



# Summary of Benefits

Maricopa | Pima | Pinal | Santa Cruz | Yuma

Banner Medicare Advantage Prime HMO



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2022 Banner Medicare Advantage Prime HMO

# 2022 Summary of Benefits

This is a summary of drug and health services covered by Banner Medicare Advantage Prime HMO January 1, 2022 - December 31, 2022.

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 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.BannerHealth.com/Medicare](http://www.BannerHealth.com/Medicare).



## 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/Medicare](http://www.BannerHealth.com/Medicare)



## 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: Maricopa, Pima, Pinal, Santa Cruz, and Yuma.

## Which Doctors, Hospitals, and Pharmacies Can I Use?



Banner Prime has a network of doctors, hospitals, pharmacies, and other providers. If you use providers who 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 on our website: [www.BannerHealth.com/Medicare](http://www.BannerHealth.com/Medicare). Or call us, and we will send you a copy of the provider directory and pharmacy directory.



## What Do We Cover?

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

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

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

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at [www.BannerHealth.com/Medicare](http://www.BannerHealth.com/Medicare).
- 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 Benefits* booklet, or use the Medicare Plan Finder on [www.medicare.gov](http://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](http://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.

### Important Information

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 your Evidence of Coverage for more information.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.  
Call (844) 549-1857, TTY 711.

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

Benefits	Maricopa   Pima   Pinal   Santa Cruz   Yuma
Monthly Plan Premium	<p>\$0 per month.</p> <p>You must continue to pay your Medicare Part B premium.</p>
Annual Plan Deductible	<p>\$0 plan deductible</p>
Annual Out of-Pocket Limit	<p>\$2,775 annual out-of-pocket limit for services you receive from in-network providers.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered Part A and Part B services, and we will pay the full cost for the rest of the year.</p> <p>Your Medicare Part B premiums and Part D prescription drug costs do not count toward your annual maximum out-of-pocket limit.</p> <p>You must pay your Part D prescription drug cost-sharing.</p>
Inpatient Hospital Care	<p>Per benefit period*:</p> <p>Days 1 – 7: \$195 copayment per day;</p> <p>Days 8 – 90: \$0 copayment per day.</p> <p>Covered up to 90 days per benefit period*.</p> <p>Referral and prior authorization required.</p>
Outpatient Hospital – Surgery and Observation	<p>\$175 copayment per visit.</p> <p>Referral and prior authorization required.</p>
Ambulatory Surgical Center	<p>\$175 copayment per visit.</p> <p>Referral and prior authorization required.</p>

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<p>Primary Care Provider (PCP) Visits</p>	<p>\$0 copayment per visit</p>
<p>Specialist Visit</p>	<p>\$20 copayment per visit</p>
<p>Preventive Care</p>	<p>\$0 copayment per visit:</p> <ul style="list-style-type: none"> <li>Abdominal aortic aneurysm screening</li> <li>Alcohol misuse counseling</li> <li>Annual wellness exam</li> <li>Barium enemas</li> <li>Bone mass measurement</li> <li>Breast cancer screening (mammogram)</li> <li>Cardiovascular disease (behavioral therapy)</li> <li>Cardiovascular disease screening</li> <li>Cervical and vaginal cancer screening</li> <li>Colorectal cancer screening</li> <li>Depression screening</li> <li>Diabetes screening</li> <li>Diabetes self-management training</li> <li>Digital rectal exam</li> <li>EKG following "Welcome to Medicare" visit</li> <li>Glaucoma screening</li> <li>HIV screening</li> <li>Medical nutrition therapy services</li> <li>Obesity screening and counseling</li> <li>Prostate cancer screenings (PSA)</li> <li>Sexually transmitted infections screening and counseling</li> <li>Tobacco use cessation counseling</li> <li>Vaccines, including Flu, Hepatitis B, COVID-19, and pneumococcal shots</li> <li>"Welcome to Medicare" preventive visit (one time)</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<p>Emergency Care</p>	<p>\$90 copayment per visit.</p> <p>If you are admitted to the hospital within 24 hours, your copayment is waived.</p>

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Worldwide Emergency Care	\$90 copayment per visit. You are covered for up to \$25,000 per calendar year. If you are admitted to the hospital within 24 hours, your copayment is waived.
Urgently Needed Services	\$30 copayment per visit
Diagnostic Procedures, Tests, & Lab Services	\$0 - \$10 copayment per visit. Prior authorization and/or referral may apply.
X-rays	\$15 copayment per visit. Prior authorization and/or referral may apply.
General Diagnostic Radiology (such as CT scan, MRI/MRA)	\$125 copayment per visit. Prior authorization and/or referral may apply.
Complex Diagnostic Radiology (such as CT scan, MRI/MRA)	\$200 copayment per visit. Prior authorization and/or referral may apply.
Therapeutic Radiology	\$60 copayment per visit. Prior authorization and/or referral may apply.
Medicare-covered Hearing & Balance Exams	\$0 copayment per visit for diagnostic hearing and balance exams if your provider orders them to see if you need medical treatment.
Routine Hearing Exam	\$0 copayment per visit; once per calendar year.
Routine Hearing Aid Fitting/Evaluation	\$0 copayment per visit; once every 2 years.

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<p>Hearing Aids (both ears combined)</p>	<p>\$0 copayment for hearing aid(s). \$1,000 every 2 years for hearing aids and services.</p>
<p>Medicare-covered Dental</p>	<p>\$0 copayment per visit for Medicare-covered dental services (certain dental services that you get when you're in a hospital). Prior authorization and referral required.</p>
<p>Preventive Dental</p>	<p>\$0 copayment per visit: Office visit includes combined exam and cleaning: up to 1 visit every 6 months, maximum of 2 visits per year Oral exam: up to exam 1 every 6 months Cleaning: up to cleaning 1 every 6 months Fluoride treatment: up to 1 treatment every year Dental x-ray(s): up to 1 set of bitewing x-rays every year</p>
<p>Optional Supplemental Benefits – Comprehensive Dental</p>	<p>\$20.20 additional monthly premium. \$1,000 per calendar year for comprehensive dental services.</p>
<p>Medicare-covered Eye Exams</p>	<p>\$0 copayment per visit for Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye (including annual glaucoma screening).</p>
<p>Medicare-covered Eyewear</p>	<p>20% coinsurance for Medicare-covered eyeglasses or contact lenses following cataract surgery.</p>

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Routine Eye Exam	\$0 copayment for annual routine eye exam.
Routine Eyewear	\$25 copayment for routine eyewear. \$200 every 2 years for contact lenses and fitting fee or eyeglasses (frames and/or lenses).
Inpatient Mental Health Care	Per benefit period*: Days 1 – 7: \$195 copayment per day; Days 8 – 90: \$0 copayment per day. Covered up to 90 days of inpatient mental health care in a general hospital per benefit period*. Covered up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The psychiatric hospital lifetime limit does not apply to inpatient mental health care services provided in a general hospital. Referral and prior authorization required.
Outpatient Mental Health Care	\$25 copayment per individual or group visit. Referral and prior authorization may apply.
Skilled Nursing Facility (SNF)	Per benefit period*: Days 1 – 20: \$0 copayment per day; Days 21 – 100: \$178 copayment per day. Covered up to 100 days per benefit period*. Referral and prior authorization required.
Occupational Therapy, Physical Therapy & Speech Therapy	\$25 copayment per visit. Referral and prior authorization may be required.



Benefits	Maricopa   Pinal   Yuma		Pima   Santa Cruz	
Comprehensive Outpatient Rehabilitation Facility (CORF)	<p>\$25 copayment per visit. Referral and prior authorization may be required.</p>			
Ambulance – Ground & Air	<p>\$265 copayment per one-way trip. Prior authorization required for non-emergency ambulance transportation services.</p>		<p>\$250 copayment per one-way trip. Prior authorization required for non-emergency ambulance transportation services.</p>	
Transportation	Not covered			
Medicare Part B Drugs & Chemotherapy Drugs	<p>20% co-insurance. Referral and prior authorization required.</p>			
Outpatient Substance Abuse	<p>\$20 copayment per individual or group visit. Referral and prior authorization may be required.</p>			
Cardiac Rehabilitation & Intensive Cardiac Rehabilitation	<p>\$25 copayment per visit. Referral and prior authorization may be required.</p>		<p>\$45 copayment per visit. Referral and prior authorization may be required.</p>	
Medicare-covered Podiatry	<p>\$25 copayment per visit for Medicare-covered foot exams and treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases. Referral and prior authorization required.</p>			
Medicare-covered Chiropractic Care	<p>\$20 copayment per visit for Medicare-covered manual manipulation of the spine to correct subluxation. Prior authorization may be required.</p>			

Benefits	Maricopa   Pima   Pinal   Santa Cruz   Yuma
Routine Chiropractic Care	\$35 copayment per visit; 6 routine visits per calendar year.
Home Health	\$0 copayment per visit. Referral required.
Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% co-insurance. Prior authorization may be required.
Prosthetics & Medical Supplies (e.g., braces, artificial limbs)	20% co-insurance. Prior authorization required.
Renal Dialysis	20% co-insurance. Referral required.
Diabetic Supplies	\$0 copayment. Prior authorization may be required.
Diabetes Self-Management Training	\$0 copayment
Home Delivered Meals – Post-Discharge	\$0 copayment. For members discharged from an inpatient hospital or SNF stay, up to 12 meals delivered to the member’s home. Meals must be ordered within 30 days of discharge.

Benefits	Maricopa   Pima   Pinal   Santa Cruz   Yuma
Silver&Fit® Fitness Benefit	<p>\$0 copayment.</p> <p>Fitness classes/fitness kits provided by Silver&amp;Fit. Silver&amp;Fit is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on:</p> <ol style="list-style-type: none"> <li>1) Fitness center membership program,</li> <li>2) Digital fitness video program with home fitness tools, and</li> <li>3) Healthy aging program.</li> </ol>
Over-the-Counter (OTC) Health Items	<p>\$50 every 3 months.</p> <p>Unused amount rolls over to the next period.</p> <p>Member must use OTC debit card and approved vendors.</p>
Nurse Advice Line – Banner Nurse Now	<p>\$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.</p> <p>Must use in-network call line.</p>

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

# Prescription Benefits

Maricopa | Pima | Pinal | Santa Cruz | Yuma

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.BannerHeath.com/Medicare](http://www.BannerHeath.com/Medicare)>.

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

**Tier 1** – Preferred Generic (lowest cost-sharing tier)

**Tier 2** – Generic

**Tier 3** – Preferred Brand

**Tier 4** – Non-Preferred

**Tier 5** – Specialty (highest cost-sharing tier)

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## 1. Initial Coverage Stage

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Since this plan does not have a deductible, you begin in the Initial Coverage Stage. During the Initial Coverage Stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. 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.

This chart 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
Tier 1 – Preferred Generic	\$0 copayment	\$0 copayment	\$0 copayment
Tier 2 – Generic	\$5 copayment	\$5 copayment	\$5 copayment
Tier 3 – Preferred Brand	\$47 copayment	\$47 copayment	\$47 copayment
Tier 4 – Non-Preferred	\$100 copayment	\$100 copayment	\$100 copayment
Tier 5 – Specialty	33% co-insurance	33% co-insurance	33% co-insurance

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	Standard mail order cost sharing
Tier 1 – Preferred Generic	\$0 copayment	\$0 copayment
Tier 2 – Generic	\$15 copayment	\$10 copayment
Tier 3 – Preferred Brand	\$141 copayment	\$141 copayment
Tier 4 – Non-Preferred	\$300 copayment	\$300 copayment
Tier 5 – Specialty	33% co-insurance	33% co-insurance

You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total **\$4,430**. When you reach a total drug cost limit of **\$4,430**, you leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

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## 2. Coverage Gap Stage

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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 \$0 for a one-month supply of Tier 1 preferred generic drugs, 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 and preferred generic drugs and no more than 25% of the cost of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2022, that amount is **\$7,050**.

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 **\$7,050**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

### Coverage Gap Stage

Tier 1 – Preferred Generics	\$0 copayment
Generic Drugs and Brand Name Drugs	25% co-insurance

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### 3. Catastrophic Coverage Stage

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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$7,050** 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 a coinsurance or a copayment, whichever is greater:

- either – coinsurance of 5% of the cost of the drug
- or – \$3.95 for a generic drug or a drug that is treated like a generic and \$9.85 for all other drugs.

#### Catastrophic Coverage Stage

Generic Drugs  
and  
Brand Name Drugs

You pay the greater of:  
5% co-insurance  
**or**  
\$3.95 for generic/preferred  
multi-source drugs and  
\$9.85 for all other drugs

## Part D Senior Savings Model Select Insulins

The Part D Senior Savings Model allows participating Part D plans to offer a broad set of Select Insulins at a maximum \$35 copayment for a one-month supply throughout the initial coverage and coverage gap stages of Part D drug coverage.

Starting January 1, 2022, Banner Prime will offer our members a predictable, stable \$35 copayment on Select Insulins, helping you save money on your drug costs.

To find out which Select Insulins are part of this savings model, please visit [www.BannerHealth.com/Medicare](http://www.BannerHealth.com/Medicare) to review the most recent Drug List, or call (844) 549-1857, TTY 711, from 8 a.m. to 8 p.m., seven days a week, for a hard copy. Select Insulins are marked with the letters "SSM" in the Drug List.

# Optional Supplemental Benefits - Comprehensive Dental

Banner Prime offers an opportunity to customize your care with an optional supplemental dental benefits package. You can enroll in this optional supplemental dental benefits package when you enroll in our plan or during the Annual Election Period. If you have questions, you can call us at (844) 549-1857, TTY 711, 8 a.m. to 8 p.m., seven days a week.

Optional Supplemental Benefits – Comprehensive Dental	
Additional Monthly Premium	\$20.20
Annual Benefit Maximum	\$1,000 per calendar year
Annual Deductible	\$0
Restorations - In Network	
Amalgam and Resin fillings, resin infiltration of incipient smooth surface lesion, inlays/ onlays, protective restorations	20% co-insurance. Referral required.
Recement or re-bond inlay, onlay, partial restoration, crown	\$0 copayment. Prior authorization may be required.
Crowns, core build-up, pin retention-per tooth, post and core, each additional post, crown repair necessitated by restorative material failure	\$0 copayment. Prior authorization required.



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### Endodontics - In Network

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Pulpotomy and gross pulpal debridement of tooth, root canals and retreatment of previous root canal

50%

Apicoectomy/Periradicular surgery and retrograde filling

50%

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### Periodontics - In Network

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Gingivectomy-gingivoplasty, gingival flap procedure, osseous surgery, clinical crown lengthening

50%

Periodontal scaling and root planing, full mouth debridement

50%

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### Extractions - In Network

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Extractions and coronectomy

20%

Oral-antral 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	
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.