Banner Medicare Advantage Dual HMO D-SNP offered by Banner – University Care Advantage

Annual Notice of Changes for 2022

You are currently enrolled as a member of Banner – University Care Advantage HMO D-SNP. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.1 and 2.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: February 29, 2024)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 and 2.4 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in Banner Medicare Advantage Dual.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 4.2, Page 20, to learn more about your choices.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Banner Medicare Advantage Dual.
- If you join another plan between **October 15 and December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care Center number at (877) 874-3930 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- This document may be available in other formats such as braille, large print, or other alternate formats. For additional information, call our Customer Care Center at the phone number listed above.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Banner Medicare Advantage Dual

- Banner Medicare Advantage Dual HMO D-SNP has a contract with Medicare and Medicaid. Enrollment depends on contract renewal. In Arizona, the Medicaid program is called the Arizona Health Care Cost Containment System (AHCCCS).
- When this booklet says "we," "us," or "our," it means Banner Medicare Advantage Dual. When it says "plan" or "our plan," it means Banner Medicare Advantage Dual.

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Banner Medicare Advantage Dual in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.BannerHealth.com/Medicare. You may also call our Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
Deductible	This plan has deductibles for some hospital and medical services: • Medicare Part A deductible is $0 or $1,484. • Medicare Part B deductible is $0 or $203. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.	$0
Doctor office visits	Primary care visits: 0% or 20% per visit Specialist visits: 0% or 20% per visit If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.	Primary care visits: $0 copayment per visit Specialist visits: $0 copayment per visit

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	The amounts per benefit period are $0 or: • $1,484 deductible • Days 1–60: $0 copayment per day • Days 61–90: $371 copayment per day • Days 91 and beyond: $742 copayment per "lifetime reserve day" (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.	Per benefit period: • $0 copayment per day for days 1-90. • $0 copayment per day for lifetime reserve days 91-150.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 or $92 If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either $0 or $92, depending on the level of "Extra Help" you receive. If your deductible is $92: You pay the full cost of your drugs until you have paid $92 for your drugs. Copayment/coinsurance during the Initial Coverage Stage: • Generic and brand name drugs treated as generic, per prescription: o $0 copayment or o $1.30 copayment or o $3.70 copayment or o 15% of the total cost • All other drugs, per prescription: o $0 copayment or o $4.00 copayment or o $9.20 copayment or o 15% of the total cost • Select Care Drugs: o Covered under different tiers	Deductible: $480 Copayment/coinsurance during the Initial Coverage Stage: • Generic and brand name drugs treated as generic, per prescription: o $0 copayment or o $1.35 copayment or o $3.95 copayment or o 15% of the total cost • All other drugs, per prescription: o $0 copayment or o $4.00 copayment or o $9.85 copayment or o 15% of the total cost • Select Care Drugs: o You pay $0 per prescription for several maintenance medications for chronic conditions.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$7,550 If you are eligible for Medicare cost sharing assistance under AHCCCS (Medicaid), 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.	$2,900 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.

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from Banner – University Care Advantage to Banner Medicare Advantage Dual.

You will receive a new ID card. This new plan name will appear on all the other member communication you receive from us.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by AHCCCS (Medicaid).)	$0	$0 There is no change for the upcoming benefit year.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from AHCCCS (Medicaid), very few members ever reach this out-of-pocket maximum.** 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.	$7,550	$2,900 Once you have paid $2,900 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Cost	2021 (this year)	2022 (next year)
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.BannerHealth.com/Medicare. You may also call our Customer Care Center for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network has changed more than usual for 2022. An updated *Pharmacy Directory* is located on our website at www.BannerHealth.com/Medicare. You may also call our Customer Care Center for updated provider information or to ask us to mail you a *Pharmacy Directory*. **We strongly suggest that you review our current *Pharmacy Directory* to see if your pharmacy is still in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered)*, in your 2022 *Evidence of Coverage.* A copy of the Evidence of Coverage is located on our website at www.BannerHealth.com/Medicare. You may also call our Customer Care Center to ask us to mail you an Evidence of Coverage.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services	Authorization and referral required.	Authorization and referral not required.
Chiropractic Services – Medicare-covered	Authorization not required.	Some providers may require authorization through American Specialty Health.
Chiropractic Services – Routine	You are covered for up to 8 visits per calendar year.	You are covered for up to 6 visits per calendar year.
Diabetes Self-Management Training	Authorization required.	Authorization not required.
Dialysis Services	Authorization required.	Authorization not required.
EKG following "Welcome to Medicare" Preventive Visit	Authorization required.	Authorization not required.
Eye Exams – Medicare-covered	Authorization and referral required.	Authorization and referral not required.
Eyewear – Medicare-covered (one pair of eyeglasses or contact lenses after each cataract surgery)	Authorization required.	Authorization not required.
Glaucoma Screening	Authorization required.	Authorization not required.

Cost	2021 (this year)	2022 (next year)
Healthy Food Card – Special Supplemental Benefits for the Chronically Ill (SSBCI)	Not covered	Members diagnosed with one or more specified chronic conditions **may** qualify to receive the healthy food card as part of SSBCI through our contracted vendor, Solutran. You receive $75 per quarter, and any unused amount rolls over to the next period. The benefits mentioned are a part of special supplemental benefits. Not all members will qualify.
Hearing Aids (all types)	You are covered up to $2,000, both ears combined, every three years. Authorization and referral required.	You are covered for up to $1,500, both ears combined, every three years. Authorization and referral not required.
Home Health Services	Authorization and referral required.	Authorization and referral not required.
Inpatient Hospital – Acute	Each benefit period, you pay $0 or: • Days 1-60: $1,484 deductible • Days 61-90: $371 copayment per day • Days 91-150: $742 copayment per “lifetime reserve day” (up to 60 lifetime days)	Each benefit period, you pay: • Days 1-90: $0 copayment per day • Days 91-150: $0 copayment per day for lifetime reserve days

Cost	2021 (this year)	2022 (next year)
Inpatient Hospital – Psychiatric	Each benefit period, you pay $0 or: • Days 1-60: $1,484 deductible • Days 61-90: $371 copayment per day • Days 91-150: $742 copayment per "lifetime reserve day" (up to 60 lifetime days)	Each benefit period, you pay: • Days 1-90: $0 copayment per day • Days 91-150: $0 copayment per day for lifetime reserve days
Medicare Part B Covered Services • Acupuncture for chronic low back pain • Ambulance services • Ambulatory surgical center services • Cardiac rehabilitation services • Chiropractic services (Medicare covered) • Dental services (Medicare covered) • Diagnostic procedures/ tests (excluding lab tests) • Diagnostic and therapeutic radiology services • Dialysis Services • Durable medical equipment (DME) and related supplies • Emergency care • Eye exam (Medicare covered)	You pay 0% or 20% of the total cost per visit for Medicare-covered services.	You pay a $0 copayment per visit for Medicare-covered services.

Cost	2021 (this year)	2022 (next year)
• Eyewear (Medicare covered) • Hearing services (Medicare covered) • Home infusion therapy • Kidney disease education services • Medicare Part B prescription drugs • Opioid treatment program services • Outpatient hospital observation • Outpatient hospital services • Outpatient mental health care – individual and group sessions • Outpatient rehabilitation services – physical therapy, occupational therapy, and speech-language therapy • Outpatient substance abuse services – individual and group sessions • Partial hospitalization services • Podiatry services (Medicare covered) • Primary Care Provider (PCP) office visits • Prosthetic and orthotic devices and related supplies • Pulmonary rehabilitation services		

Cost	2021 (this year)	2022 (next year)
• Specialist office visits • Telehealth services • Urgently needed services		
Mental Health Specialty Services – Non-Physician	Referral required.	Referral not required.
Outpatient Blood Services	Authorization required.	Authorization not required.
Outpatient Hospital – Observation Services	Authorization required.	Authorization not required.
Outpatient Substance Abuse Services – Individual and Group Sessions	Authorization and referral required.	Authorization and referral not required.
Over-the-Counter (OTC) Items	You receive $45 per month, and any unused amount does not roll over to the next period. Banner Health partners with InComm as our contracted vendor for OTC benefits.	You receive $250 per quarter, and any unused amount will roll over to the next period. Banner Health will partner with Solutran as our contracted vendor for OTC benefits.
Physician Specialist Services	Referral required for some providers.	Referral not required for Banner-contracted provider to Banner-contracted provider.
Podiatry Services – Medicare-covered	Referral required.	Referral not required.
Podiatry Services – Routine Foot Care	Covered up to 12 visits per calendar year for routine foot care.	Covered up to 6 visits per calendar year for routine foot care.
Pulmonary Rehabilitation Services	Authorization and referral required.	Authorization and referral not required.

Cost	2021 (this year)	2022 (next year)
Skilled Nursing Facility (SNF) Care	Each benefit period, you pay $0 or: • Days 1-20: $0 copayment per day • Days 21-100: $185.50 copayment per day • Days 101 and beyond: All costs	Each benefit period, you pay a $0 copayment per day for days 1-100.
Step Therapy – Medicare Part B Prescription Drugs	Not applicable	Banner Medicare Advantage plans will utilize Part B step therapy. Step therapy is a utilization tool that requires you to first try another drug to treat your medical condition before Banner Medicare Advantage plans will cover the drug your physician may have initially prescribed.
Value-Based Insurance Design (VBID) Program	Not participating in program	Banner Medicare Advantage plans will be participating in Medicare's VBID program. You pay a $0 copayment for these benefits: 1. **All** Banner Medicare Advantage plan members will be eligible for the following VBID benefits: • Wellness and Healthcare Planning (WHP): Members may participate in one of three Wellness Classes • Advanced Care Planning (ACP)

Cost	2021 (this year)	2022 (next year)
		2. Members who have been diagnosed with diabetes, musculoskeletal disorder (MSD) and/or dementia who agree to participate in a care management program **may** qualify for one or more of our VBID programs. These programs have extra benefits designed to help manage the above chronic conditions: • Exercise Physiologist for Dial a Diabetes • Simple Therapy on Demand (MSD) • In-Home Attendant Care (Dementia) – Eligible ALTCS members with dementia plus one of five chronic conditions and an acute hospital stay in the past 30 days can receive up to 20 hours of additional in-home attendant care, beyond their Medicaid benefit, twice each plan year

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call our Customer Care Center.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call our Customer Care Center to ask for a list of covered drugs that treat the same medical condition.

Current formulary exceptions will still be covered next year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to

reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call our Customer Care Center and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Your deductible amount is either $0 or $92, depending on the level of "Extra Help" you receive.	Your deductible amount is $480, but the amount you pay out of pocket depends on the level of "Extra Help" you receive. During this stage, you pay the low income subsidy (LIS, or "Extra Help") cost sharing for Select Care drugs until the yearly deductible has been met.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic and brand name drugs treated as generic:** You pay per prescription: • $0 copayment or • $1.30 copayment or • $3.70 copayment or • 15% of the total cost **All other drugs:** You pay per prescription: • $0 copayment or • $4.00 copayment or • $9.20 copayment or • 15% of the total cost **Select Care Drugs:** Covered under different tiers	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic and brand name drugs treated as generic:** You pay per prescription: • $0 copayment or • $1.35 copayment or • $3.95 copayment or • 15% of the total cost **All other drugs:** You pay per prescription: • $0 copayment or • $4.00 copayment or • $9.85 copayment or • 15% of the total cost **Select Care Drugs:** You pay $0 per prescription for several maintenance medications for chronic conditions.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**. For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Grace Period for Loss of Medicaid Eligibility	Our plan is for people who are eligible for both Medicare and Medicaid. If you are no longer eligible for Medicaid, we will continue to provide coverage under this plan for six months. During this time, you must regain eligibility for Medicaid to remain on our plan.	Our plan is for people who are eligible for both Medicare and Medicaid. If you are no longer eligible for Medicaid, we will continue to provide coverage under this plan for two months. During this time, you must regain eligibility for Medicaid to remain on our plan.
Nurse Now – 24/7 Nurse Advice Line	Nurse Now 24/7 Nurse Advice Line Phone Number: (844) 259-9494	Banner Nurse On-Call is the new name for Nurse Now. The phone number for Banner Nurse On-Call is (602) 747-7990 or (888) 747-7990, 24 hours a day, 7 days a week.
Pharmacy Benefit Manager (PBM)	Banner Health partners with MedImpact as our PBM.	Banner Health will partner with Express Scripts, Inc. (ESI) as our PBM. There may be some changes to your benefits, including minor formulary drug updates, and an expanded network of pharmacies for obtaining your prescription medications. ESI will also be the preferred vendor for certain medical supplies.

Cost	2021 (this year)	2022 (next year)
Reimbursement Requests for Part D Prescription Drugs	If you paid the full cost for a prescription and want to ask for reimbursement from the plan, you may send a request asking us to pay our share of the cost for the drug you have received. Mail your request for reimbursement, together with any bills or receipts, to us at this address: Banner – University Care Advantage Attn: Customer Care Center 2701 E. Elvira Road Tucson, AZ 85756	If you paid the full cost for a prescription and want to ask for reimbursement from the plan, you may send a request asking us to pay our share of the cost for the drug you have received. Mail or fax your request for reimbursement, together with any bills or receipts, to the address/fax number below: Express Scripts Attn: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718 Fax #: (608) 741-5483
Website Address – Banner Medicare Advantage Plans	The Banner – University Care Advantage website address is www.BannerUCA.com	The Banner Medicare Advantage Dual website address will be www.BannerHealth.com/Medicare.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Banner Medicare Advantage Dual

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Banner Medicare Advantage Dual.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year, but if you want to change for 2022, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Banner Medicare Advantage Dual.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Banner Medicare Advantage Dual.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact our Customer Care Center if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with AHCCCS (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare and AHCCCS (Medicaid)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Arizona, the SHIP is called the Arizona State Health Insurance Assistance Program (Arizona SHIP).

The Arizona SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. The Arizona SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call the Arizona SHIP at (800) 432-4040. You can learn more about the Arizona SHIP by visiting their website (des.az.gov).

For questions about your Arizona Health Care Cost Containment System (AHCCCS) benefits, contact AHCCCS at (855) 432-7587, TTY: (800) -367-8939, Monday through Friday, 8 a.m. to 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your AHCCCS coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have AHCCCS (Medicaid), you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State AHCCCS (Medicaid) Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Arizona ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (602) 364-3610 or (800) 334-1540.

SECTION 8 Questions?

Section 8.1 – Getting Help from Banner Medicare Advantage Dual

Questions? We're here to help. Please call our Customer Care Center at (877) 874-3930. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Banner Medicare Advantage Dual. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.BannerHealth.com/Medicare. You may also call our Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.BannerHealth.com/Medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 8.3 – Getting Help from AHCCCS (Medicaid)

To get information from AHCCCS (Medicaid), you can call (855) 432-7587, TTY: (800) 367-8939, Monday through Friday, 8 a.m. to 5 p.m.