continued)	The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit and the Silver&Fit logo are trademarks of ASH and used with permission here. Kits are based on availability and subject to change. Fitness center participation may vary by location and is subject to change.



Foot Care (Podiatry Services)

Benefit	What you pay
Foot Exams and Treatment (Medicare-covered)	**0% coinsurance** Prior authorization is required.
Routine Podiatry Visits	**$0 copayment** Limit of 6 visits every year. Prior authorization is required.



Home Delivered Meals

Benefit	What you pay
Home Delivered Meals	**$0 copayment** for up to 14 meals delivered to the member's home immediately following surgery or after each inpatient stay in a hospital or skilled nursing facility. Meals must be ordered within 30 days of discharge. Benefit coordination assistance from the plan will be provided as needed. Referral is required.



Home Health Care

Benefit	What you pay
Home Health Care	**$0 copayment** May require prior authorization.



Medical Equipment and Supplies

Benefit	What you pay
Durable Medical Equipment (e.g., Wheelchairs, Oxygen)	**0% coinsurance** May require prior authorization.
Medical Supplies	**0% coinsurance** May require prior authorization.
Prosthetics (e.g., braces, artificial limbs)	**0% coinsurance** May require prior authorization.
Diabetic Shoes and Inserts	**0% coinsurance** Prior authorization is required.
Diabetic Monitors	**0% coinsurance** for diabetic monitors. Prior authorization is required.
Diabetic Monitoring Supplies	**0% coinsurance** for diabetic monitoring supplies such as blood glucose test strips, lancets, supplies for external infusion pumps, supply allowance for continuous glucose monitors, and blood glucose control/calibration solutions. Diabetic monitoring supplies and services are limited to certain manufacturers. May require prior authorization.



Nurse Advice Line

Benefit	What you pay
Nurse On Call	**$0 copayment** for health care advice, 24 hours a day, 7 days a week, from a nursing professional to help answer your immediate health care questions.



Opioid Treatment Program Services and Outpatient Substance Use Disorder Services

Benefit	What you pay
Opioid Treatment Program Services	**0% coinsurance** Prior authorization is required.
Outpatient Substance Abuse Use Disorder Services (Individual or Group Sessions)	**0% coinsurance**



Other Medicare-covered Preventive Services

Benefit	What you pay
Digital Rectal Exam	**0% coinsurance**
EKG Following Welcome to Medicare Visit	**0% coinsurance**



Over the Counter (OTC) Benefit

Benefit	What you pay
OTC Benefits	Each quarter you are enrolled with the plan you receive a **$300** allowance loaded to your &more card to purchase OTC items such as aspirin, vitamins, cold and cough preparations, and bandages. OTC items are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan.



Over the Counter (OTC) Benefit (continued)

Benefit	What you pay
OTC Benefits (continued)	Unused funds do not roll over and expire at the end of the quarter. For complete program details including instructions, store locator, for a list of eligible OTC items that may be accessed using your &more card, for issues using your &more card and terms and conditions, please visit andmorehealth.com or the andmore mobile app or by calling 1-855-AND-MORE (1-855-263-6673). &more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Incorporated. Use of this card is subject to the terms and conditions of the Cardholder Agreement.



Rewards

Rewards	
Annual Wellness Visit	**$50 reward** for completion during the plan benefit year.
Breast Cancer Screening	**$25 reward** for completion during the plan benefit year.
Colorectal Cancer Screening	**$25 reward** for completion during the plan benefit year.



Special Supplemental Benefits for the Chronically Ill (SSBCI)

Benefit	What you pay
SSBCI Healthy Food and Produce and / or Utilities Benefits	Members who have one or more chronic conditions and that meet certain criteria may be eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI). The SSBCI listed as follows are part of a combined benefit package along with your Over-The-Counter (OTC) Benefit. Each quarter you are eligible and enrolled with the plan you receive a **$300** allowance loaded to your &more card. In addition to OTC items, you may also use your allowance to pay for Healthy Food and Produce or Utility expenses.

Special Supplemental Benefits for the Chronically Ill (SSBCI) (continued)

Benefit	What you pay
SSBCI Healthy Food and Produce and / or Utilities Benefits (continued)	**Healthy Food and Produce** Approved foods, such as produce, dairy, meat and seafood, frozen items, packaged items, and drinks. Certain items, such as alcohol, candy, sodas, and desserts are not covered due to Medicare rules. **Utilities** Utility expenses such as gas, electric, water, phone and internet. Unused funds do not roll over and expire at the end of the quarter. For complete program details including instructions, store locator, for issues using your &more card and terms and conditions, please visit andmorehealth.com or the andmore mobile app or by calling 1-855-AND-MORE (1-855-263-6673). The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization / adverse outcomes and require intensive care coordination to manage chronic conditions such as diabetes mellitus, chronic kidney disease (CKD), cardiovascular disorders, chronic and disabling mental health conditions, and chronic heart failure. Not all members with a chronic condition will qualify, as other coverage criteria may apply. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage. &more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Incorporated. Use of this card is subject to the terms and conditions of the Cardholder Agreement.

Telehealth Services

Benefit	What you pay
Telehealth Services (Medicare-covered)	**0% coinsurance** May require prior authorization.

Medicare Part D Prescription Drugs

Because you are eligible for AHCCCS (Medicaid), and you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug costs. As shown below, there are "drug payment stages" for your Medicare Part D prescription drug coverage under Banner Medicare Advantage Dual. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Prescription Drug Stages	
Out-of-Pocket Threshold	**$2,400** Total yearly out-of-pocket drug costs are the total copayment or coinsurance costs paid by you. However, because you get "Extra Help" paying for your prescription drug coverage, you may not reach the **$2,400** out of pocket.
Prescription Drug Deductible	**$0** Because you get "Extra Help" paying for your prescription drug coverage, you will not pay the standard Part D deductible, and coverage will begin in the Initial Coverage Stage.
Initial Coverage Limit	Because you get "Extra Help", you begin in the Initial Coverage Stage. During the Initial Coverage Stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost until your total yearly out-of-pocket drug costs reach **$2,400**. Total yearly out-of-pocket drug costs are the total copayment or coinsurance costs paid by you. However, because you get "Extra Help" paying for your prescription drug coverage, you may not reach the **$2,400** out of pocket. You will pay your "Extra Help" or LIS cost sharing per prescription until you reach **$2,400**. You may get your drugs at network retail or mail order pharmacies.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$2,400**, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Initial Coverage Stage

Your share of the cost when you get a **one-month (31-day)** or a **three-month (90-day) supply** of a covered Part D prescription drug:

What you pay (Initial Coverage)	
Generics (including brand drugs treated as generic)	**$0, $1.65, or $5.80** (each prescription)
All other drugs	**$0, $5.00, or $14.40** (each prescription)

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Prescriptions filled at an out-of-network pharmacy are covered at the same cost sharing as an in-network pharmacy. For more information on your prescription drug benefit, please call us, or access the Evidence of Coverage online at www.BannerHealth.com/MA.

Important message about what you pay for Part D vaccines: Our plan covers many vaccines at no cost to you.

Important message about what you pay for Part D insulins: Because you qualify for and are receiving "Extra Help" or the low-income subsidy (LIS), you will never pay more than your LIS cost sharing amount for a one-month supply.

Please refer to the Drug List for a list of covered drugs, vaccines and insulin. A copy of the Drug List can be found on our website: www.BannerHealth.com/MA.

Arizona Health Care Cost Containment System (AHCCCS)
Medicare Advantage Special Needs Plans for Dual Eligible Members 2027 Benefits

In order for you to better understand your health care options, the following chart notes your charges for certain services under the Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) as an individual who has both Medicare and AHCCCS (Medicaid).

Your Medicare cost sharing responsibility is based on your level of AHCCCS (Medicaid) eligibility.

- Qualified Medicare Beneficiary (QMB) - $0. Your Medicare cost sharing amounts will be paid by your AHCCCS (Medicaid) Health Plan unless otherwise noted below.
- Non-QMB with Medicare Parts A and B – Your Medicare cost sharing amounts will be paid by your AHCCCS (Medicaid) Health Plan only when the benefit is also covered by AHCCCS (Medicaid).

Benefit	As an AHCCCS QMB Dual Eligible – You Pay:	As an AHCCCS Non-QMB Dual Eligible – You Pay:	As a Banner Medicare Advantage Dual Member – You Pay (see previous section for coverage details):
ACUTE AND LONG-TERM CARE MEDICAID PROGRAMS (1)			
Inpatient Hospital Stay	$0	$0	**$0**
Inpatient Behavioral Health Care Stay	$0	$0	**$0**
Nursing Facility Services	$0	$0	**$0**
Home Health Care Visit	$0	$0	**0%**
Primary Care Physician (PCP) Visits	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over (2). $0 for ages 20 and under.	**0%**
Specialist Physician Visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**0%**

Benefit	As an AHCCCS QMB Dual Eligible – You Pay:	As an AHCCCS Non-QMB Dual Eligible – You Pay:	As a Banner Medicare Advantage Dual Member – You Pay (see previous section for coverage details):
Medicare-Covered Services, including Chronic/Complex Case Management, etc.	$0	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**0%**
Chiropractic Visits	$0	$0 for ages 20 and under; $0 to $2.30, for ages 21 over depending on eligibility (2), for up to 20 medically necessary visits beginning October 1st of each year (additional visits may be authorized if medically necessary)	**0%**
Podiatry Services Visit	$0	$0	**0%**
Outpatient Behavioral Health Care Visit	$0	$0	**0%**
Outpatient Substance Abuse Care Visit	$0	$0	**0%**
Ambulatory Surgical Center or Outpatient Hospital Facility Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**0%**
Ambulance Services	$0	$0	**0%**
Emergency Services	$0	$0	**0%**
Urgently Needed Care Visit	$0	$0 to $4 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**0%**
Outpatient Occupational / Physical / Speech Therapy Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**0%**

Benefit	As an AHCCCS QMB Dual Eligible – You Pay:	As an AHCCCS Non-QMB Dual Eligible – You Pay:	As a Banner Medicare Advantage Dual Member – You Pay (see previous section for coverage details):
Durable Medical Equipment	$0	$0	**0%**
Prosthetic Devices	$0	$0. *Lower limb microprocessor controlled limb or joint not covered for ages 21 and over.*	**0%**
Diabetes Self-Monitoring Training & Supplies (when provided as part of a PCP visit)	$0	$0	**0%**
Community Health Worker (CHW) Visit	$0	$0	**$0**
Diagnostic Tests, X-rays, and Laboratory Services (including COVID-19 diagnostic & testing services)	$0	$0	**0%**
Colorectal Screening	$0	$0	**$0**
Flu and Pneumonia Vaccines	$0	$0	**$0**
Screening Mammogram	$0	$0	**$0**
Pap Smear and Pelvic Exam	$0	$0	**$0**
Prostate Cancer Screening	$0	$0	**$0**
Renal Dialysis or Nutritional Therapy for End-Stage Renal Disease	$0	$0	**0%**

Benefit	As an AHCCCS QMB Dual Eligible – You Pay:	As an AHCCCS Non-QMB Dual Eligible – You Pay:	As a Banner Medicare Advantage Dual Member – You Pay (see previous section for coverage details):
Prescription Medications (3)	$0	$0 to $2.30 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	Generics (including brand drugs treated as generic): **$0, $1.65 or $5.80** (each prescription) All other drugs: **$0, $5.00, or $14.40** (each prescription)
Hearing Exams, Routine Hearing Tests, and Fitting Evaluations for a Hearing Aid	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**0% coinsurance** for Medicare-covered hearing exams. **$0 copayment** for routine hearing services.
Hearing Aids	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**$0**
Cochlear Implants	$0	$0	**$0**
Routine Eye Exam, Eyeglasses, Contact Lenses, Lenses and Frames	$0 for ages 20 and under. *Not covered for ages 21and over unless following cataract surgery.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**$0**
Adult Emergency Dental Services	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	**$0**
Non-Emergency Medically Necessary Transportation	$0	$0	**$0**

Benefit	As an AHCCCS QMB Dual Eligible – You Pay:	As an AHCCCS Non-QMB Dual Eligible – You Pay:	As a Banner Medicare Advantage Dual Member – You Pay (see previous section for coverage details):
LONG-TERM CARE MEDICAID PROGRAMS *ONLY* (1)			
Nursing Facility Services	Cost sharing determined by AHCCCS	Cost sharing determined by AHCCCS	**Not covered.**
Respite Services	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*	**Not covered.**
Home and Community Based Services	Member contribution determined by AHCCCS	Member contribution determined by AHCCCS	**Not covered.**
Adult Preventive Dental Services (4)	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	**$0**

(1) Acute Medicaid Programs include AHCCCS Complete Care (ACC), ACC with a Regional Behavioral Health Agreement (ACC-RBHA), and the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Long Term Care Medicaid Programs include Elderly and/or Physically Disabled (E-PD) and the Division of Developmental Disabilities (DDD).

(2) See the AHCCCS Website for additional beneficiary cost sharing, copayment and benefits related information.

(3) Medicare Part D copayment amounts are the sole responsibility of the beneficiary. AHCCCS (Medicaid) health plans cannot assist with the payment of these amounts, except for behavioral health medications for those beneficiaries determined to be Seriously Mentally Ill (SMI) utilizing allowable Non-Title XIX / XXI funding.

(4) In addition to Adult Emergency Dental Services described above.

Banner Medicare Advantage

Banner Medicare Advantage Dual HMO D-SNP

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: We provide free language assistance services and auxiliary aids and services. To request these free services, call us at 877-874-3930, TTY 711, 8 a.m. to 8 p.m., seven days a week.

Spanish: Ofrecemos servicios gratuitos de asistencia lingüística y ayudas y servicios auxiliares. Para solicitar estos servicios gratuitos, llámenos al 877-874-3930, TTY 711, de 8 a.m. a 8 p.m., siete días a la semana.

Navajo: Bilagáana bizaad bee áká'a'doowoł dóó bee áká'a'doowołígíí t'áá jíík'é bee nihił yá'át'éehgo áńdaalyaa. Díí t'áá jíík'e bee áká'a'doowoł biniiyé, kojį' béésh bee hodíilnih 877-874-3930, TTY 711, 8 a.m. dóó 8 p.m. t'áá ákwíí jí bee.

Chinese: 我们提供免费的语言帮助服务以及辅助设备和服务。如需这些免费服务，请致电 877-874-3930 (TTY 711)，工作时间为每周七天，每天上午 8 点至晚上 8 点。

Vietnamese: Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và thiết bị hỗ trợ hoàn toàn miễn phí. Để yêu cầu các dịch vụ miễn phí này, vui lòng gọi cho chúng tôi theo số 877-874-3930, TTY 711, từ 8 giờ sáng đến 8 giờ tối, bảy ngày trong tuần.

Arabic: نقدِّم خدمات مساعدة لغوية مجانية، ووسائل وأدوات مساعدة إضافية. لطلب هذه الخدمات المجانية، يُرجى الاتصال بنا على الرقم 877-874-3930، أو عبر هاتف TTY على الرقم 711، طوال أيام الأسبوع من الساعة 8 صباحًا حتى الساعة 8 مساءً.

Tagalog: Nagbibigay kami ng mga libreng serbisyo na tulong sa wika at mga auxiliary aid at serbisyo. Upang humiling ng mga libreng serbisyo na ito, tawagan kami sa 877-874-3930, TTY 711, 8 a.m. hanggang 8 p.m., pitong araw sa isang linggo.

Korean: 당사는 언어 지원 서비스와 지원 도구 및 서비스를 무료로 제공합니다. 이러한 무료 서비스를 요청하려면 877-874-3930, TTY 711 번으로 연락해 주십시오. 주 7일, 오전 8시부터 오후 8시까지 운영합니다.

French: Nous offrons des services d'assistance linguistique gratuits ainsi que des aides et services auxiliaires. Pour demander ces services gratuits, appelez-nous au 877-874-3930, TTY 711, de 8 h a.m. à 8 h p.m., sept jours sur sept.

German: Wir bieten kostenlose Sprachunterstützung sowie Hilfsmittel und Dienstleistungen an. Um diese kostenlosen Dienstleistungen in Anspruch zu nehmen, rufen Sie uns bitte unter der Nummer 877-874-3930, TTY 711, von 8 a.m. bis 8 p.m., sieben Tage die Woche, an.

Russian: Мы бесплатно оказываем услуги языковой поддержки, а также дополнительные услуги и поддержку. Чтобы запросить такие бесплатные услуги, свяжитесь с нами по номеру 877-874-3930, TTY 711, в любой день недели с 8 утра до 8 вечера.

Japanese: 無料の言語および補助器具の支援サービスを提供しています。これらの無料サービスをご希望の場合は、877-874-3930（TTY 711）までお電話ください。一週間（月曜日から日曜日まで）8 a.m.から8 p.m.まで対応しております。

Persian: ما خدمات رایگان کمک زبانی و تسهیلات و خدمات جانبی را فراهم می‌کنیم. برای درخواست این خدمات رایگان، با شماره تلفن 877-874-3930، TTY 711 از ساعت 8 صبح تا 8 شب، هفت روز هفته تماس بگیرید.

Syriac: ܒܫܢܝ ܕܥ ܬܫܡܫ ܒܠܫܢܐ ܕܐܬܪܐ ܘܓܡ ܫܘܠܡܢ ܕܐܬܪܐ ܘܫܘܠܡܢ ܕܐܬܪܐ ܕܡܬܩܒܠ ܐܢܬ ܠܓܒܝܢ. ܠܡܬܩܒܠ ܒܝܕ ܫܘܠܡܢ ܕܐܬܪܐ ܕܡܬܩܒܠ ܐܢܬ ܠܓܒܝܢ، ܡܟ ܠܚܘ ܒܡܣܦܪ 877-874-3930، TTY 711، ܡܢ 8 ܩܕܡ ܛܘܪܐ ܥܕ 8 ܒܠܝܐ، ܒܟܠ ܫܒܘܥܐ ܕܡܬܩܒܠ ܐܢܬ ܠܓܒܝܢ.

Serbian: Pružamo besplatne jezičke usluge, kao i pomoćna sredstva i usluge zarad lakše komunikacije. Da biste zatražili ove besplatne usluge, pozovite nas na 877-874-3930, TTY 711, svakog dana od 8 ujutru do 8 uveče.

Thai: เราให้บริการช่วยเหลือด้านภาษาฟรี รวมถึงให้ความช่วยเหลือและบริการสนับสนุนอื่นๆ หากต้องการขอรับบริการฟรีเหล่านี้ โปรดติดต่อเราทางหมายเลข 877-874-3930, TTY 711 เวลา 8 a.m. ถึง 8 p.m. ทุกวัน