2026 Summary of Benefits

Banner Medicare Advantage Prime HMO *(H5843-001)*

This is a summary of drug and health services covered January 1, 2026 - December 31, 2026.

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 844-549-1857, TTY 711.

If you are not a member of this plan, call toll-free 844-549-1858, TTY 711.

Our website: *www.BannerHealth.com/MA*.

Who Can Join?

To join Banner Medicare Advantage Prime, 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 county in Arizona: Maricopa.

Which Doctors, Hospitals, and Pharmacies Can I Use?

Banner Medicare Advantage Prime has a network of doctors, hospitals, pharmacies, and other providers. If you use 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 view our 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 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.

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Tips For Comparing Your Medicare Choices

This *Summary of Benefits* booklet gives you a summary of what Banner Medicare Advantage Prime 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 Prime HMO 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, 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.

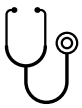
Plan Premium, Deductible, and Maximum Out-of-Pocket *(MOOP)*

Out-of-Pocket Costs	
Monthly Plan Premium	**$0** per month. You must continue to pay your Medicare Part B premium.
Annual Medical Deductible	This plan does not have a medical deductible.
Maximum Out-of-Pocket *(does not include prescription drugs)*	**$2,995** 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.

Medical and Hospital Benefits

Hospital Coverage and Ambulatory Surgery Center

Benefit	What you pay
Inpatient Hospital Stay	Per benefit period: **$275 copayment per day for days 1-7** **$0 copayment per day for days 8-90** Our plan covers for 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	**$200 copayment** **$0 copayment** for diagnostic preventive colonoscopy. May require prior authorization.
Hospital Observation Services	**$200 copayment per stay**
Ambulatory Surgery Center	**$100 copayment** **$0 copayment** for diagnostic preventive colonoscopy. May require prior authorization.



Primary Care Provider *(PCP)* and Specialist Visits

Benefit	What you pay
PCP	**$0 copayment**
Specialist	**$15 copayment** May require prior authorization.

Preventive Care Screenings and Annual Physical Exam

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

- Abdominal aortic aneurysm screening
- Alcohol misuse screening & counseling
- Bone mass measurement
- Breast cancer screening *(mammogram)*
- Cardiovascular disease screenings
- Cardiovascular disease *(behavioral therapy)*
- Cervical and vaginal cancer screening
- Colorectal cancer screenings:
  - Blood based biomarker tests
  - Colonoscopies
  - Computed tomography *(CT)* colonography
  - Fecal occult blood tests
  - Flexible sigmoidoscopies
  - Multi-target stool DNA tests
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Glaucoma screenings
- Hepatitis B virus screenings
- Hepatitis C virus screenings
- HIV screening
- Immunizations *(shots)* – including:
  - COVID-19 vaccines
  - Flu shots
  - Hepatitis B shots
  - Pneumococcal shots
- Lung cancer screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program *(MDPP)*
- Obesity screening and therapy
- Pre-exposure prophylaxis *(PrEP)* for HIV prevention
- Prostate cancer screening
- Sexually transmitted infections screening & counseling
- Smoking and tobacco use cessation *(counseling to stop smoking or tobacco use)*
- "Welcome to Medicare" preventive visit & yearly "Wellness" visit

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

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.

Emergency and Urgent Care

Benefit	What you pay
Emergency Care	**$120 copayment** ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.
Worldwide Emergency Care	This plan includes a **$25,000** annual benefit amount *(allowance)* every year for the worldwide benefit. **$120 copayment**
Urgent Care	**$0 copayment**

Diagnostic Labs, Tests, and Radiological Services

Benefit	What you pay
Diagnostic Tests & Procedures	**$0 copayment** May require prior authorization.
Lab Services	**$0 copayment** May require prior authorization.
Diagnostic Radiology Services *(e.g., MRIs, CT scan, Nuclear Medicine Services, etc.)*	**$125 copayment** May require prior authorization.
Outpatient X-rays	**$0 copayment** May require prior authorization.
Therapeutic Radiology Services *(e.g. Radiation Therapy for Cancer, etc.)*	**$60 copayment** Prior authorization is required.

Hearing Services

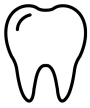
This plan includes up to a $1,000 annual benefit amount *(allowance)* for covered services. Covers hearing aids, repairs, maintenance parts and fitting fees. Any cost above $1,000 is your responsibility, additional hearing aids are not covered. You must use Banner Medicare Advantage Prime's network of contracted providers for these services.

Benefit	What you pay
Hearing Exam *(Medicare-covered)*	**$0 copayment**
Hearing Exam *(Routine)*	**$0 copayment** Limit 1 exam every year.
Fitting / Evaluation for Hearing Aids	**$0 copayment** Limit 1 visit every year. Prior authorization is required.
Prescription Hearing Aids	This plan includes up to a **$1,000** annual benefit amount *(allowance)* every year. **$0 copayment** Limit of 1 hearing aid every year per ear. Prior authorization is required.

Dental Services

This plan includes up to a $1,000 annual benefit amount *(allowance)* for preventive and comprehensive dental services. Cost of all visits will be deducted from yearly coverage amount. Any cost above $1,000 is your responsibility. You must use Banner Medicare Advantage Prime's network of contracted providers for these services.

Benefit	What you pay
Dental Services *(Medicare-covered)*	**20% coinsurance**

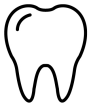


Dental Services *(continued)*

Benefit	What you pay
Combined Preventive & Comprehensive Dental Services	This plan includes up to a **$1,000** annual benefit amount *(allowance)* for preventive and comprehensive dental services.

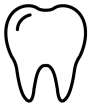
Preventive Dental Services	**$0 copayment**
	Preventive coverage includes:
	• Oral Exam: up to 2 exams per calendar year.
	• Cleaning: up to 2 cleanings per calendar year.
	• Fluoride Treatment: up to 2 treatments per calendar year.
	• Dental X-ray(s):
	  ○ 1 of 1-4 bitewings or intraoral tomosynthesis bitewing per 12 months
	  ○ 1 intraoral tomosynthesis – periapical radiographic image per 12 months
	  ○ 2 intraoral occlusal radiographic images per 24 months
	  ○ 1 of intraoral comprehensive series radiographic images, panoramic radiographic image, 7-8 vertical bitewings, intraoral tomosynthesis-comprehensive series per 36 months

Comprehensive Dental Services	Comprehensive coverage includes: **Restorative services: 50% coinsurance** • Fillings – 1 per tooth 24 months • Inlays / onlays / crowns and post, core and pins - 1 per 60 months per tooth • Recement or rebonding inlay or crown – 1 per tooth per 24 months after 6 months of placement • Protective restoration – 1 per tooth per lifetime **Endodontics: 50% coinsurance** • Pulpotomy or pupal debridement, root canals, apicoectomy, retrograde filling – 1 per tooth per lifetime **Periodontics: 50% coinsurance** • Gingivectomy – 1 per quadrant per 36 months • Gingival flap procedure – 1 per quadrant per 36 months • Clinical crown lengthening – 1 per tooth per lifetime • Osseous surgery – 1 per quadrant per 36 months • Periodontal scaling and root planing – 1 per quadrant per 36 months



Dental Services *(continued)*

Benefit	What you pay
Comprehensive Dental Services *(continued)*	Comprehensive coverage includes *(continued)*: **Periodontics *(continued)*: 50% coinsurance** • Scaling in presence of generalized moderate or severe inflammation – 2 per calendar year • Full mouth debridement – 1 per 36 months • Periodontal Maintenance – 4 per 12 months **Removable Prosthodontics: 50% coinsurance** • Removable complete, partial, immediate dentures – 1 per 60 months • Overdentures – 1 per 60 months • Adjustments – not allowed within 6 months of placement • Repairs – 1 per arch per 12 months after 6 months of placement • Replace missing / broken teeth or add clasp to partial denture – 1 per tooth per 12 months after 6 months of placement • Rebase or reline – 1 per 36 months after 6 months of placement **Maxillofacial prosthetics: 50% coinsurance** **Fixed Prosthodontics: 50% coinsurance** • Fixed dentures *(bridges)* and retainers – 1 per tooth per 60 months • Re-cement, rebond or repair partial dentures – 1 per 24 months after 6 months of placement **Oral and Maxillofacial Surgery: 50% coinsurance** • Extractions – 1 per tooth per lifetime • Oralantral fistula closure, closure of sinus perforation – 2 per arch per lifetime • Alveoplasty – 1 per quadrant per lifetime • Vestibuloplasty – 1 per arch per lifetime • Removal of exostosis – 2 per arch per lifetime • Removal of torus palatinus – 1 per lifetime • Reduction of osseuous tuberosity – 2 per lifetime • Guided tissue regeneration – 1 per 60 months • Frenectomy, frenulectomy or frenulopasty – 1 per arch per lifetime **Adjunctive general services: 50% coinsurance** • Consultation – 1 per provider per location • Facility or Surgical Center call – 6 per year



Dental Services *(continued)*

Benefit	What you pay
Comprehensive Dental Services *(continued)*	Comprehensive coverage includes *(continued)*: **Adjunctive general services *(continued)*: 50% coinsurance** • Application of desensitizing medicament – 2 per 12 months • Treatment of complications (post-surgical) – 1 per year • Occlusal analysis – mounted case – 1 per 60 months • Occlusal adjustment – 1 per 12 months Prior authorization is required for all comprehensive dental services with the exception of removable prosthodontics.

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.

Vision Services

This plan includes up to a $250 annual benefit amount *(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.
- Average savings of 20%-25% on additional lens upgrades.

Any costs above annual allowances or additional lens upgrades are member responsibility. You must use a VSP Advantage network provider for these services.

Benefit	What you pay
Eye Exam *(Medicare-covered)*	**0% coinsurance.** Includes annual glaucoma screening.
Eyewear *(Medicare-covered)*	**20% coinsurance** for Medicare-covered eyeglasses or contact lenses after cataract surgery.
Routine Eye Exam	**$0 copayment** for annual routine eye *(eye refraction)* exam. Limit 1 exam every year.

Vision Services *(continued)*

Benefit	What you pay
Supplemental Eyewear	This plan includes up to a **$250** annual benefit amount *(allowance)* for frames or contact lenses *(fitting and contacts)*. **$25 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)***	**$25 copayment**
Outpatient Psychiatric Services ***(Individual or Group Sessions)***	**$25 copayment**
Intensive Outpatient Program Services	**$55 copayment** May require prior authorization.
Partial Hospitalization Program	**$55 copayment** May require prior authorization.

Skilled Nursing Facility and Rehabilitation Services

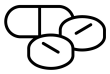
Benefit	What you pay
Skilled Nursing Facility ***(Medicare-covered)***	Per benefit period: **$0 copayment per day for days 1-20** **$178 copayment per day for days 21-100** Our plan covers for 100 days per benefit period for Medicare-covered skilled nursing facility *(SNF)*.

Skilled Nursing Facility and Rehabilitation Services *(continued)*

Benefit	What you pay
Skilled Nursing Facility ***(Medicare-covered) (continued)***	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.
Cardiac Rehabilitation Services	**$25 copayment** Prior authorization is required.
Intensive Cardiac Rehabilitation Services	**$25 copayment** Prior authorization is required.
Occupational Therapy Visits	**$0 copayment** Prior authorization is required.
Physical Therapy, Speech / Language Therapy Visits	**$0 copayment** Prior authorization is required.
Pulmonary Rehabilitation Services	**$20 copayment**

Ambulance and Transportation Services

Benefit	What you pay
Ambulance Services	**$265 copayment** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip. May require prior authorization.
Routine Transportation ***(non-emergent)***	**Not covered.**



Medicare Part B Drugs

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

Benefit	What you pay
Chemotherapy / Radiation Drugs	**0% to 20% coinsurance** for chemotherapy / radiation drugs. Prior authorization is required.
Medicare Part B Insulin	**0% to 20% coinsurance, up to a $35 maximum per month**
Other Part B Drugs	**0% to 20% coinsurance** for other Medicare Part B drugs. Prior authorization is required.

Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.

Other Benefits

Chiropractic Care

Benefit	What you pay
Chiropractic Visit ***(Medicare-covered)***	**$20 copayment** Prior authorization is required.
Routine Chiropractic Visit	**$35 copayment** Limit 6 visits every year.

Diabetes Self-Management Training

Benefit	What you pay
Diabetes Self-Management Training	**$0 copayment**

Dialysis and Kidney Disease Services

Benefit	What you pay
Dialysis Services ***(Medicare-covered)***	**20% coinsurance**
Kidney Disease Education Services	**$0 copayment** Referral is required.

Fitness Benefit

Benefit	What you pay
Fitness Benefit – Silver&Fit®	**$0 copayment** for access to fitness clubs, 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 video and home fitness tools • Healthy aging 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 & Treatment ***(Medicare-covered)***	**$0 copayment** Prior authorization is required.

Home Delivered Meals

Benefit	What you pay
Meal Delivery	**$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. Prior authorization 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)*	**20% coinsurance** May require prior authorization.
Prosthetics *(e.g., braces, artificial limbs)*	**20% coinsurance** May require prior authorization.
Diabetic Shoes & Inserts	**20% coinsurance** for Medicare-covered therapeutic shoes & inserts. Prior authorization is required.
Diabetic Supplies	**$0 copayment** for Medicare-covered diabetic supplies. Diabetic supplies and services are limited to certain manufacturers. When diabetic supplies are obtained at a pharmacy, select insulin supplies are available at a **$0 copayment**. For a list of select insulin supplies that have a $0 copayment, refer to the plan's formulary located on our website at *www.BannerHealth.com/MA*. 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.

Outpatient Substance Abuse

Benefit	What you pay
Outpatient Substance Abuse ***(Individual or Group Sessions)***	**$20 copayment**

Over the Counter *(OTC)* Benefit

Benefit	What you pay
OTC Benefits	Each quarter you are enrolled with the plan you receive a **$65** 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. You can learn more and access your benefits by visiting *andmorehealth.com*, by downloading the andmore mobile app, or by calling 1-855-AND-MORE *(1-855-263-6673, TTY 711)*. Unused funds do not roll over and expire every three months. For complete program details, store locator, and terms and conditions, go to *andmorehealth.com* or call 1-855-AND-MORE *(1-855-263-6673, TTY 711)* Monday-Friday, 8am-8pm local time, excluding holidays. *&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

Reward	
Annual Wellness Visit	**$25 reward** for completion during the plan benefit year.
Colorectal Cancer Screening	**$25 reward** for completion during the plan benefit year.
Flu Shot	**$25 reward** for receiving annual flu shot during plan benefit year.

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

Benefit	What you pay
SSBCI 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 enrolled with the plan you receive a **$65** allowance loaded to your *&more card*. In addition to OTC items, you may also use your allowance to purchase Healthy Food and Produce items or pay Utilities expenses. **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** Utilities expenses such as gas, electric, and water at select utilities providers. You can learn more and access your benefits by visiting *andmorehealth.com*, by downloading the andmore mobile app, or by calling 1-855-AND-MORE *(1-855-263-6673, TTY 711)*. Unused funds do not roll over and expire every three months. For complete program details, store locator, and terms and conditions, go to *andmorehealth.com* or call 1-855-AND-MORE *(1-855-263-6673; TTY 711)* Monday-Friday, 8 am – 8 pm local time, excluding holidays.

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

Benefit	What you pay
SSBCI Food and Produce and/or Utilities Benefits *(continued)*	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 and require intensive care coordination to manage chronic conditions such as diabetes mellitus, chronic kidney disease *(CKD)*, cardiovascular disorders, chronic heart failure, and chronic lung disorders. 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 to $25 copayment** May require prior authorization.

Medicare Part D Prescription Drugs

As shown below, there are "drug payment stages" for your Medicare Part D prescription drug coverage under Banner Medicare Advantage Prime. 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 Stages	
Out-of-Pocket Threshold	**$2,100**
Prescription Drug Deductible	There is no deductible for drugs in Tier 1 and Tier 2. Coverage for drugs on these tiers begin in the Initial Coverage Stage. There is a **$440** deductible for drugs in Tier 3, Tier 4, Tier 5. You pay the full cost for your drugs in these tiers until you reach the deductible amount. When the deductible amount has been met, you will move to the Initial Coverage Stage.
Initial Coverage Limit	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 **$2,100**. Total yearly out-of-pocket drug costs are the total copayment or coinsurance costs paid by you. You may get your drugs at network retail pharmacies and 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 **$2,100**, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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*.

Initial Coverage Stage

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

One-month Supply

This chart shows your share of the cost when you get a **one-month *(31-day)* supply** of a covered Part D prescription drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Preferred Generic	$0 copayment	$0 copayment
Tier 2: Generic	$5 copayment	$5 copayment
Tier 3: Preferred Brand	$47 copayment	$47 copayment
Tier 4: Non-Preferred Brand	50% coinsurance	50% coinsurance
Tier 5: Specialty	28% coinsurance	28% coinsurance

This chart shows your share of the cost when you get a **one-month *(31-day)* supply** of a covered Part D prescription insulin drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Covered Insulin	$0 copayment	$0 copayment
Tier 2: Covered Insulin	You pay the lesser of 25% coinsurance or $5 copayment	You pay the lesser of 25% coinsurance or $5 copayment
Tier 3: Covered Insulin	You pay the lesser of 25% coinsurance or $35 copayment	You pay the lesser of 25% coinsurance or $35 copayment
Tier 4: Covered Insulin	You pay the lesser of 25% coinsurance or $35 copayment	You pay the lesser of 25% coinsurance or $35 copayment

Long-term Supply

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

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Preferred Generic	$0 copayment	$0 copayment
Tier 2: Generic	$15 copayment	$10 copayment
Tier 3: Preferred Brand	$141 copayment	$94 copayment
Tier 4: Non-Preferred Brand	50% coinsurance	50% coinsurance
Tier 5: Specialty	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

This chart shows your share of the cost when you get a **long-term *(90-day)* supply** of a covered Part D prescription insulin drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Covered Insulin	$0 copayment	$0 copayment
Tier 2: Covered Insulin	You pay the lesser of 25% coinsurance or $15 copayment	You pay the lesser of 25% coinsurance or $10 copayment
Tier 3: Covered Insulin	You pay the lesser of 25% coinsurance or $105 copayment	You pay the lesser of 25% coinsurance or $70 copayment
Tier 4: Covered Insulin	You pay the lesser of 25% coinsurance or $105 copayment	You pay the lesser of 25% coinsurance or $70 copayment
Tier 5: Covered Insulin	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

If you receive “Extra Help”:

If you receive "Extra Help" for your drugs you will have a $0 deductible. Prior to reaching your annual **$2,100** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- Generics *(including brand drugs treated as generics)*: $0, $1.60, or $5.10 *(each prescription)*
- All other drugs: $0, $4.90, or $12.65 *(each prescription)*

After reaching your annual $2,100 out-of-pocket limit, you will pay $0 for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your Low-Income Subsidy *(LIS)* rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 *(TTY: 1-800-325-0778)*, Monday – Friday, 8 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your *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: you won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on or Part D phase you are in.

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*.

Banner Medicare Advantage

Banner Medicare Advantage Prime HMO

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 844-549-1857, 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 844-549-1857, 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 844-549-1857, 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 844-549-1857 (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 844-549-1857, 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 844-549-1857، 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 844-549-1857, 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 844-549-1857, TTY 711 번으로 연락해 주십시오. 주 7일, 오전 8시부터 오후 8시까지 운영합니다.

French: Nous Nous offrons des services d’assistance linguistique gratuits ainsi que des aides et services auxiliaires. Pour demander ces services gratuits, appelez-nous au 844-549-1857, 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 844-549-1857, 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 844-549-1857, 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、844-549-1857（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 844-549-1857، TTY 711 از ساعت 8 صبح تا 8 شب، هفت روز هفته تماس بگیرید.

Syriac: ܒܫܒܝ ܕܐ ܬܫܡ ܕܝ ܡܥܓܬܐ ܕܫܘܬܦܐ ܕܐܬܪܐ ܘܕܡܥܓܬܐ ܕܐܬܪܐ ܕܝܬ̈ܝ. ܠܗܠܝܢ ܒܥܝ ܕܡܥܓܬܐ ܕܫܘܬܦܐ ܕܐܬܪܐ ܕܝܬ̈ܝ، ܡܝ ܟܦ ܒܝ 844-549-1857، TTY 711، ܒܝ 8 ܕܨܒܚܐ ܥܕ 8 ܒܠܝܠܝ، ܫܒܥ ܝܘ̈ܡܝ ܒܫܒܘܥܐ.

Serbian: Pružamo besplatne jezičke usluge, kao i pomoćna sredstva i usluge zarad lakše komunikacije. Da biste zatražili ove besplatne usluge, pozovite nas na 844-549-1857, TTY 711, svakog dana od 8 ujutru do 8 uveče.

Thai: เราให้บริการช่วยเหลือด้านภาษาฟรี รวมถึงให้ความช่วยเหลือและบริการสนับสนุนอื่นๆ หากต้องการขอรับบริการฟรีเหล่านี้ โปรดติดต่อเราทางหมายเลข 844-549-1857, TTY 711 เวลา 8 a.m. ถึง 8 p.m. ทุกวัน