



2021

Summary of Benefits

Pima | Maricopa | Pinal

Banner Medicare Advantage Prime HMO H5843, 001, 002



H5843_SB001002CY21_C

2021 Summary of Benefits

This is a summary of drug and health services covered by Banner Medicare Advantage Prime HMO January 1, 2021 - December 31, 2021.

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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You may also access our Evidence of Coverage online at: www.BannerMA.com.



Hours Of Operation

You can call us 8 a.m. to 8 p.m., 7 days a week.



How To Contact Us

If you are a member of this plan, call toll-free (844) 549-1857; TTY users call 711.
If you are not a member of this plan, call toll-free (844) 549-1858; TTY users call 711.
Our website: www.BannerMA.com



Who Can Join?

To join Banner 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 counties in Arizona:

PBP 001: **Maricopa & Pinal**

PBP 002: **Pima**



Which Doctors, Hospitals, and Pharmacies Can I Use?

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

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

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

What Do We Cover?

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

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

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

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

Tips For Comparing Your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Banner 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 Benefit booklets 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, 7 days a week. TTY users should call 1-877-486-2048.

Important Information

Banner Medicare Advantage Prime HMO is a Health Maintenance Organization with a Medicare contract. Enrollment in Banner Medicare Advantage Prime HMO depends on contract renewal.

Banner Medicare Advantage Prime HMO complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-549-1857 (TTY: 711).

Out-of-network/non-contracted providers are under no obligation to treat Banner Medicare Advantage Prime HMO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Monthly Plan Premium	You pay \$0 per month.	You pay \$0 per month.
Medicare Part B Premium	You must continue to pay your Medicare Part B premium. Medicare Part B premiums and plan premiums do not apply to your maximum out-of-pocket limit.	
Deductible	This plan has no medical deductibles.	This plan has no medical deductibles.
Maximum Out-of-Pocket Responsibility	<p>Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$4,450 for services you receive from in-network providers <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Refer to the "Medicare & You" handbook for Medicare-covered services.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$4,450 for services you receive from in-network providers <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Refer to the "Medicare & You" handbook for Medicare-covered services.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
Inpatient Hospital Coverage	Referral and prior authorization required.	
Inpatient Hospital	\$200 copayment per day for days 1 through 7	\$200 copayment per day for days 1 through 7
Inpatient Hospital Benefit Period	<p>We cover up to 90 days of inpatient hospital stays.</p> <p>Cost sharing begins on the day you are admitted and ends on day of discharge.</p> <p>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.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>	
Outpatient Hospital Coverage	Referral and prior authorization required.	
Outpatient Hospital	You pay a \$225 copayment	You pay a \$225 copayment

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Doctor Visits	<ul style="list-style-type: none"> o Coverage includes certain additional telehealth services, including: Urgently needed services; PCP visits; Physician Specialist visits; Mental health specialist services for individual or groups sessions; Psychiatric services for individual or group sessions; Occupational, Physical and/or Speech Therapy providers as allowed by Medicare. See specific sections for cost-sharing. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. o Generally, the telehealth service must be with a provider that you have an established relationship with and use an interactive audio and video communications system that permits real-time communication. o Prior authorization and/or referral from your PCP may apply. 	
Primary Care Providers	You pay a \$0 copayment	You pay a \$0 copayment
Specialist Visit	You pay a \$30 copayment	You pay a \$25 copayment
Preventive Care	Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.	
<ul style="list-style-type: none"> ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (Mammogram) ▪ Cardiovascular disease (behavior therapy) ▪ Cardiovascular disease screening ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings ▪ Depression screening ▪ Diabetes screenings ▪ HIV screening <p><i>*see next page for more</i></p>	You pay a \$0 copayment	You pay a \$0 copayment

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
<p><i>Continued...</i></p> <ul style="list-style-type: none"> Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots Welcome to Medicare preventive visit (One-time) Annual Wellness Exam 	You pay a \$0 copayment	You pay a \$0 copayment
Emergency Care	<p>If you are admitted to the hospital within 24 hours, your copayment is waived. If you need inpatient care after your out-of-network emergency condition is stabilized, your cost sharing may be less if you return to a network hospital. Coverage limited to the U.S. and its territories.</p>	
	You pay a \$90 copayment	You pay a \$90 copayment
Urgently Needed Services	<p>Coverage limited to the U.S. and its territories. Coverage may be available through telehealth.</p>	
	You pay a \$40 copayment	You pay a \$30 copayment
Diagnostic radiology service (such as MRI, CT scans)	Referral and prior authorization required.	
Diagnostic tests and procedures, and lab services	You pay a \$10 copayment	You pay a \$10 copayment

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Outpatient X-rays	You pay a \$20 copayment	You pay a \$20 copayment
General Diagnostic radiology services (Such as MRIs, CT scans)	You pay a \$125 copayment	You pay a \$125 copayment
Complex Diagnostic radiology services (Such as MRIs, CT scans)	You pay a \$200 copayment	You pay a \$200 copayment
Therapeutic radiology services	You pay a \$60 copayment	You pay a \$60 copayment
Hearing service (Medicare Covered)	Medicare-covered Hearing Services are exams to diagnose and treat diseases and conditions of the ear.	
Hearing exam to diagnose and treat hearing and balance issues	You pay a \$0 copayment	You pay a \$0 copayment
Hearing Services (Supplemental)	Our plan pays up to \$1,000 every two years for hearing aids and services. Cost of all exams - including annual hearing exam - will deduct from total coverage amount. Prior authorization required for hearing aids.	
Routine Hearing exam once a year fitting/evaluation	You pay a \$0 copayment	You pay a \$0 copayment
Hearing aids (Both ears combined)	You pay a \$0 copayment	You pay a \$0 copayment
Dental Services (Medicare covered)	Referral and prior authorization required.	
Medicare-covered dental procedures	You pay a \$0 copayment	You pay a \$0 copayment
Dental Services (Preventive Dental Services)	<p>Preventative Dental Services</p> <ul style="list-style-type: none"> • Office visit includes combined exam and cleaning (for up to 1 every six months, maximum 2 per year). • Oral exam (for up to 1 every six months) • Cleaning (for up to 1 every six months) • Fluoride treatment (for up to 1 every year; treatment must be during a preventative office visit) • Dental x-ray(s) (for up to 1 set of x-rays every year; must be during a preventative office visit.) <p>Authorization and/or referrals are not required for preventative dental services.</p>	

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Preventive Dental Care	You pay a \$0 copayment	You pay a \$0 copayment
Comprehensive Dental Services (Non-Medicare Covered)	Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.	
Dental Coverage Exclusions	Our plan does not cover the following: Dental implants; Dental procedures solely for cosmetic/aesthetic reasons; Cost for missing dental appointments; Dental procedures that are inconsistent with the ADA guidelines as indicated in the DentaQuest Provider Manual.	
Vision Services	We cover: <ul style="list-style-type: none"> • One routine eye exam covered per year. Cost of annual routine visit will not be deducted from total coverage amount for vision related benefits. Office visit cost share may apply if other physician services are performed in conjunction with eye exam. • Glasses and contact lenses. Glasses include lenses and frames. Contacts include hardware and fitting fee, up to coverage amount. Coverage includes receipt of glasses and contacts in one coverage period. Referral and prior authorization required for eye exam and Medicare-covered eyewear.	
Medicare Covered Vision Exam including yearly glaucoma screening	You pay a \$0 copayment	You pay a \$0 copayment
Vision Services (Supplemental)	Benefit coverage limited to \$200 every 2 years for contact lenses and fitting fee or eyeglasses (frames and/or lenses).	
Eye Exam (Routine, one per year)	You pay a \$0 copayment	You pay a \$0 copayment
Eyewear (Frames/contact lenses)	You pay a \$25 copayment	You pay a \$25 copayment
Mental Health Services	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Some services may be available by telehealth. Referral and prior authorization may apply.	

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Inpatient Mental Health	You pay a \$225 copayment for days 1 through 7	You pay a \$225 copayment for days 1 through 7
Inpatient Mental Health Benefit Period	<p>Referral and prior authorization required. We cover up to 90 days of inpatient hospital stays.</p> <p>Cost sharing begins on the day you are admitted and ends on day of discharge.</p> <p>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.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>	
Outpatient group therapy visit Outpatient individual therapy visit	You pay a \$35 copayment	You pay a \$35 copayment
Outpatient substance abuse group therapy visit Outpatient substance abuse individual therapy visit	You pay a \$30 copayment	You pay a \$30 copayment
Skilled Nursing Facility	<p>Our plan covers up to 100 days in a Skilled Nursing Facility (SNF). Referral and prior authorization required.</p>	
SNF Inpatient stay	<p>You pay a \$0 copayment for days 1 through 20</p> <p>You pay a \$178 copayment for days 21 through 100</p>	<p>You pay a \$0 copayment for days 1 through 20</p> <p>You pay a \$178 copayment for days 21 through 100</p>
SNF Benefit Period	<p>A benefit period begins the day you enter a skilled nursing facility (SNF). The benefit period ends when you haven't received any 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.</p>	
Rehabilitative Therapy	Referral and prior authorization required.	

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Occupational Therapy, Physical therapy and speech and language therapy visit	You pay a \$35 copayment	You pay a \$40 copayment
Cardiac rehabilitation services Intensive cardiac rehabilitation services	You pay a \$25 copayment	You pay a \$45 copayment
Ambulance	Cost sharing applies for one-way trips. Prior authorization required for non-emergency ambulance services.	
Ground Air	You pay a \$265 copayment	You pay a \$250 copayment
Transportation	Not Covered	
Medicare Part B Drugs	A separate physician office copayment may apply if other services are rendered at the time of the visit. Referral and prior authorization required.	
Chemotherapy drugs and Other Part B drugs	20% coinsurance	20% coinsurance
Outpatient Surgical Services	Referral and prior authorization required.	
Ambulatory Surgical Center and Outpatient Surgery	You pay a \$225 copayment	You pay a \$225 copayment

Banner Medicare Advantage Prime HMO

Prescription Drug Benefits

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. Every drug on the plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1 – Preferred Generic (Lowest Cost-Sharing Tier)

Tier 2 – Generic

Tier 3 – Preferred Brand

Tier 4 – Non-Preferred Brand

Tier 5 – Specialty Drugs (Highest Cost-Sharing Tier)

Tier 6 – Select Care Drugs (Certain \$0 copayment drugs)

1. Deductible Stage

You begin in this stage when you fill your first prescription of the year. During the Deductible Stage, you pay all costs for your Part D prescription drugs until you meet the plan deductible.

	Maricopa Pinal	Pima
Annual Part D Deductible	\$150	\$200

Once you meet the deductible, you will move to the Initial Coverage Stage.

2. Initial Coverage Stage

During the Initial Coverage Stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

The chart on the next page shows your share of the cost when you get a one-month supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing	Long-term care (LTC) cost sharing	Out-of-network cost sharing
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$2.00 Copay	\$2.00 Copay	\$2.00 Copay
Cost-Sharing Tier 2 (Non-preferred Generic Drugs)	\$12.00 Copay	\$12.00 Copay	\$12.00 Copay
Cost-Sharing Tier 3 (Preferred Brand Name Drugs)	\$47.00 Copay	\$47.00 Copay	\$47.00 Copay
Cost-Sharing Tier 4 (Non-preferred Brand Name Drugs)	\$100.00 Copay	\$100.00 Copay	\$100.00 Copay
Cost-Sharing Tier 5 (Specialty Drugs)			
Maricopa Pinal	30% Coinsurance	30% Coinsurance	30% Coinsurance
Pima	29% Coinsurance	29% Coinsurance	29% Coinsurance
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 Copay	\$0 Copay	\$0 Copay

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

Tier	Standard retail cost sharing (in-network)	Mail-order cost sharing
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$6.00 Copay	\$4.00 Copay
Cost-Sharing Tier 2 (Non-preferred Generic Drugs)	\$36.00 Copay	\$24.00 Copay
Cost-Sharing Tier 3 (Preferred Brand Name Drugs)	\$141.00 Copay	\$141.00 Copay
Cost-Sharing Tier 4 (Non-preferred Brand Name Drugs)	\$300.00 Copay	\$300.00 Copay
Cost-Sharing Tier 5 (Specialty Drugs)	N/A	N/A
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 Copay	\$0 Copay

You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total \$4,130. When you reach a total drug cost limit of \$4,130, you leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

3. Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for certain drugs. You pay no more than \$2.00 for a 1-month supply of preferred generic drugs (tier 1) and \$0 for Select Care Drugs (tier 6), and the plan pays the rest. The amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs, preferred generic and select care drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2021, that amount is \$6,550.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$6,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

4. Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$6,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:

- – *either* – Coinsurance of 5% of the cost of the drug
- – *or* – \$3.70 for a generic drug or a drug that is treated like a generic and \$9.20 for all other drugs.

Additional Benefits

Banner Medicare Advantage Prime HMO		
Health Benefits	Maricopa Pinal	Pima
Home Delivered Meals	For members discharged from an inpatient hospital or skilled nursing facility stay, we cover up to 12 meals delivered to the member's home. Meals must be ordered within 30 days of discharge. Prior authorization is required.	
Meal Benefit	You pay a \$0 copayment	You pay a \$0 copayment
Fitness Benefit	We offer a fitness benefit called Silver&Fit, one of the largest and most diverse Senior Healthy Aging and Exercise programs nationally. It is a three-pronged initiative which focuses on 1) Fitness Center Membership Program, 2) Digital Fitness Video Program with Home Fitness Tools, and 3) Healthy Aging Program.	
Silver&Fit	There is no cost for fitness classes or fitness kits provided by Silver&Fit	There is no cost for fitness classes or fitness kits provided by Silver&Fit
Podiatry Services	Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. Referral and prior authorization required.	
Medicare-covered foot care	You pay a \$35 copayment	You pay a \$30 copayment
Medical Equipment and Supplies	We cover all medically necessary DME covered by Original Medicare. Prior authorization required.	
Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay 20% coinsurance	You pay 20% coinsurance
Prosthetics (e.g., braces, artificial limbs)	You pay 20% coinsurance	You pay 20% coinsurance

Banner Medicare Advantage Prime HMO

Health Benefits	Maricopa Pinal	Pima
Diabetes supplies and services (limited to specific manufacturers)	You pay 20% coinsurance	You pay 20% coinsurance
Over-the-Counter Health Products	Allowance amount does not roll over to next period. Items may only be purchased for enrollee. Member must use loyalty card and approved vendors.	
OTC Card	\$50 allowance every 3 months	\$50 allowance every 3 months
Chiropractic Care	Medicare-covered benefit and up to six routine chiropractic care visits per year.	
Manual manipulation of the spine to correct subluxation	You pay a \$20 copayment	You pay a \$20 copayment
Routine Chiropractic Care	You pay a \$35 copayment	You pay a \$35 copayment
Nurse on Call	24 hours a day, 7 days a week health care advice from a nursing professional to help answer your immediate health care questions. Must use in-network call line. No cost.	
Home Health Care	Referral and prior authorization required.	
Home Health Care	You pay a \$0 copayment	You pay a \$0 copayment
Renal Dialysis	Referral and prior authorization required.	
Renal Dialysis	You pay 20% coinsurance	You pay 20% coinsurance

Optional Dental Benefits

Banner Medicare Advantage Prime offers an opportunity to customize your care with an optional supplemental dental benefit. You can add these extra benefits when you sign for our plan or during the Annual Enrollment Period. The information below will tell you about the optional dental benefit you can add to your plan. If you have questions, you can call us at (844) 549–1858 TTY 711, 8 a.m. to 8 p.m., 7 days a week.

Monthly Premium	\$20.20
Maximum Benefit	\$1,000 per year
Deductible	\$0
Restorations	
	In Network
Amalgam and Resin fillings, resin infiltration of incipient smooth surface lesion, inlays/onlays, protective restorations	20%
Recement or re-bond inlay, onlay, partial restoration, crown	20%
Crowns, core build-up, pin retention-per tooth, post and core, each additional post, crown repair necessitated by restorative material failure	50%
Endodontics	
	In Network
Pulpotomy and gross pulpal debridement of tooth, root canals and retreatment of previous root canal	50%
Apicoectomy/Periradicular surgery and retrograde filling	50%
Periodontics	
	In Network
Gingivectomy-gingivoplasty, gingival flap procedure, osseous surgery, clinical crown lengthening	50%
Periodontal scaling and root planing, full mouth debridement	50%

Extractions	
	In Network
Extractions and coronectomy	20%
Oralantral fistula closure, primary closure of a sinus perforation	50%
Alveoloplasty, Vestibuloplasty	50%
Removal of lateral exostosis (maxilla or mandible), removal of Torus Palatinus	50%
Reduction of osseous tuberosity, removal of torus mandibularis	50%
Frenulectomy, frenuloplasty, excision of hyperplastic tissue, excision of pericoronal gingiva	50%
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	
	In Network
Removable dentures-complete, partial, immediate, overdentures, fixed partial dentures-pontics and retainers, retainer crowns	50%

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your 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.