Banner – University Advantage (HMO SNP) offered by Banner – University Care Advantage

Annual Notice of Changes for 2019

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?

- Look in Section 2.3 and 2.4 for information about our Provider Directory and Pharmacy Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 to learn more about your choices.

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

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

- If you want to **keep** Banner – University Care Advantage, you don't need to do anything. You will stay in Banner – University Care Advantage.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in section 4.2, page 19 to learn more about your choices.

4. ENROLL: To change plans, join a plan between **now** and **December 31, 2018**

- If you **don't join another plan by December 31, 2018**, you will stay in Banner – University Care Advantage.
- If you **join another plan by December 31, 2018**, your new coverage will start the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in section 5, page 21 to learn more.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care Center at (877) 874-3930 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., 7 days a week.

- This document may be available in other formats such as braille, large print or other alternate formats. For additional information, call our Customer Care Center at the phone number listed above.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Banner – University Care Advantage

- Banner – University Care Advantage is an HMO SNP with a Medicare contract. Enrollment in Banner – University Care Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Banner – University Advantage. When it says "plan" or "our plan," it means Banner – University Care Advantage.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Banner – University Care Advantage in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the Evidence of Coverage to see if other benefit or cost changes affect you.

These are 2018 cost sharing amounts and may change for 2019. Banner – University Care Advantage will provide updated rates as soon as they are released.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0

Cost	2018 (this year)	2019 (next year)
Deductible	The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. Members of Banner – University Care Advantage do not pay a deductible as long as your eligibility status as a full benefit dual eligible member does not change during the year. If your AHCCCS (Medicaid) status changes during the year, please call AHCCCS (Medicaid) or our Customer Care Center to see how this may impact you. ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*	The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. Members of Banner – University Care Advantage do not pay a deductible as long as your eligibility status as a full benefit dual eligible member does not change during the year. If your AHCCCS (Medicaid) status changes during the year, please call AHCCCS (Medicaid) or our Customer Care Center to see how this may impact you. ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*
Doctor office visits	Primary care visits: 0% or 20% coinsurance per visit Specialist visits: 0% or 20% coinsurance per visit ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*	Primary care visits: 0% or 20% coinsurance per visit Specialist visits: 0% or 20% coinsurance per visit ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*

Cost	2018 (this year)	2019 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	In 2018, the amounts (◊) for each benefit period were $0 or: • Medicare deductible amount $1,340 • $0 coinsurance for each benefit period days 1 through 60 • $335 copay per day for days 61 through 90 • $670 copay per day for 60 lifetime reserve days ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*	In 2018, the amounts (◊) for each benefit period were $0 or: • Medicare deductible amount $1,340 • $0 coinsurance for each benefit period days 1 through 60 • $335 copay per day for days 61 through 90 • $670 copay per day for 60 lifetime reserve days These amounts may change for 2019. BUCA will notify you of the 2019 Medicare Inpatient cost-sharing amounts when they are announced by the Federal government. ◊ *Your cost-sharing is determined by your level of AHCCCS (Medicaid) eligibility. Contact your AHCCCS (Medicaid) plan.*

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 - $83 If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either $0 or $83, depending on the level of "Extra Help" you receive. If your deductible is $83: You pay the full cost of your drugs until you have paid $83 for your drugs. Copayment during the Initial Coverage Stage: • Generic and brand name drugs treated as generic: $0 copay or $1.25 copay or $3.35 copay or 15% coinsurance per prescription • Brand name drugs and all other drugs: $0 copay or $3.70 copay or $8.35 copay or 15% coinsurance per prescription • Copayment amounts depend on your income and institutional status.	Deductible: $0 - $85 If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either $0 or $85, depending on the level of "Extra Help" you receive. If your deductible is $85: You pay the full cost of your drugs until you have paid $85 for your drugs. Copayment during the Initial Coverage Stage: • Generic and brand name drugs treated as generic: $0 copay or $1.25 copay or $3.40 copay or 15% coinsurance per prescription • Brand name drugs and all other drugs: $0 copay or $3.80 copay or $8.50 copay or 15% coinsurance per prescription • Copayment amounts depend on your income and institutional status.

Cost	2018 (this year)	2019 (next year)
Members of Banner – University Care Advantage do not pay a deductible as long as your eligibility status as a full benefit dual eligible member does not change during the year. If your AHCCCS (Medicaid) status changes during the year, please call AHCCCS (Medicaid) or contact our Customer Care Center to see how this may impact you. If you do not receive "Extra Help" **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $415.		
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$6,700 If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$6,700 If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Annual Notice of Changes for 2019
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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from University Care Advantage to Banner – University Care Advantage. We will mail you a new ID card in December 2018. Beginning January 1, 2019, all member communication will say Banner – University Advantage.

SECTION 2 Changes to Medicare Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by AHCCCS (Medicaid.))	$0	$0

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

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

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from AHCCCS (Medicaid), very few members ever reach this out-of-pocket maximum.** If you are eligible for AHCCCS (Medicaid) assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.BannerUCA.com. You may also call our Customer Care Center for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

Starting in 2019, our plan will only use Sonora Quest laboratories for laboratory services for our members. If your PCP or specialist needs you to get lab work done, you must use Sonora Quest laboratories. Please see Chapter 4 of the Evidence of Coverage for more information about your lab benefits.

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

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

Section 2.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.BannerUCA.com. You may also call our Customer Care Center for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

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

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Chiropractic services	0% or 20% coinsurance for Medicare-covered Chiropractic services, no referral or prior authorization required. Manual manipulation of the spine to correct subluxation. Routine chiropractic care: 8 routine non-Medicare visits allowed per calendar year. There is no coinsurance, copayment, or deductible for routine chiropractic care. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.	0% or 20% coinsurance for Medicare-covered Chiropractic services, no referral or prior authorization required. Manual manipulation of the spine to correct subluxation. Routine chiropractic care: 6 routine non-Medicare visits allowed per calendar year. There is no coinsurance, copayment, or deductible for routine chiropractic care. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.
Colorectal cancer screening	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. 0% or 20% coinsurance per barium enema treatment. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.

Cost	2018 (this year)	2019 (next year)
Diabetes self-management training, diabetic services and supplies	There is no coinsurance, copayment, or deductible for the Medicare-covered Diabetes Self-Management Training. 0% or 20% coinsurance for Medicare-covered Diabetic Supplies and Therapeutic Shoes or Inserts. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.	0% or 20% coinsurance for the Medicare-covered Diabetes Self-Management Training. 0% or 20% coinsurance for Medicare-covered Diabetic Supplies and Therapeutic Shoes or Inserts. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.
Emergency care	$80 maximum per visit amount. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.	$90 maximum per visit amount. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.
Over-the-Counter Card	$60 per month to be used at participating stores for certain over-the-counter medicines and health-related items. Unused monthly amount does not roll over into following month.	$60 per month to be used at participating stores for certain over-the-counter medicines and health-related items. Includes Nicotine Replacement Therapy. Unused monthly amount does not roll over into following month.

Cost	2018 (this year)	2019 (next year)
Personal Emergency Response System (PERS)	If requested by enrollee or participating health care professional, an in-home Personal Emergency Response System (PERS) will be provided to notify appropriate personnel of an emergency (e.g., a fall). The provided PERS will not include cellular telephones and must be provided by a participating or contracted vendor. There is no coinsurance, copayment, or deductible for plan covered PERS.	Not covered.
Podiatry Services	0% or 20% coinsurance for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. There is no coinsurance, copayment, or deductible for routine podiatry services. 12 routine visits per year for routine foot care. (Routine visits require prior authorization or referral). If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.	0% or 20% coinsurance for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. There is no coinsurance, copayment, or deductible for routine podiatry services. 6 routine visits per year for routine foot care. (Routine visits require prior authorization or referral). If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.

Cost	2018 (this year)	2019 (next year)
Prostate cancer screening exams	There is no coinsurance, copayment, or deductible for an annual PSA test.	There is no coinsurance, copayment, or deductible for an annual PSA test. 0% or 20% coinsurance for digital rectal exam. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay 0% of the total cost.

Cost	2018 (this year)	2019 (next year)
Skilled nursing facility (SNF) care	In 2018, the amounts (◊) for each benefit period were $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $167.50 coinsurance per day of each benefit period. • Days 101 and beyond: all costs. A benefit period begins the day you go into a skilled nursing facility. 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 skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. A referral and authorization is required for Skilled Nursing facility services. A 3 day hospital stay is required for a Skilled Nursing Facility stay. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*	In 2018, the amounts (◊) for each benefit period were $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $167.50 coinsurance per day of each benefit period. • Days 101 and beyond: all costs. These amounts may change for 2019. BUCA will notify you of the 2019 Medicare Inpatient cost-sharing amounts when they are announced by the Federal government. A benefit period begins the day you go into a skilled nursing facility. 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 skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. A referral and authorization is required for Skilled Nursing facility services. A 3 day hospital stay is not required for a Skilled Nursing Facility stay. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Cost	2018 (this year)	2019 (next year)
Transportation Services	There is no copayment or coinsurance for transportation benefits. Thirty-two (32) non-emergent one-way trips allowed per calendar year by taxi. Trips are to and from plan-approved location for supplemental services. Our transportation benefit is a mandatory supplemental benefit.	Not covered.

Cost	2018 (this year)	2019 (next year)
"Welcome to Medicare" Preventive Visit	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. 0% or 20% coinsurance for Medicare-Covered EKG following Welcome Visit◊ Referral and prior authorization required. ◊*Your cost-sharing is determined by your level of Medicaid eligibility. Contact your Medicaid plan.*

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days supply of medication rather than the amount provided in 2018 (91 days supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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

Starting in 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 31-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. 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." Phone numbers for our Customer Care Center are in Section 8.1 of this booklet.

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

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

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $83 depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	Your deductible amount is either $0 or $85 depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)
Members of Banner – University Care Advantage do not pay a deductible as long as your eligibility status as a full benefit dual eligible member does not change during the year. If your AHCCCS (Medicaid) status changes during the year, please call AHCCCS (Medicaid) or contact our Customer Care Center to see how this may impact you. If you do not receive "Extra Help" **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $415.		

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy. 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*.	Your cost for a one-month (31-day) supply filled at a network pharmacy with standard cost-sharing: **Cost-Sharing*** • Generic and brand name drugs treated as generic You pay $0, $1.25, or $3.35 copay or 15% coinsurance per prescription • Brand name drugs and all other drugs You pay $0, $3.70 or $8.35 copay or 15% coinsurance per prescription Once you have paid $5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). _____ **Your copayments depend on income and institutional status.*	Your cost for a one-month (31-day) supply filled at a network pharmacy with standard cost-sharing: **Cost-Sharing*** • Generic and brand name drugs treated as generic You pay $0, $1.25, or $3.40 copay or 15% coinsurance per prescription • Brand name drugs and all other drugs You pay $0, $3.80 or $8.50 copay or 15% coinsurance per prescription Once you have paid $5,100 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). _____ **Your copayments depend on income and institutional status.*

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

This section explains some of the administrative changes to your plan. Please review this information carefully.

Cost	2018 (this year)	2019 (next year)
Plan website link	In 2018, your plan website can be found at the following: www.universitycareadvantage.com).	In 2019, your plan website can be found at the following: www.BannerUCA.com.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Banner – University Care Advantage

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, you will automatically stay enrolled as a member of our plan for 2019.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

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

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

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 31. The change will take effect on January 1, 2019.

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

In certain situations, changes are also allowed at other times of the year. For example, people with AHCCCS (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

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

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

Arizona SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Arizona SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Arizona SHIP at 1 (800) 432-4040. You can learn more about Arizona SHIP by visiting their website (azdes.gov).

For questions about your Arizona Health Care Cost Containment System (AHCCCS Medicaid) benefits, contact AHCCCS (Medicaid), at (1(855) HEA-PLUS (1-855-432-7587) AZ Relay Service for the hearing impaired - 1-800-367-8939. Calls answered Monday through Friday 8 a.m. – 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your AHCCCS (Medicaid) coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

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

SECTION 8 Questions?

Section 8.1 – Getting Help from Banner – University Care Advantage

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

Read your 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Banner – University Care Advantage. 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.

Visit our Website

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

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 8.3 – Getting Help from AHCCCS (Medicaid)

To get information from AHCCCS (Medicaid) you can call 1(855) 432-7587. TTY users should call 1(800) 367-8939.

Banner – University Care Advantage is an HMO SNP with a Medicare contract. Enrollment in Banner – University Care Advantage depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 874-3930 (TTY: 711).

Banner – University Care Advantage (HMO SNP) 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 1-877-874-3930 (TTY: 711).