2019 SUMMARY OF BENEFITS

BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP) H4931, 001

COCHISE, GILA, GRAHAM, GREENLEE, AND LA PAZ COUNTIES

Banner
University Health Plans
Banner – University Care Advantage

H4931_SB001CY19_M

2019 SUMMARY OF BENEFITS

BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP) H4931, 001

This is a summary of drug and health services covered by Banner – University Care Advantage (HMO SNP) January 1, 2019 - December 31, 2019.

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 see our Evidence of Coverage online at: www.BannerUCA.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 (877) 874-3930; TTY users call 711.
- If you are not a member of this plan, call toll-free (877) 874-3938; TTY users call 711.
- Our website: www.BannerUCA.com

WHO CAN JOIN?

To join **Banner – University Care Advantage (HMO SNP),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B and the Arizona Health Care Cost Containment System or AHCCCS (Medicaid), and live in our service area. Our service area includes the following counties in Arizona: Cochise, Gila, Graham, Greenlee and La Paz.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Banner – University Care Advantage (HMO SNP) 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.BannerUCA.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.BannerUCA.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 – University Care Advantage (HMO SNP) 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 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 http://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 – University Care Advantage is an HMO SNP with a Medicare contract. Enrollment in Banner – University Care Advantage depends on contract renewal..

This information is not a complete description of benefits. Call 1-877-874-3930, 8 a.m. to 8 p.m., 7 days a week, TTY 711, for more information.

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.

Out-of-network/non-contracted providers are under no obligation to treat Banner – University Care Advantage 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.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-874-3930 (TTY: 711).

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay nothing. You must continue to pay your Medicare Part B premium.	The monthly Part B premium is paid for by the State in some cases. Your cost-sharing is determined by your level of Medicaid eligibility.
Deductible	This plan has deductibles for some hospital and medical services. $0 or $183 per year for in-network services, depending on your level of Medicaid eligibility. This amount may change for 2019. The plan will provide updated rates as soon as Medicare releases them.	Your cost-sharing is determined by your level of Medicaid eligibility.
Maximum Out of-Pocket Responsibility **(does not include prescription drugs)**	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you may pay nothing for Medicare-covered services, depending on your level of AHCCCS (Medicaid) eligibility. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. 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. Refer to the “Medicare & You” handbook for Medicare-covered services. For AHCCCS (Medicaid)-covered services, refer to the Medicaid Coverage section in this document. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	The most you pay for co-pays, co-insurance and other costs for medical services for the year.

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Inpatient Hospital Coverage	The co-pays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In 2018 the amounts for each benefit period were $0 or: • $1,340 deductible for days 1 through 60 • $335 co-pay per day for days 61 through 90 • $670 co-pay per day for 60 lifetime reserve days These amounts may change for 2019. The plan will provide updated rates as soon as Medicare releases them.	Your cost-sharing is determined by your level of Medicaid eligibility. Authorization and/ or a referral from your doctor may be required.
Outpatient Hospital Coverage	0% or 20% of the cost	Authorization and/or a referral from your doctor may be required. Your cost-sharing is determined by your level of Medicaid eligibility.
Doctor Visits • Primary • Specialist	 0% or 20% of the cost 0% or 20% of the cost	Authorization and/ or a referral from your doctor is required for specialist visits. Your cost-sharing is determined by your level of Medicaid eligibility.

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Preventive Care	Our plan covers these preventive services at no cost to you: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screening • 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 Our plan also covers preventive services with 0% or 20% cost sharing depending on your level of Medicaid eligibility: • Barium Enemas • Diabetes Self Management Training • Digital Rectal Exams • EKG following Welcome Visit • Glaucoma Screening	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	0% or 20% of the cost (up to $90) If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	Your cost-sharing is determined by your level of Medicaid eligibility.

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Urgently Needed Services	0% or 20% of the cost (up to $65)	Your cost-sharing is determined by your level of Medicaid eligibility.
Diagnostic Services/ Labs/ Imaging • Diagnostic radiology service (e.g., MRI) • Lab services • Diagnostic tests and procedures • Outpatient x-rays	 0% or 20% of the cost You pay nothing 0% or 20% of the cost 0% or 20% of the cost	Authorization and/ or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
Hearing Services • Medicare-covered care • Additional Hearing Care	Medicare-covered hearing exam to diagnose and treat hearing issues: 0% or 20% of the cost. Your cost-sharing is determined by your level of Medicaid eligibility. Routine hearing exam (1 per year): **FREE**	This plan covers both Medicare-covered hearing care and Additional Hearing Care. Authorization and/ or a referral from your doctor may be required.

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Dental Services • Medicare-covered care	Limited dental care: 0% or 20% of the cost Your cost-sharing is determined by the level of your Medicaid eligibility.	This plan covers both Medicare-covered dental care and Additional Dental Care. Authorization and/or a referral from your doctor is required for some services. Our plan pays up to $1,500 every year for Additional Dental Care.
• Additional Dental Care	Preventive: Oral exams (2 per year): **FREE** Cleanings (2 per year): **FREE** X -rays (1 per year): **FREE** Fluoride treatment (1 per year): **FREE** Comprehensive: **FREE** Covered services: restorative services, diagnostic services, endodontics, periodontics/extractions/ prosthodontics, bridges, dentures, other oral/ maxillofacial surgery, and other services.	
Vision Services • Medicare-covered care	Medicare-covered vision exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 0% or 20% of the cost. Medicare-covered eyeglasses or contact lenses after cataract surgery: 0% or 20% of the cost. Your cost-sharing is determined by your level of Medicaid eligibility.	This plan covers both Medicare-covered vision care and Additional Vision Care. Authorization and/ or a referral from your doctor may be required.
• Additional Vision Care	Eyeglasses (frames and lenses): **FREE** Contact lenses and fitting fee: **FREE** Our plan pays up to $125 every two years for non-Medicare-covered eyeglasses and/or contact lenses. Routine eye exam: **Not covered**	

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Mental Health Services • Inpatient visit	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. The co-pays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In 2018 the amounts for each benefit period were $0 or: • $1,340 deductible for days 1 through 60 • $335 co-pay per day for days 61 through 90 • $670 co-pay per day for 60 lifetime reserve days These amounts may change for 2019. The plan will provide updated rates as soon as Medicare releases them.	Authorization and/or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
• Outpatient group therapy visit	0% or 20% of the cost	
• Outpatient individual therapy visit	0% or 20% of the cost	

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Skilled Nursing Facility	Our plan covers up to 100 days in a SNF. In 2018 the amounts for each benefit period were $0 or: You pay nothing for days 1 through 20 $167.50 co-pay per day for days 21 through 100 These amounts may change for 2019. The plan will provide updated rates as soon as Medicare releases them.	Authorization and/or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
Physical Therapy		Authorization and/or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
• Occupational therapy visit	0% or 20% of the cost	
• Physical therapy and speech and language therapy visit	0% or 20% of the cost	
• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks)	0% or 20% of the cost	
Ambulance	0% or 20% of the cost	Authorization and/or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
Transportation	**Not Covered**	

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Medicare Part B Drugs	0% or 20% of the cost for chemotherapy drugs 0% or 20% of the cost for other Part B drugs	Authorization and/or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.

PRESCRIPTION DRUGS

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. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

Your cost-sharing is determined by the level of "Extra Help" you receive. If you don't qualify for low-income subsidy, then you pay the Medicare Part D cost sharing outlined in the Evidence of Coverage. If you do qualify for low-income subsidy, then you pay:

RETAIL NETWORK PHARMACY (31 DAY SUPPLY)	
Annual Prescription Deductible	$0 or $85
Generic Drugs (including brand treated as generic)	$0, $1.25 or $3.40 co-pay or 15% of the total cost
All Other Drugs	$0, $3.80 or $8.50 co-pay or 15% of the total cost

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Foot Care (podiatry services) • Medicare-covered care • Routine Foot Care	Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/ or meet certain conditions: 0% or 20% of the cost. Your cost-sharing is determined by your level of Medicaid eligibility. **FREE** 6 routine, non-Medicare-covered foot care visits allowed per calendar year. For these visits: • No co-insurance • No co-pay • No deductible	This plan covers both Medicare-covered foot care and Routine Foot Care. Authorization and/ or a referral from your doctor are required.
Medical Equipment/ Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies and services	0% or 20% of the cost 0% or 20% of the cost 0% or 20% of the cost	Authorization and/ or a referral from your doctor is required for some services. Your cost-sharing is determined by your level of Medicaid eligibility.
Over-the-Counter Items	**FREE** $40 monthly benefit. Benefit amount does not roll over month to month.	Over-the-Counter items may only be purchased for the enrollee.

PREMIUMS AND BENEFITS	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)	WHAT YOU SHOULD KNOW
Chiropractic Care • Medicare-covered care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): 0% or 20% of the cost. Your cost-sharing is determined by your level of Medicaid eligibility.	This plan covers both Medicare-covered chiropractic care and Routine Chiropractic Care. Authorization and/or a referral from your doctor may be required.
• Routine Chiropractic Care	**FREE** 6 routine non-Medicare-covered visits allowed per calendar year. For these visits: • No co-insurance • No co-pay • No deductible	
Outpatient Substance Abuse • Group therapy visit • Individual therapy visit	0% or 20% of the cost 0% or 20% of the cost	Authorization and/or a referral from your doctor may be required. Your cost-sharing is determined by your level of Medicaid eligibility.
Renal Dialysis Services	0% or 20% of the cost	Authorization and/or a referral from your doctor may be required. Your cost-sharing is determined by your level of Medicaid eligibility.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR DUAL ELIGIBLE MEMBERS
2019 BENEFITS

In order for you to better understand your health care options, the following chart notes your charges for certain services under the Arizona Health Care Cost Containment System (Medicaid) as an individual who has both Medicare and Medicaid.

Your Medicare cost sharing responsibility is based on your level of Medicaid eligibility.

- Qualified Medicare Beneficiary (QMB) – $0. Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan unless otherwise noted below.
- Non-QMB with Medicare Parts A and B – Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan only when the benefit is also covered by Medicaid.

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1)			
Inpatient Hospital Stay	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Inpatient Behavioral Health Care Stay	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Nursing Facility Services	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Home Health Care Visit	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Primary Care Physician (PCP) Visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over (2). $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1)			
Specialist Physician Visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.
Medicare-Covered Services, including Chiropractic Care Visit, Chronic/ Complex Case Management, etc,	$0	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**Covered**. See previous section for applicable cost-sharing amount.
Podiatry Services Visit	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Outpatient Behavioral Health Care Visit	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Outpatient Substance Abuse Care Visit	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Ambulatory Surgical Center or Outpatient Hospital Facility Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.
Ambulance Services	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
ACUTE <u>AND</u> LONG TERM CARE MEDICAID PROGRAMS (1)			
Emergency Services	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Urgently Needed Care Visit	$0	$0 to $4 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.
Outpatient Occupational/ Physical/Speech Therapy Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.
Durable Medical Equipment	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Prosthetic Devices	$0	$0. *Lower limb microprocessor controlled limb or joint not covered for ages 21 and over.*	**Covered**. See previous section for applicable cost-sharing amount.
Diabetes Self-Monitoring Training & Supplies (when provided as part of a PCP visit)	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Diagnostic Tests, X-rays, and Laboratory Services	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1)			
Colorectal Screening	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Flu and Pneumonia Vaccines	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Screening Mammogram	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Pap Smear and Pelvic Exam	$0	$0	**Covered**. See previous section for applicable cost-sharing amount.
Prostate Cancer Screening	$0	$0	**Covered**.See previous section for applicable cost-sharing amount.
Renal Dialysis or Nutritional Therapy for End-Stage Renal Disease	$0	$0	**Covered**.See previous section for applicable cost-sharing amount.
Prescription Medications (3)	$0	$0 to $2.30 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.	**Covered**. See previous section for applicable cost-sharing amount.

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1)			
Hearing Exams, Routine Hearing Tests, and Fitting Evaluations for a Hearing Aid	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**Medicare Covered Hearing Care Covered and Additional Routine Hearing Exam Covered. Fitting Evaluation for a Hearing Aid not covered.** See previous section for applicable cost-sharing amount.
Hearing Aids	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**Not Covered.**
Routine Eye Exam, Eyeglasses, Contact Lenses, Lenses and Frames	$0 for ages 20 and under. *Not covered for ages 21and over unless following cataract surgery*	$0 for ages 20 and under. *Not covered for ages 21 and over.*	**Eyeglasses, Contact Lenses, Lenses and Frames Covered. Routine Eye Exam not covered.**. See previous section for applicable cost-sharing amount.
Adult Emergency Dental Services	$0. For ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0. For ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	**Covered**. See previous section for applicable cost-sharing amount.
Non-Emergency Medically Necessary Transportation	$0	$0	**Not Covered.**

BENEFIT	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non QMB Dual Eligible – You Pay:	BANNER – UNIVERSITY CARE ADVANTAGE (HMO SNP)
LONG TERM CARE MEDICAID PROGRAMS ONLY (1)			
Nursing Facility Services	Cost sharing determined by AHCCCS	Cost sharing determined by AHCCCS	**Not Covered.**
Respite Services	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*	**Not Covered.**
Home and Community Based Services	Member Contribution determined by AHCCCS	Member Contribution determined by AHCCCS	**Not Covered.**
Adult Preventive Dental Services (4)	$0. For ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0. For ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	**Covered.** See previous section for applicable cost-sharing amount.

(1) Acute Medicaid Programs include AHCCCS Complete Care (ACC), Regional Behavioral Health Authorities (RBHAs) and Children's Medical and Dental Plan (CMDP). Long Term Care Medicaid Programs include Elderly and Physically Disabled (E-PD) and Division of Developmental Disabilities (DDD).

(2) See the AHCCCS Website for additional beneficiary cost sharing, co-payment and benefits related information.

(3) Medicare Part D co-payment amounts are the sole responsibility of the beneficiary. AHCCCS health plans cannot assist with the payment of these amounts, except for behavioral health medications for those beneficiaries determined to be Seriously Mentally Ill (SMI) utilizing allowable Non-Title XIX funding.

(4) In addition to Adult Emergency Dental Services described above.