2024 Summary of Benefits

This is a summary of drug and health services covered by Banner Medicare Advantage Plus PPO, January 1, 2024 - December 31, 2024.

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 (844) 549-1859, TTY 711.

If you are not a member of this plan, call toll-free (844) 556-7685, TTY 711.

Our website: www.BannerHealth.com/MA.

Who Can Join?

To join Banner Medicare Advantage Plus, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Arizona: Maricopa, Pima, Pinal, Santa Cruz, and Yuma.

Which Doctors, Hospitals, and Pharmacies Can I Use?

Banner Medicare Advantage Plus has a network of doctors, hospitals, pharmacies, and other providers. Banner Medicare Advantage Plus members have the option of using in-network or out-of-network providers. Out-of-network providers may have higher copayments or coinsurance than our in-network providers.

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

You can see our plan's provider directory and pharmacy directory 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 Plus 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 www.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 www.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.

Banner Medicare Advantage Plus PPO has a contract with Medicare. 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 the Evidence of Coverage for more information.

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.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Monthly Plan Premium	**$20** per month. You must continue to pay your Medicare Part B premium.	**$20** per month. You must continue to pay your Medicare Part B premium.	**$20** per month. You must continue to pay your Medicare Part B premium.
Deductible	**$0** plan deductible.	**$0** plan deductible.	**$0** plan deductible.
Maximum Out-of-Pocket Responsibility	**$4,350** annual out-of-pocket limit for services you receive from in-network providers. **$8,700** combined annual out-of-pocket limit for services you receive from in-network and out-of-network providers.	**$4,350** annual out-of-pocket limit for services you receive from in-network providers. **$8,700** combined annual out-of-pocket limit for services you receive from in-network and out-of-network providers.	**$4,350** annual out-of-pocket limit for services you receive from in-network providers. **$8,700** combined annual out-of-pocket limit for services you receive from in-network and out-of-network providers.
Inpatient Hospital Coverage**	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day, Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day, Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day, Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.
Outpatient Hospital Coverage (Medicare-covered)**	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
Ambulatory Surgery Center Services (Medicare-covered)**	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$250 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Doctor Visits (Medicare-covered) ○ Primary care	In-Network: **$0 copayment** per visit. Out-of-Network: **$35 copayment** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **$35 copayment** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **$35 copayment** per visit.
○ Specialists**	In-Network: **$30 copayment** per visit. Out-of-Network: **$70 copayment** per visit.	In-Network: **$30 copayment** per visit. Out-of-Network: **$70 copayment** per visit.	In-Network: **$30 copayment** per visit. Out-of-Network: **$70 copayment** per visit.
Preventive Care (Medicare-covered)	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. Our plan covers many preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. Our plan covers many preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. Our plan covers many preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.
○ Annual physical exam	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
Emergency Care	**$90 copayment** per visit. If you are admitted to the hospital within 24 hours, your copayment is waived.	**$90 copayment** per visit. If you are admitted to the hospital within 24 hours, your copayment is waived.	**$90 copayment** per visit. If you are admitted to the hospital within 24 hours, your copayment is waived.
Urgently Needed Services	**$0 copayment** per visit.	**$0 copayment** per visit.	**$0 copayment** per visit.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Diagnostic Services/Labs/ Imaging (Medicare-covered)**			
○ Diagnostic radiology service (such as MRI, CT scans)	In-Network: **$125 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$125 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$125 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
○ Lab services	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
○ Diagnostic tests and procedures	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$10 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
○ Outpatient x-rays	In-Network: **$20 copayment** per visit. Out-of-Network: **$27 copayment** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **$27 copayment** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **$27 copayment** per visit.
○ Therapeutic radiology services (such as radiation treatment for cancer)	In-Network: **$60 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$60 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$60 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Hearing Services			
○ Medicare-covered hearing exam	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
○ Routine hearing exam	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.
○ Routine Hearing Aid Fitting/ Evaluation	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.	In-Network: **$0 copayment** per visit, once per calendar year. Out-of-Network: **40% coinsurance** per visit, once per calendar year.
○ Hearing aids	In-Network: **$0 copayment** for hearing aid(s). Out-of-Network: **40% coinsurance** for hearing aid(s). Hearing Aids (all types) – $1,000 coverage limit every year, both ears combined. Covers hearing aids, repairs, maintenance parts and fitting fees. Any cost above $1,000 is your responsibility, additional hearing aids are not covered.	In-Network: **$0 copayment** for hearing aid(s). Out-of-Network: **40% coinsurance** for hearing aid(s). Hearing Aids (all types) – $1,000 coverage limit every year, both ears combined. Covers hearing aids, repairs, maintenance parts and fitting fees. Any cost above $1,000 is your responsibility, additional hearing aids are not covered.	In-Network: **$0 copayment** for hearing aid(s). Out-of-Network: **40% coinsurance** for hearing aid(s). Hearing Aids (all types) – $1,000 coverage limit every year, both ears combined. Covers hearing aids, repairs, maintenance parts and fitting fees. Any cost above $1,000 is your responsibility, additional hearing aids are not covered.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Dental Services			
○ Medicare-covered dental services	In-Network: **0% coinsurance** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **0% coinsurance** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **0% coinsurance** per visit. Out-of-Network: **40% coinsurance** per visit.
○ Preventive Dental Services	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. • Office visit includes combined exam and cleaning • Oral exam:1 every 6 months (2 per calendar year) • Cleaning:1 every 6 months (2 per calendar year) • Fluoride treatment: 1 treatment per calendar year • Dental x-ray(s): up to 1 set of bitewing x-rays every 12 months	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. • Office visit includes combined exam and cleaning • Oral exam:1 every 6 months (2 per calendar year) • Cleaning:1 every 6 months (2 per calendar year) • Fluoride treatment: 1 treatment per calendar year • Dental x-ray(s): up to 1 set of bitewing x-rays every 12 months	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. • Office visit includes combined exam and cleaning • Oral exam:1 every 6 months (2 per calendar year) • Cleaning:1 every 6 months (2 per calendar year) • Fluoride treatment: 1 treatment per calendar year • Dental x-ray(s): up to 1 set of bitewing x-rays every 12 months

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Optional Supplemental Benefits – Comprehensive Dental**	**$28.50** additional monthly premium. Coverage limit of **$1,000 every year** for comprehensive dental services. Any cost above **$1,000** is your responsibility. See below for more details on the Optional Supplemental Dental Benefit.	**$28.50** additional monthly premium. Coverage limit of **$1,000 every year** for comprehensive dental services. Any cost above **$1,000** is your responsibility. See below for more details on the Optional Supplemental Dental Benefit.	**$28.50** additional monthly premium. Coverage limit of **$1,000 every year** for comprehensive dental services. Any cost above **$1,000** is your responsibility. See below for more details on the Optional Supplemental Dental Benefit.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Vision Services			
○ Medicare-covered eye exam	In-Network: **$0 copayment** per visit (including annual glaucoma screening). Out-of-Network: **50% coinsurance** per visit.	In-Network: **$0 copayment** per visit (including annual glaucoma screening). Out-of-Network: **50% coinsurance** per visit.	In-Network: **$0 copayment** per visit (including annual glaucoma screening). Out-of-Network: **50% coinsurance** per visit.
○ Medicare-covered eyewear	In-Network: **$0 copayment** for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: **40% coinsurance** per pair.	In-Network: **$0 copayment** for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: **40% coinsurance** per pair.	In-Network: **$0 copayment** for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: **40% coinsurance** per pair.
○ Routine eye exam	In-Network: **$0 copayment** for annual routine eye (eye refraction) exam. Out-of-Network: **40% coinsurance** for annual routine eye exam.	In-Network: **$0 copayment** for annual routine eye (eye refraction) exam. Out-of-Network: **40% coinsurance** for annual routine eye exam.	In-Network: **$0 copayment** for annual routine eye (eye refraction) exam. Out-of-Network: **40% coinsurance** for annual routine eye exam.
○ Supplemental eyewear	In-Network: **$0 copayment** for routine eyewear. Out-of-Network: **40% coinsurance** per pair. $200 coverage limit for eyewear. Eyeglasses (lenses and frames) are limited to one pair every year and contact lenses are unlimited every year. Any cost above $200 is your responsibility.	In-Network: **$0 copayment** for routine eyewear. Out-of-Network: **40% coinsurance** per pair. $200 coverage limit for eyewear. Eyeglasses (lenses and frames) are limited to one pair every year and contact lenses are unlimited every year. Any cost above $200 is your responsibility.	In-Network: **$0 copayment** for routine eyewear. Out-of-Network: **40% coinsurance** per pair. $200 coverage limit for eyewear. Eyeglasses (lenses and frames) are limited to one pair every year and contact lenses are unlimited every year. Any cost above $200 is your responsibility.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Mental Health Services (Medicare-covered)** ○ Inpatient visit	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day**, **Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day**, **Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.	Per benefit period*: In-Network: **Days 1-5: $275 copayment per day**, **Days 6-90: $0 copayment per day**. Out-of-Network: **Days 1-90: 40% coinsurance per day**.
○ Outpatient individual and group therapy visit	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$40 copayment** per individual or group visit.	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$40 copayment** per individual or group visit.	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$40 copayment** per individual or group visit.
Skilled Nursing Facility (Medicare-covered)**	Per benefit period*: In-Network: **Days 1-20: $0 copayment per day Days 21-100: $178 copayment per day**. Out-of-Network: **Days 1-100: $195 copayment per day**.	Per benefit period*: In-Network: **Days 1-20: $0 copayment per day Days 21-100: $178 copayment per day**. Out-of-Network: **Days 1-100: $195 copayment per day**.	Per benefit period*: In-Network: **Days 1-20: $0 copayment per day Days 21-100: $178 copayment per day**. Out-of-Network: **Days 1-100: $195 copayment per day**.
Rehabilitation Services (Medicare-covered)** ○ Occupational therapy visit	In-Network: **$40 copayment** per visit.	In-Network: **$40 copayment** per visit.	In-Network: **$40 copayment** per visit.
○ Physical therapy and speech and language therapy visit	In-Network: **$40 copayment** per visit.	In-Network: **$40 copayment** per visit.	In-Network: **$40 copayment** per visit.

Premiums and Benefits	Maricopa & Pinal	Pima & Santa Cruz	Yuma
Rehabilitation Services (Medicare-covered)** (continued) ◦ Occupational, physical therapy, and speech and language therapy visit	Out-of-Network: **40% coinsurance** per visit.	Out-of-Network: **40% coinsurance** per visit.	Out-of-Network: **40% coinsurance** per visit.
Ambulance (Medicare-covered)	**$250 copayment** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip.	**$250 copayment** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip.	**$250 copayment** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip.
Transportation (non-emergent)	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs**	In-Network: **0% to 20% coinsurance** for chemotherapy drugs. Out-of-Network: **40% coinsurance**. In-Network: **0% to 20% coinsurance** for other Part B drugs. Out-of-Network: **40% coinsurance**.	In-Network: **0% to 20% coinsurance** for chemotherapy drugs. Out-of-Network: **40% coinsurance**. In-Network: **0% to 20% coinsurance** for other Part B drugs. Out-of-Network: **40% coinsurance**.	In-Network: **0% to 20% coinsurance** for chemotherapy drugs. Out-of-Network: **40% coinsurance**. In-Network: **0% to 20% coinsurance** for other Part B drugs. Out-of-Network: **40% coinsurance**.

* A benefit period begins the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services with ** may require your provider to obtain prior authorization from the plan.

Prescription Benefits

As shown below, there are “drug payment stages” for your Medicare Part D prescription drug coverage under Banner Medicare Advantage Plus. 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. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. Please call us or access our Evidence of Coverage online at www.BannerHealth.com/MA.

PRESCRIPTION DRUG BENEFITS	
Prescription Drug Stages	**Maricopa, Pima, Pinal, Santa Cruz & Yuma**
Deductible Stage	There is no deductible for Banner Medicare Advantage Plus.
Initial Coverage Stage	Since this plan does not have a deductible, 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 drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and Medicare Insurer. You may get your drugs at network retail pharmacies and mail order pharmacies.
Coverage Gap Stage	You will pay a **$0 copay** for Tier 1 drugs in this stage. Most Medicare drug plans have a coverage gap stage (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$5,030**. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total **$8,000**, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000**, the plan pays the full cost of your covered Part D drugs. You pay nothing.

Initial Coverage Stage – Banner Medicare Advantage Plus

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

This chart shows your share of the cost when you get a **one-month supply** of a covered Part D prescription drug:

TIER	Maricopa, Pima, Pinal, Santa Cruz & Yuma		
	Standard retail cost sharing	Long-term care (LTC) cost sharing	Out-of-network cost sharing
Tier 1: Preferred Generic	**$0 copayment**	**$0 copayment**	**$0 copayment**
Tier 2: Generic	**$5 copayment**	**$5 copayment**	**$5 copayment**
Tier 3: Preferred Brand	**$35 copayment for insulin drugs and $47 copayment for all other drugs on this tier**	**$35 copayment for insulin drugs and $47 copayment for all other drugs on this tier**	**$35 copayment for insulin drugs and $47 copayment for all other drugs on this tier**
Tier 4: Non-Preferred Brand	**$35 copayment for insulin drugs and $100 copayment for all other drugs on this tier**	**$35 copayment for insulin drugs and $100 copayment for all other drugs on this tier**	**$35 copayment for insulin drugs and $100 copayment for all other drugs on this tier**
Tier 5: Specialty	**33% coinsurance**	**33% coinsurance**	**33% coinsurance**

Your share of the cost when you get a **long-term (90-day) supply** of a covered Part D prescription drug:

TIER	**Maricopa, Pima, Pinal, Santa Cruz & Yuma**	
	Standard retail cost sharing	Standard mail order cost sharing
Tier 1: Preferred Generic	**$0 copayment**	**$0 copayment**
Tier 2: Generic	**$15 copayment**	**$10 copayment**
Tier 3: Preferred Brand	**$105 copayment for insulin drugs and $141 copayment for all other drugs on this tier**	**$105 copayment for insulin drugs and $141 copayment for all other drugs on this tier**
Tier 4: Non-Preferred Brand	**$105 copayment for insulin drugs and $300 copayment for all other drugs on this tier**	**$105 copayment for insulin drugs and $300 copayment for all other drugs on this tier**
Tier 5: Specialty	**A long-term supply is not available for drugs in Tier 5.**	**Mail order is not available for drugs in Tier 5.**

Coverage Gap Stage – Banner Medicare Advantage Plus

Standard Retail & Mail Order Cost-Sharing

MARICOPA, PIMA, PINAL, SANTA CRUZ & YUMA			
TIER	**DRUGS COVERED**	**ONE-MONTH SUPPLY**	**THREE-MONTH SUPPLY**
Tier 1: Preferred Generic	All	**$0 copayment**	**$0 copayment**

OTHER BENEFITS			
Premiums and Benefits	**Maricopa & Pinal**	**Pima & Santa Cruz**	**Yuma**
Outpatient Substance Abuse	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$70 copayment** per individual or group visit.	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$70 copayment** per individual or group visit.	In-Network: **$30 copayment** per individual or group visit. Out-of-Network: **$70 copayment** per individual or group visit.
Cardiac Rehabilitation & Intensive Cardiac Rehabilitation	In-Network: **$20 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
Foot Care (podiatry services)** o Medicare-covered foot exams and treatment	In-Network: **$30 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$30 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$30 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.
Chiropractor Visits o Medicare-covered**	In-Network: **$20 copayment** per visit. Out-of-Network: **$70 copayment** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **$70 copayment** per visit.	In-Network: **$20 copayment** per visit. Out-of-Network: **$70 copayment** per visit.
o Routine	In-Network: **$35 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. 6 routine visits per calendar year.	In-Network: **$35 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. 6 routine visits per calendar year.	In-Network: **$35 copayment** per visit. Out-of-Network: **40% coinsurance** per visit. 6 routine visits per calendar year.
Home Health Care	In-Network: **$0 copayment** per visit. Out-of-Network: **50% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **50% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **50% coinsurance** per visit.

OTHER BENEFITS			
Premiums and Benefits	**Maricopa & Pinal**	**Pima & Santa Cruz**	**Yuma**
Medical Equipment/ Supplies (Medicare-covered)**			
○ Durable Medical Equipment (e.g., wheelchairs, oxygen)	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.
○ Prosthetics (e.g., braces, artificial limbs)	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.	In-Network: **20% coinsurance**. Out-of-Network: **50% coinsurance**.
○ Diabetes supplies	In-Network: **0% coinsurance** for Medicare-covered diabetic supplies. **20% coinsurance** for Medicare-covered therapeutic shoes. Out-of-Network: **40% coinsurance** for Medicare-covered diabetic supplies. **40% coinsurance** for Medicare-covered therapeutic shoes.	In-Network: **0% coinsurance** for Medicare-covered diabetic supplies. **20% coinsurance** for Medicare-covered therapeutic shoes. Out-of-Network: **40% coinsurance** for Medicare-covered diabetic supplies. **40% coinsurance** for Medicare-covered therapeutic shoes.	In-Network: **0% coinsurance** for Medicare-covered diabetic supplies. **20% coinsurance** for Medicare-covered therapeutic shoes. Out-of-Network: **40% coinsurance** for Medicare-covered diabetic supplies. **40% coinsurance** for Medicare-covered therapeutic shoes.
Diabetes Self-Management Training	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.	In-Network: **$0 copayment** per visit. Out-of-Network: **40% coinsurance** per visit.

OTHER BENEFITS			
Premiums and Benefits	**Maricopa & Pinal**	**Pima & Santa Cruz**	**Yuma**
Meals	In-Network: **$0 copayment** per meal. Out-of-Network: **40% coinsurance** per meal. For members discharged from an inpatient hospital or Skilled Nursing Facility (SNF) stay, up to 12 meals delivered to the member's home.	In-Network: **$0 copayment** per meal. Out-of-Network: **40% coinsurance** per meal. For members discharged from an inpatient hospital or Skilled Nursing Facility (SNF) stay, up to 12 meals delivered to the member's home.	In-Network: **$0 copayment** per meal. Out-of-Network: **40% coinsurance** per meal. For members discharged from an inpatient hospital or Skilled Nursing Facility (SNF) stay, up to 12 meals delivered to the member's home.
Silver&Fit® Fitness Benefit	In-Network: **$0 copayment** for fitness classes/kits. Out-of-Network: **40% coinsurance** for fitness benefits. Fitness classes/fitness kits provided by Silver&Fit. Silver&Fit is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on: • Fitness center membership program • Digital fitness video program with home fitness tools • Healthy aging program.	In-Network: **$0 copayment** for fitness classes/kits. Out-of-Network: **40% coinsurance** for fitness benefits. Fitness classes/fitness kits provided by Silver&Fit. Silver&Fit is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on: • Fitness center membership program • Digital fitness video program with home fitness tools • Healthy aging program.	In-Network: **$0 copayment** for fitness classes/kits. Out-of-Network: **40% coinsurance** for fitness benefits. Fitness classes/fitness kits provided by Silver&Fit. Silver&Fit is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on: • Fitness center membership program • Digital fitness video program with home fitness tools • Healthy aging program.

OTHER BENEFITS			
Premiums and Benefits	**Maricopa & Pinal**	**Pima & Santa Cruz**	**Yuma**
Nurse Advice Line – Nurse On Call	In-Network: **$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. Out-of-Network: **40% coinsurance** for nurse advice line.	In-Network: **$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. Out-of-Network: **40% coinsurance** for nurse advice line.	In-Network: **$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. Out-of-Network: **40% coinsurance** for nurse advice line.
Worldwide Emergency Care	**$90 copayment** per visit. **$25,000 coverage limit**	**$90 copayment** per visit. **$25,000 coverage limit**	**$90 copayment** per visit. **$25,000 coverage limit**
Telehealth Services	In-Network: **$0-$40 copayment** per visit. Out-of-Network: PCP - **$35 copayment** per visit Urgent Care - **$0 copayment** per visit Specialists - **$70 copayment** per visit Other Professionals - **$70 copayment** per visit Mental Health - **$40 copayment** per visit OT - **40% coinsurance** per visit PT/ST - **40% coinsurance** per visit	In-Network: **$0-$40 copayment** per visit. Out-of-Network: PCP - **$35 copayment** per visit Urgent Care - **$0 copayment** per visit Specialists - **$70 copayment** per visit Other Professionals - **$70 copayment** per visit Mental Health - **$40 copayment** per visit OT - **40% coinsurance** per visit PT/ST - **40% coinsurance** per visit	In-Network: **$0-$40 copayment** per visit. Out-of-Network: PCP - **$35 copayment** per visit Urgent Care - **$0 copayment** per visit Specialists - **$70 copayment** per visit Other Professionals - **$70 copayment** per visit Mental Health - **$40 copayment** per visit OT - **40% coinsurance** per visit PT/ST - **40% coinsurance** per visit
Colorectal Cancer Screening	**$25** Healthy Benefits reward for annual completion during plan benefit year.	**$25** Healthy Benefits reward for annual completion during plan benefit year.	**$25** Healthy Benefits reward for annual completion during plan benefit year.
Breast Cancer Screening	**$25** Healthy Benefits reward for annual completion during plan benefit year.	**$25** Healthy Benefits reward for annual completion during plan benefit year.	**$25** Healthy Benefits reward for annual completion during plan benefit year.

Banner Medicare Advantage Plus offers an opportunity to customize your care with an optional supplemental dental benefits package. You can enroll in this optional supplemental dental benefits package when you enroll in our plan or during the Annual Election Period. If you have questions, you can call us at (844) 549-1859, TTY 711, 8 a.m. to 8 p.m., seven days a week.

OPTIONAL SUPPLEMENTAL BENEFITS – COMPREHENSIVE DENTAL	
Premiums and Benefits	**Maricopa, Pima, Pinal, Santa Cruz & Yuma**
Additional Monthly Premium	**$28.50**
Annual Benefit Maximum	**$1,000 every year**
Annual Deductible	**$0**
Restorations – In & Out of Network**	**20% coinsurance** - Amalgam and Resin fillings, resin infiltration of incipient smooth surface lesion, inlays or onlays, protective restorations, Recement or re-bond inlay, onlay, partial restoration, crown **50% coinsurance** - Crowns, core build-up, pin retention-per tooth, post and core, each additional post, crown repair necessitated by restorative material failure
Endodontics – In & Out of Network**	**50% coinsurance** - Pulpotomy and gross pulpal debridement of tooth, root canals and retreatment of previous root canal; Apicoectomy/Periradicular surgery and retrograde filling
Periodontics - In & Out of Network**	**50% coinsurance** - Gingivectomy/gingivoplasty, gingival flap procedure, osseous surgery, clinical crown lengthening; Periodontal scaling and root planing, full mouth debridement
Extractions – In & Out of Network**	**20% coinsurance** - Extractions and coronectomy **50% coinsurance** - Oralantral fistula closure, primary closure of a sinus perforation, Alveoloplasty, Vestibuloplasty, Removal of lateral exostosis (maxilla or mandible), removal of Torus Palantinus, Reduction of osseous tuberosity, removal of torus mandibularis, Frenulectomy, frenuloplasty, excision of hyperplastic tissue, excision of periocornal gingiva
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services – In & Out of Network**	**20% coinsurance** - Adjustments, repairs, repair base or framework or replace missing or broken tooth or clasp, add tooth, add clasp on dentures, rebase and reline dentures, tissue conditioning **50% coinsurance** - Removable dentures-complete, partial, immediate, overdentures, fixed partial dentures-pontics and retainers, retainer crowns

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see the Evidence of Coverage for details.

Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

Please contact our Customer Care Center for benefit details or go online to www.BannerHealth.com/MA.

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Banner Medicare Advantage Plus PPO

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-549-1859, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-549-1859, TTY 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-549-1859, TTY 711。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-549-1859, TTY 711。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-549-1859, TTY 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-549-1859, TTY 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-549-1859, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-549-1859, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-549-1859, TTY 711 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-549-1859, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-549-1859, TTY 711. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-549-1859, TTY 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-549-1859, TTY 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-549-1859, TTY 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-549-1859, TTY 711. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-549-1859, TTY 711. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-549-1859, TTY 711 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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