Banner Medicare Advantage Plus (PPO) offered by Banner Health Insurance Group

Annual Notice of Changes for 2023

You are currently enrolled as a member of Banner Medicare Advantage Plus. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.BannerHealth.com/MA. (You may also call our Customer Care Center to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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

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

- If you don't join another plan by December 7, 2022, you will stay in Banner Medicare Advantage Plus.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Banner Medicare Advantage Plus.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care Center number at (844) 549-1859 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven 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 Plus

- Banner Medicare Advantage Plus PPO has a contract with Medicare. Enrollment depends on contract renewal.
- When this document says "we," "us," or "our", it means Banner Health Insurance Group. When it says "plan" or "our plan," it means Banner Medicare Advantage Plus.

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

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023....4

SECTION 1 Changes to Benefits and Costs for Next Year....6

Section 1.1 – Changes to the Monthly Premium....6
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts....7
Section 1.3 – Changes to the Provider and Pharmacy Networks....7
Section 1.4 – Changes to Benefits and Costs for Medical Services....8
Section 1.5 – Changes to Part D Prescription Drug Coverage....12

SECTION 2 Administrative Changes....15

SECTION 3 Deciding Which Plan to Choose....15

Section 3.1 – If you want to stay in Banner Medicare Advantage Plus....15
Section 3.2 – If you want to change plans....16

SECTION 4 Deadline for Changing Plans....16

SECTION 5 Programs That Offer Free Counseling about Medicare....17

SECTION 6 Programs That Help Pay for Prescription Drugs....17

SECTION 7 Questions?....18

Section 7.1 – Getting Help from Banner Medicare Advantage Plus....18
Section 7.2 – Getting Help from Medicare....19

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

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Banner Medicare Advantage Plus in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$25	$25
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $4,500 From network and out-of-network providers combined: $9,000	From network providers: $4,350 From network and out-of-network providers combined: $8,700
Doctor office visits	**<u>In-Network</u>** Primary care visits: $0 copayment per visit Specialist visits: $30 copayment per visit **<u>Out-of-Network</u>** Primary care visits: $35 copayment per visit Specialist visits: $70 copayment per visit	**<u>In-Network</u>** Primary care visits: $0 copayment per visit Specialist visits: $30 copayment per visit **<u>Out-of-Network</u>** Primary care visits: $35 copayment per visit Specialist visits: $70 copayment per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**<u>In-Network</u>** Per benefit period: Days 1-5: $275 copayment per day Days 6-90: $0 copayment per day Lifetime reserve days 91-150: $0 copayment per day. **<u>Out-of-Network</u>** Per benefit period: Days 1-90: 40% coinsurance per day	**<u>In-Network</u>** Per benefit period: Days 1-5: $275 copayment per day Days 6-90: $0 copayment per day Lifetime reserve days 91-150: $0 copayment per day. **<u>Out-of-Network</u>** Per benefit period: Days 1-90: 40% coinsurance per day
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copayment • Drug Tier 2: $5 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: $100 copayment • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copayment • Drug Tier 2: $5 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: $100 copayment • Drug Tier 5: 33% coinsurance

To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the letters "SSM" in the Drug List. If you have questions about the Drug List, you can also call our Customer Care Center (Phone numbers for our Customer Care Center are printed on the front cover of this document).

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$25	$25 There is no change for the upcoming benefit year.
Optional Supplemental Benefits – Comprehensive Dental Package	$20.20	$23.50

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see Section 6 regarding “Extra Help” from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

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

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,500	$4,350 Once you have paid $4,350 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$9,000	$8,700 Once you have paid $8,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.BannerHealth.com/MA. You may also call our Customer Care Center for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact our Customer Care Center so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Referral Requirements for: Inpatient Hospital, Inpatient Psychiatric Hospital, Skilled Nursing Facility, Partial Hospitalization, Home Health Services, Occupational Therapy, Physical Therapy, Speech Therapy, Physician Specialist Services, Mental Health Services, Podiatry, Other Healthcare Professional, Psychiatric Services, Telehealth, Opioid Services, Outpatient Diagnostic Therapy, Outpatient Diagnostic Radiation, Lab Services, X-Rays, Outpatient Hospital Services, Outpatient Hospital Observation Services, Ambulatory Surgical Center, Dialysis	Referral is required.	Referral is <u>not</u> required.

Cost	2022 (this year)	2023 (next year)
Annual Physical Exam	**In- and Out-of-Network** Annual physical exams are not covered.	**In-Network** You pay a $0 copayment per visit for an annual physical exam. **Out-of-Network** You pay 40% coinsurance for an annual physical exam.
Hearing Aids	**In- and Out-of-Network** $1,000 coverage limit every 2 years for plan-covered hearing aids/ services, both ears combined, in-network and out-of-network combined.	**In- and Out-of-Network** $1,000 coverage limit every year for plan-covered hearing aids/ services, both ears combined, in-network and out-of-network combined.
Hearing Exams (Non-Medicare-covered)	**In-Network** You pay a $0 copayment for each routine hearing aid fitting/evaluation visit (Fitting/Evaluation for Hearing Aid(s) – 1 every 2 years). **Out-of-Network** You pay 40% coinsurance for each routine hearing aid fitting/evaluation visit (Fitting/Evaluation for Hearing Aid(s) – 1 every 2 years).	**In-Network** You pay a $0 copayment for each routine hearing aid fitting/evaluation visit (Fitting/Evaluation for Hearing Aid(s) – 1 every year). **Out-of-Network** You pay 40% coinsurance for each routine hearing aid fitting/evaluation visit (Fitting/Evaluation for Hearing Aid(s) – 1 every year).

Cost	2022 (this year)	2023 (next year)
Help with Certain Chronic Conditions	Musculoskeletal Diagnosis Doorknobs/Ramp Benefit Members who have had a MSK diagnosis on a claims based look back period within the last 12 months are eligible for up to $300 on American Disabilities Act (ADA)-compliant doorknobs and up to $2,000 on permanent ramps may be available to you – totaling up to $2,300 in home modifications per plan year. Simple Therapy Program for Musculoskeletal Diagnosis If you have had an MSD diagnosis in the past 12 months (or are diagnosed during the plan year), you may be eligible for Simple Therapy benefit. Simply Therapy is an on-demand program that includes an app you download to your smartphone. This program also includes: coaches, physical therapists, and providers to help you prevent and recover from injuries; guided exercise programs and real-time monitoring by a care team through the program app; and referrals to a PCP or medical specialist if your symptoms worsen or additional treatment options are needed.	Musculoskeletal Diagnosis Doorknobs/Ramp Benefit Home modifications are not covered. Simple Therapy Program for Musculoskeletal Diagnosis Simply Therapy benefit program is not covered.

Cost	2022 (this year)	2023 (next year)
Over-the-Counter (OTC) Items	**Out-of-Network** You pay 40% coinsurance for OTC items. Plan covers up to $50 every three months in and out of network combined.	**Out-of-Network** You pay a $0 copayment for OTC items. Plan covers up to $50 every three months in and out of network combined.
Pulmonary Rehabilitation Services (Medicare-covered)	**In-Network** You pay a $30 copayment for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** You pay a $20 copayment for each Medicare-covered pulmonary rehabilitation services visit.
Remote Access Technologies – Nursing Hotline	**In- and Out-of-Network** Remote access technologies are not covered.	**In-Network** You pay a $0 copayment for Banner Nurse On-Call: 24 hours a day, seven days a week, health care advice from a nursing professional to help answer your immediate health care questions. **Out-of-Network** You pay 40% coinsurance for Banner Nurse On-Call: 24 hours a day, seven days a week, health care advice from a nursing professional to help answer your immediate health care questions.

Cost	2022 (this year)	2023 (next year)
Urgently Needed Services	**<u>In- and Out-of-Network</u>** You pay a $30 copayment for each Medicare-covered urgent care visit.	**<u>In- and Out-of-Network</u>** You pay a $0 copayment for each Medicare-covered urgent care visit.
Vision Care (Non-Medicare-covered Eyewear)	**<u>In- and Out-of-Network</u>** $200 coverage limit every 2 years for plan-covered routine eyewear (glasses or contact lenses), in-network and out-of-network combined.	**<u>In- and Out-of-Network</u>** $200 coverage limit every year for plan-covered routine eyewear (glasses or contact lenses), in-network and out-of-network combined.

Section 1.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact our Customer Care Center for more information.

Starting in 2023, 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.

We have made changes to the list of insulin drugs that will be covered as Select Insulins at a lower cost-sharing. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the letters "SSM" in the Drug List. If you have questions about the Drug List, you can also call our Customer Care Center (Phone numbers for our Customer Care Center are printed on the front cover of this document).

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. If 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." The information below shows the changes 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.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call our Customer Care Center for more information.

Important Message About What You Pay for Insulin - 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.

Getting Help from Medicare – If you chose this plan because you were looking for insulin coverage at $35 or less a month, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Customer Care Center number at (844) 549-1859 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week.

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

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
	Preferred Generic Drugs: You pay $0 copayment per prescription.	**Preferred Generic Drugs:** You pay $0 copayment per prescription.
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.	**Generic Drugs:** You pay $5 copayment per prescription.	**Generic Drugs:** You pay $5 copayment per prescription.
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*.	**Preferred Brand Name Drugs:** You pay $47 copayment per prescription.	**Preferred Brand Name Drugs:** You pay $47 copayment per prescription.
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.	**Non-preferred Drugs:** You pay $100 copayment per prescription.	**Non-preferred Drugs:** You pay $100 copayment per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Specialty Drugs:** You pay 33% coinsurance per prescription. _______________ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Specialty Drugs:** You pay 33% coinsurance per prescription. _______________ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Durable Medical Equipment (DME) Providers	This plan has preferred durable medical equipment providers.	This plan does not have preferred durable medical equipment providers.
Part D Long-Term Drug Supply	The plan provides a 100-day supply of Part D prescription drugs.	The plan provides a 90-day supply of most Part D prescription drugs.
Service area	The service area for this plan is Pima County.	The service area for this plan is Pima and Santa Cruz Counties.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Banner Medicare Advantage Plus

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 Plus.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Banner Health Insurance Group offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

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 Plus.
- 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 Plus.
- 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 so.
    - *– 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.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with 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.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Arizona State Health Insurance Assistance Program 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 Arizona State Health Insurance Assistance Program at (800) 432-4040. You can learn more about Arizona State Health Insurance Assistance Program by visiting their website (des.az.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State 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 Arizona ADAP at (602) 364-3610 or (800) 334-1540.

SECTION 7 Questions?

Section 7.1 – Getting Help from Banner Medicare Advantage Plus

Questions? We're here to help. Please call our Customer Care Center at (844) 549-1859. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Banner Medicare Advantage Plus. 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/MA. 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/MA. 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 7.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

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.

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。