



**2024 PFFS**  
Medicare Advantage Plans



**Starts with me**

available in **39 counties**

Y0083\_24ABM\_H4213\_PFFS\_KIT4\_M  
00631.02.04-0523

BlueMedicare Value (PFFS)  
BlueMedicare Preferred (PFFS)



**Benefits at a glance**

**BlueMedicare Value (PFFS)**

**BlueMedicare Preferred (PFFS)**

# ARKANSAS BLUE MEDICARE PFFS BENEFITS

## Health & Wellness Coverage

Plan Benefits	BlueMedicare Value (PFFS) H4213-016-001/003/004	BlueMedicare Preferred (PFFS) H4213-017-001/005/006
Monthly Premium	\$29/\$29/\$39	\$50/\$60/\$90
Combined In- & Out-of-Network Max Out-of-Pocket	\$7,500	\$7,500
Plan Deductible	\$1,000 (out-of-network only)	\$1,000 (out-of-network only)
Monthly Part B Giveback	No	No
PCP	\$20 copay	\$20 copay
Specialist	\$50 copay	\$50 copay
Inpatient Hospital	\$390 copay per day, days 1–5	\$390 copay per day, days 1–5
ER	\$95 copay	\$95 copay
Outpatient Hospital	\$340 copay	\$340 copay
Labs	0%–20% coinsurance	0%–20% coinsurance
X-Rays	20% coinsurance	20% coinsurance
Diabetic Supplies (preferred)	\$0 copay (at a network pharmacy)	\$0 copay (at a network pharmacy)
Blue Medicare Sapphire Card	Not covered	Not covered
Dental (preventive & comprehensive, including unlimited extractions)	\$2,000 per year	\$2,000 per year
Vision (eyewear)	Medicare-covered only	Medicare-covered only
Hearing Aids	\$699/\$999 copay	\$699/\$999 copay
<b>NEW AND IMPROVED!</b> Quarterly Over-the-Counter (OTC)	Not covered	Not covered
<b>NEW!</b> Monthly Food & Produce	Not covered	Not covered
Transportation	Not covered	Not covered
Post-Acute Meals	Not covered	Not covered
SilverSneakers®	\$0 copay	\$0 copay
In-Home Support Services	Not covered	Not covered

Consult the Summary of Benefits (SB) for more information. These are in-network benefits. You pay these amounts when you visit doctors, hospitals, and other providers who have contracted with Arkansas Blue Medicare. To accommodate members who travel and may live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within the State of Arkansas from non-contracted providers (providers not in our network). Out-of-network/non-contracted providers are under no obligation to treat plan 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.

## Prescription Drug Coverage

Plan Benefits	BlueMedicare Value (PFFS) H4213-016-001/003/004	BlueMedicare Preferred (PFFS) H4213-017-001/005/006
Part D Deductible	No Part D coverage	\$545 (T2–T5)
Tier 1 (30-day fill)		\$15 copay
Tier 2 (30-day fill)		\$20 copay
Tier 3 (30-day fill)		\$47 copay
Tier 4 (30-day fill)		32% coinsurance
Tier 5 (30-day fill)		25% coinsurance
Tier 6 (30-day fill)		\$0 copay
Supplemental Gap Coverage		Not covered
ED/Weight-Loss Drugs		Not covered
Insulin Products (Tier 3, Tier 4, & Tier 5)*		\$35 copay (30-day supply)
Prescription Drug Coverage Periods		
Deductible Stage	No Part D coverage	You begin in this stage when you fill your first Tier 2, Tier 3, Tier 4, or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach \$545. After that, you only pay your share.
Initial Coverage Stage		You remain in this stage until your total yearly drug costs (total drug costs paid by you and by our plan) reach \$5,030.
Coverage Gap Stage		All tiers: 25% coinsurance
Catastrophic Coverage Stage		After your yearly out-of-pocket drug costs reach \$8,000, you pay \$0 for your drugs for the rest of the plan year.

\*The copay amount for covered insulin products applies through the Deductible, Initial Coverage, and Coverage Gap Stages. The Part D deductible does not apply to covered insulin products.



## 2024 Arkansas Blue Medicare PFFS counties served:

**H4213-016-001/H4213-017-001:** Baxter, Boone, Clark, Conway, Craighead, Fulton, Garland, Greene, Hot Spring, Izard, Marion, Newton, Ouachita, Poinsett, Polk, Searcy, St. Francis, Van Buren, Woodruff

**H4213-016-003/H4213-017-005:** Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, Yell

**H4213-016-004/H4213-017-006:** Cleburne, Jefferson, Lonoke, Pulaski, Saline, White



Call **1-855-591-9794** (TTY: 711)



Visit [www.arkbluemedicare.com](http://www.arkbluemedicare.com)



### October 1 to March 31:

We're available seven days a week from 8:00 a.m. to 8:00 p.m. Central time, except for Thanksgiving Day and Christmas Day.

### April 1 to September 30:

We're available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central time.

Please contact [Medicare.gov](http://www.Medicare.gov) or **1-800-MEDICARE** to get information on all of your options. USABLE Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association. Arkansas Blue Medicare is the marketing name for USABLE PPO Insurance Company and USABLE HMO, Inc. USABLE PPO Insurance Company and USABLE HMO, Inc. are affiliates of Arkansas Blue Cross. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Plans are not available in all counties. Enrollment in Arkansas Blue Medicare depends on contract renewal.

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# 2024 Summary of Benefits

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**BlueMedicare Value (PFFS) H4213-016-001**

**BlueMedicare Value (PFFS) H4213-016-003**

**BlueMedicare Value (PFFS) H4213-016-004**

## This Summary of Benefits

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This is a summary of the benefits for:

- BlueMedicare Value (PFFS) H4213-016-001
- BlueMedicare Value (PFFS) H4213-016-003
- BlueMedicare Value (PFFS) H4213-016-004

The benefit information in this document is a summary of what we cover and your cost share. It does not list every service, limitation, or exclusion. To get a complete list of covered services, call us and ask for an “Evidence of Coverage” or “EOC.” You can also find all of our EOCs on our website at [www.arkbluemedicare.com](http://www.arkbluemedicare.com).

If you’d like to learn more about the coverage and costs of Original Medicare, review the current “Medicare & You” handbook. You can find 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**.

## Plan Eligibility

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To join, you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan’s service area

## Service Area

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- The service area for BlueMedicare Value (PFFS) H4213-016-001 includes the following Arkansas counties: Baxter, Boone, Clark, Conway, Craighead, Fulton, Garland, Greene, Hot Spring, IZard, Marion, Newton, Ouachita, Poinsett, Polk, Searcy, St. Francis, Van Buren, and Woodruff.
- The service area for BlueMedicare Value (PFFS) H4213-016-003 includes the following Arkansas counties: Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, and Yell.
- The service area for BlueMedicare Value (PFFS) H4213-016-004 includes the following

Arkansas counties: Cleburne, Jefferson, Lonoke, Pulaski, Saline, and White.

## BlueMedicare Value (PFFS) H4213-016-001/-003/-004 Is A PFFS Plan

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A PFFS plan is a private fee-for-service health plan offered by a private insurance company. Our PFFS plans have a network of contracted healthcare providers and facilities – these are in-network providers. Providers and facilities who are not contracted with our plan are considered out-of-network. As a PFFS member, you’ll have the choice of going to an in-network or out-of-network provider or facility. Generally, your out-of-pocket costs for an out-of-network provider will be higher than for one who is in-network. Additionally, the out-of-network provider must agree to accept our plan’s payment terms and conditions.

BlueMedicare Value (PFFS) does not require members or their providers to get prior authorization or a referral from the plan as a condition for covering medically necessary covered services. If you have any questions about if we’ll cover a medical service or care you’re considering, call us in advance and ask if it’ll be covered.

## How to Contact Us

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If you’re a current member of one of these plans, call us at **1-844-463-1088 (TTY: 711)**. If you’re not a member of one of these plans, call us at **1-855-591-9794 (TTY: 711)**.

**October 1 to March 31:** We’re available seven days a week from 8:00 a.m. to 8:00 p.m. Central, except for Thanksgiving and Christmas.

**April 1 to September 30:** We’re available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can also visit our website at [www.arkbluemedicare.com](http://www.arkbluemedicare.com).

	<b>BlueMedicare Value (PFFS) H4213-016-001</b>	<b>BlueMedicare Value (PFFS) H4213-016-003</b>	<b>BlueMedicare Value (PFFS) H4213-016-004</b>
<b>Monthly Premium, Deductible, and Limits</b>			
<b>Monthly Plan Premium</b> You must continue to pay your Medicare Part B premium.	\$29	\$29	\$39
<b>Medical Deductible</b>	\$1,000 (out-of-network only)	\$1,000 (out-of-network only)	\$1,000 (out-of-network only)
<b>Annual Maximum Out-of-Pocket Costs</b> It's the most you'll pay out of your own pocket (copays and/or coinsurance) for medical services for the year. Once you reach this amount, our plan will pay 100% of your medical costs for the rest of the plan year.  Combined in- and out-of-network	\$7,500	\$7,500	\$7,500



For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
<b>Inpatient Hospital</b>	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance
<b>Outpatient Hospital</b>						
Outpatient surgery/non-surgery	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
Outpatient observation	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
<b>Ambulatory Surgical Center (ASC) Services</b>	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
<b>Doctor Visits</b>						
Primary care provider (PCP)	\$20 copay	40% coinsurance	\$20 copay	40% coinsurance	\$20 copay	40% coinsurance
Specialist	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
<b>Preventive Care</b>	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance

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	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

## Medical Benefits

### Preventive Care – More Information

Services include: Abdominal aortic aneurysm screening, alcohol misuse counseling, Annual Wellness Visit, barium enema, bone mass measurement, breast cancer screening (mammogram), cardiovascular disease (behavioral therapy), cardiovascular screening, cervical and vaginal cancer screening, colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, diabetes self-management training, digital rectal exam, electrocardiogram (EKG), glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare diabetes prevention program, obesity screening and counseling, prostate cancer screening (PSA), sexually transmitted infections screening and counseling, tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), vaccines (including flu, hepatitis B, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time). Any additional preventive services approved by Medicare during the plan year will be covered.

<b>Emergency Room (ER)</b>	\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)		\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)		\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)	
<b>Urgently Needed Services</b>	\$50 copay		\$50 copay		\$50 copay	
<b>Diagnostic Services/Labs/Imaging</b>						
Diagnostic test – spirometry	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance

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	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

### Medical Benefits

Diagnostic test – home-based sleep study	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other diagnostic tests and procedures	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Lab services – genetic testing	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other lab services (except genetic testing)	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance
Radiology – DEXA scan	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
Radiology – diagnostic mammogram	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance
Radiology – ultrasound	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance
All other diagnostic radiology services	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
Radiation therapy	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
X-rays	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance

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	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

**Medical Benefits**

**Diagnostic Services/Labs/Imaging – More Information**

- If you receive multiple services at the same location (e.g., the emergency room or freestanding diagnostic radiology office), you will pay the highest copay amount of all the services provided.
- If the cost share for one service is a copay and the cost share for another service is a coinsurance, you may be asked to pay both the copay and coinsurance.

Hearing Services	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
Medicare-covered hearing exams	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Routine hearing exam (1 per year)	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Hearing aid fittings/evaluation (1 year of follow-up visits with hearing aid purchase)	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Hearing aids (Advanced / Premium – up to 2 hearing aids per year, 1 per ear)	\$699 / \$999 copay per hearing aid		\$699 / \$999 copay per hearing aid		\$699 / \$999 copay per hearing aid	

**Hearing Services – More Information**

- TruHearing providers must be used for the routine hearing exam.
- TruHearing hearing aids must also be used.

Dental – Preventive Services	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
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For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

**BlueMedicare Value (PFFS) H4213-016-001**

**BlueMedicare Value (PFFS) H4213-016-003**

**BlueMedicare Value (PFFS) H4213-016-004**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**Medical Benefits**

Exams (up to 2 per calendar year)

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

Cleanings (2 per calendar year)

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

X-rays (1 per calendar year to every 3 calendar years depending on the service)

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

\$0 copay

50% coinsurance

Fluoride treatments

Not covered

Not covered

Not covered

**Dental – Comprehensive Services**

Medicare-covered dental services

\$50 copay

40% coinsurance

\$50 copay

40% coinsurance

\$50 copay

40% coinsurance

Diagnostic services

Not covered

Not covered

Not covered

Non-routine services

Not covered

Not covered

Not covered

Restorative services (1 per calendar year)

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

Endodontics

Not covered

Not covered

Not covered

Periodontics (up to 2 per calendar year to every 3 calendar years depending on the service)

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

Extractions (unlimited per calendar year)

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

20% coinsurance

50% coinsurance

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	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
Prosthodontics/Other oral-maxillofacial surgery/Other services (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Dental annual allowance (combined preventive and comprehensive services, in-network and out-of-network)	\$2,000		\$2,000		\$2,000	
<b>Dental – Dental Xtra<sup>SM</sup></b> This program is for members who have diabetes, coronary artery disease (CAD), have suffered a stroke, or have been diagnosed with oral cancer, head and neck cancers, or Sjögren’s syndrome. The program provides qualifying members with enhanced dental benefits.  The benefits mentioned here are part of a special supplemental program for the chronically ill. Not all members qualify for them.	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

## Medical Benefits

### Dental Services – More Information

- Covered dental services are subject to conditions, limitations, exclusions, and maximums.
- Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate.

Vision Services						
Medicare-covered diabetic retinopathy screening	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
Medicare-covered glaucoma screening	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
All other Medicare-covered eye exams	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Medicare-covered eyewear	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Routine eye exam	Not covered		Not covered		Not covered	
Routine eyewear	Not covered		Not covered		Not covered	
Routine eyewear annual allowance	Not covered		Not covered		Not covered	
<b>Mental Health</b>						

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

**BlueMedicare Value (PFFS) H4213-016-001**

**BlueMedicare Value (PFFS) H4213-016-003**

**BlueMedicare Value (PFFS) H4213-016-004**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**In-Network or Out-of-Network (out of AR)**

**Out-of-Network (in AR)**

**Medical Benefits**

Inpatient hospital	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance
Outpatient mental health specialty and psychiatric visits (individual and group therapy sessions)	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance
<b>Skilled Nursing Facility (SNF) Services</b>	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance
<b>Rehabilitation/Therapy Services</b>						
Physical therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance
Occupational therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance
Speech therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance



For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

**BlueMedicare  
Value (PFFS)  
H4213-016-001**

**BlueMedicare  
Value (PFFS)  
H4213-016-003**

**BlueMedicare  
Value (PFFS)  
H4213-016-004**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**Medical Benefits**

**Ambulance Services**

Ground ambulance

\$325  
copay

\$325  
copay

\$325  
copay

\$325  
copay

\$325  
copay

\$325  
copay

Air ambulance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

**Transportation (health-related)**

Not covered

Not covered

Not covered

**Medicare Part B Drugs**

Insulin products (e.g., for an insulin pump)

\$35  
copay

40%  
coinsurance

\$35  
copay

40%  
coinsurance

\$35  
copay

40%  
coinsurance

Chemotherapy/Radiation drugs

0%–20%  
coinsurance

40%  
coinsurance

0%–20%  
coinsurance

40%  
coinsurance

0%–20%  
coinsurance

40%  
coinsurance

Other Part B drugs

0%–20%  
coinsurance

40%  
coinsurance

0%–20%  
coinsurance

40%  
coinsurance

0%–20%  
coinsurance

40%  
coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

**BlueMedicare  
Value (PFFS)  
H4213-016-001**

**BlueMedicare  
Value (PFFS)  
H4213-016-003**

**BlueMedicare  
Value (PFFS)  
H4213-016-004**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**Additional Medical Benefits**

**Podiatry Services (foot care)**

Medicare-covered services

Routine services

**Medicare-Covered Chiropractic Services**

**Medical Equipment and Supplies**

Durable medical equipment (DME)

Prosthetics

Medical supplies

Diabetic supplies – testing supplies from our preferred manufacturers Lifescan and Roche

Diabetic supplies – continuous glucose monitors (CGMs) from our preferred manufacturers Dexcom and FreeStyle

Diabetic therapeutic shoes or inserts

\$50  
copay

40%  
coinsurance

\$50  
copay

40%  
coinsurance

\$50  
copay

40%  
coinsurance

Not covered

Not covered

Not covered

\$15  
copay

40%  
coinsurance

\$15  
copay

40%  
coinsurance

\$15  
copay

40%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
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20%  
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20%  
coinsurance

\$0  
copay

20%  
coinsurance

\$0  
copay

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\$0  
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\$0  
copay

20%  
coinsurance

\$0  
copay

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

20%  
coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

**BlueMedicare  
Value (PFFS)  
H4213-016-001**

**BlueMedicare  
Value (PFFS)  
H4213-016-003**

**BlueMedicare  
Value (PFFS)  
H4213-016-004**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**Additional Medical Benefits**

**Additional Rehabilitation Services**

Cardiac rehabilitation

\$30  
copay

40%  
coinsurance

\$30  
copay

40%  
coinsurance

\$30  
copay

40%  
coinsurance

Intensive cardiac rehabilitation

\$55  
copay

40%  
coinsurance

\$55  
copay

40%  
coinsurance

\$55  
copay

40%  
coinsurance

Pulmonary rehabilitation

\$15  
copay

40%  
coinsurance

\$15  
copay

40%  
coinsurance

\$15  
copay

40%  
coinsurance

Supervised exercise therapy for peripheral artery disease (PAD)

\$25  
copay

40%  
coinsurance

\$25  
copay

40%  
coinsurance

\$25  
copay

40%  
coinsurance

**Telehealth**

PCP, specialist, urgently needed, and outpatient mental health (individual and group therapy sessions) services

\$0  
copay

Not  
covered

\$0  
copay

Not  
covered

\$0  
copay

Not  
covered

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<p><b>Walmart Wellness Benefits Card – OTC</b>            You'll be able to get over-the-counter (OTC) items from Walmart with our new and improved quarterly OTC benefit. Conveniently shop in-store at your local Walmart, online at <b>Walmart.com</b>, or through the Walmart app using your Walmart Wellness Benefits Card for OTC. (You can also call or mail in your order.) With thousands of products online and in store, an easy-to-use catalog, and a preloaded debit card, accessing your OTC benefit will be quick and easy. (Unused funds at the end of each quarter do not rollover to the next quarter.)</p>	Not covered		Not covered		Not covered	

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<p><b>Walmart Wellness Benefits Card – Food &amp; Produce</b></p> <p>If you have been diagnosed with a chronic health condition, you may be able to get the Walmart Wellness Benefits Card for food and produce. You can use the preloaded debit card to purchase healthy food and fresh produce from your local Walmart. (Only one debit card will be issued, which will have two separate “purses” on it – one for OTC and the other for food and produce.) This food and produce benefit is a monthly allowance, and unused funds at the end of each month do not rollover to the next month.</p> <p>The benefit mentioned here is part of a special supplemental program for the chronically ill. Not all members qualify for it.</p>	Not covered		Not covered		Not covered	
<p><b>Blue Medicare Sapphire Card</b></p> <p>You’ll receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses (in-network and out-of-network) for <u>covered</u> dental, vision, and hearing services. The annual allowance is combined for in-network and out-of-network services.</p>	Not covered		Not covered		Not covered	

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<b>In-Home Support Services</b> You can get a set number of hours per year for help with activities of daily living (ADLs) (e.g., bathing and dressing) and instrumental activities of daily living (IADLs) (e.g., errands and transportation to appointments). Scheduling your visits is easy and convenient (visits must be in two-hour or four-hour increments).	Not covered		Not covered		Not covered	
<b>SilverSneakers®</b> You'll have access to a fitness benefit at participating SilverSneakers facilities (instructor-led group exercise classes and exercise equipment), ways to get active outside of traditional gyms, and digital/ virtual options.	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used
<b>24-Hour Nurse Advice Line</b>	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used
<b>Additional Physical Exam</b> This is in addition to the Medicare-covered Annual Wellness Visit.	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance

	BlueMedicare Value (PFFS) H4213-016-001		BlueMedicare Value (PFFS) H4213-016-003		BlueMedicare Value (PFFS) H4213-016-004	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<b>Meals Benefit</b> Immediately following surgery or discharge from a hospital stay, you can get two nutritious meals per day for seven days (a total of 14 meals per year) delivered to your home.	Not covered		Not covered		Not covered	
<b>Worldwide Emergency/Urgent Care Services</b> Up to \$15,000 per year combined for emergency and urgently needed services outside the U.S.	20% coinsurance		20% coinsurance		20% coinsurance	

Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal.

## Pre-Enrollment Checklist

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Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-855-591-9794** (TTY: 711).

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.arkbluemedicare.com** or call **1-855-591-9794** (TTY: 711) to view a copy of the EOC.
- Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- Reviewing/Completing this Pre-Enrollment Checklist will not affect your current or future coverage.





# 2024 Summary of Benefits

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**BlueMedicare Preferred (PFFS) H4213-017-001**

**BlueMedicare Preferred (PFFS) H4213-017-005**

**BlueMedicare Preferred (PFFS) H4213-017-006**

## This Summary of Benefits

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This is a summary of the benefits for:

- BlueMedicare Preferred (PFFS) H4213-017-001
- BlueMedicare Preferred (PFFS) H4213-017-005
- BlueMedicare Preferred (PFFS) H4213-017-006

The benefit information in this document is a summary of what we cover and your cost share. It does not list every service, limitation, or exclusion. To get a complete list of covered services, call us and ask for an “Evidence of Coverage” or “EOC.” You can also find all of our EOCs on our website at [www.arkbluemedicare.com](http://www.arkbluemedicare.com).

If you’d like to learn more about the coverage and costs of Original Medicare, review the current “Medicare & You” handbook. You can find 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**.

## Plan Eligibility

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To join, you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan’s service area

## Service Area

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- The service area for BlueMedicare Preferred (PFFS) H4213-017-001 includes the following Arkansas counties: Baxter, Boone, Clark, Conway, Craighead, Fulton, Garland, Greene, Hot Spring, IZard, Marion, Newton, Ouachita, Poinsett, Polk, Searcy, St. Francis, Van Buren, and Woodruff.
- The service area for BlueMedicare Preferred (PFFS) H4213-017-005 includes the following Arkansas counties: Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, and Yell.
- The service area for BlueMedicare Preferred (PFFS) H4213-017-006 includes the following

Arkansas counties: Cleburne, Jefferson, Lonoke, Pulaski, Saline, and White.

## BlueMedicare Preferred (PFFS) H4213-017-001/-005/-006 Are PFFS Plans

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A PFFS plan is a private fee-for-service health plan offered by a private insurance company. Our PFFS plans have a network of contracted healthcare providers and facilities – these are in-network providers. Providers and facilities who are not contracted with our plan are considered out-of-network. As a PFFS member, you’ll have the choice of going to an in-network or out-of-network provider or facility. Generally, your out-of-pocket costs for an out-of-network provider will be higher than for one who is in-network. Additionally, the out-of-network provider must agree to accept our plan’s payment terms and conditions.

BlueMedicare Preferred (PFFS) does not require members or their providers to get prior authorization or a referral from the plan as a condition for covering medically necessary covered services. If you have any questions about if we’ll cover a medical service or care you’re considering, call us in advance and ask if it’ll be covered.

## How to Contact Us

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If you’re a current member of one of these plans, call us at **1-844-463-1088 (TTY: 711)**. If you’re not a member of one of these plans, call us at **1-855-591-9794 (TTY: 711)**.

**October 1 to March 31:** We’re available seven days a week from 8:00 a.m. to 8:00 p.m. Central, except for Thanksgiving and Christmas.

**April 1 to September 30:** We’re available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can also visit our website at [www.arkbluemedicare.com](http://www.arkbluemedicare.com).

	<b>BlueMedicare Preferred (PFFS) H4213-017-001</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-005</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-006</b>
<b>Monthly Premium, Deductible, and Limits</b>			
<b>Monthly Plan Premium</b> You must continue to pay your Medicare Part B premium.	\$50	\$60	\$90
<b>Medical Deductible</b>	\$1,000 (out-of-network only)	\$1,000 (out-of-network only)	\$1,000 (out-of-network only)
<b>Annual Maximum Out-of-Pocket Costs</b> It's the most you'll pay out of your own pocket (copays and/or coinsurance) for medical services for the year. Once you reach this amount, our plan will pay 100% of your medical costs for the rest of the plan year.			
Combined in- and out-of-network	\$7,500	\$7,500	\$7,500

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	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
<b>Inpatient Hospital</b>	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$390 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance
<b>Outpatient Hospital</b>						
Outpatient surgery/non-surgery	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
Outpatient observation	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
<b>Ambulatory Surgical Center (ASC) Services</b>	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
<b>Doctor Visits</b>						
Primary care provider (PCP)	\$20 copay	40% coinsurance	\$20 copay	40% coinsurance	\$20 copay	40% coinsurance
Specialist	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
<b>Preventive Care</b>	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance

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BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

**Medical Benefits**

**Preventive Care – More Information**

Services include: Abdominal aortic aneurysm screening, alcohol misuse counseling, Annual Wellness Visit, barium enema, bone mass measurement, breast cancer screening (mammogram), cardiovascular disease (behavioral therapy), cardiovascular screening, cervical and vaginal cancer screening, colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, diabetes self-management training, digital rectal exam, electrocardiogram (EKG), glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare diabetes prevention program, obesity screening and counseling, prostate cancer screening (PSA), sexually transmitted infections screening and counseling, tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), vaccines (including flu, hepatitis B, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time). Any additional preventive services approved by Medicare during the plan year will be covered.

<b>Emergency Room (ER)</b>	\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)		\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)		\$95 copay  (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)	
	\$50 copay		\$50 copay		\$50 copay	
<b>Urgently Needed Services</b>	\$50 copay		\$50 copay		\$50 copay	
<b>Diagnostic Services/Labs/Imaging</b>						
	Diagnostic test – spirometry	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance

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	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
Diagnostic test – home-based sleep study	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other diagnostic tests and procedures	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Lab services – genetic testing	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other lab services (except genetic testing)	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance
Radiology – DEXA scan	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
Radiology – diagnostic mammogram	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance
Radiology – ultrasound	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance
All other diagnostic radiology services	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance	\$340 copay	40% coinsurance
Radiation therapy	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
X-rays	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

**Medical Benefits**

**Diagnostic Services/Labs/Imaging – More Information**

- If you receive multiple services at the same location (e.g., the emergency room or freestanding diagnostic radiology office), you will pay the highest copay amount of all the services provided.
- If the cost share for one service is a copay and the cost share for another service is a coinsurance, you may be asked to pay both the copay and coinsurance.

Hearing Services						
Medicare-covered hearing exams	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Routine hearing exam (1 per year)	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Hearing aid fittings/evaluation (1 year of follow-up visits with hearing aid purchase)	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Hearing aids (Advanced / Premium – up to 2 hearing aids per year, 1 per ear)	\$699 / \$999 copay per hearing aid		\$699 / \$999 copay per hearing aid		\$699 / \$999 copay per hearing aid	

**Hearing Services – More Information**

- TruHearing providers must be used for the routine hearing exam.
- TruHearing hearing aids must also be used.

Dental – Preventive Services			
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For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
Exams (up to 2 per calendar year)	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance
Cleanings (2 per calendar year)	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance
X-rays (1 per calendar year to every 3 calendar years depending on the service)	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance
Fluoride treatments	Not covered		Not covered		Not covered	
<b>Dental – Comprehensive Services</b>						
Medicare-covered dental services	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Diagnostic services	Not covered		Not covered		Not covered	
Non-routine services	Not covered		Not covered		Not covered	
Restorative services (1 per calendar year)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Endodontics	Not covered		Not covered		Not covered	
Periodontics (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Extractions (unlimited per calendar year)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance



For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)

**Medical Benefits**

Prosthodontics/Other oral-maxillofacial surgery/Other services (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Dental annual allowance (combined preventive and comprehensive services, in-network and out-of-network)	\$2,000		\$2,000		\$2,000	

<p><b>Dental – Dental Xtra<sup>SM</sup></b></p> <p>This program is for members who have diabetes, coronary artery disease (CAD), have suffered a stroke, or have been diagnosed with oral cancer, head and neck cancers, or Sjögren’s syndrome. The program provides qualifying members with enhanced dental benefits.</p> <p>The benefits mentioned here are part of a special supplemental program for the chronically ill. Not all members qualify for them.</p>	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance
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**Dental Services – More Information**

- Covered dental services are subject to conditions, limitations, exclusions, and maximums.
- Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate.

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	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
<b>Vision Services</b>						
Medicare-covered diabetic retinopathy screening	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
Medicare-covered glaucoma screening	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance
All other Medicare-covered eye exams	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Medicare-covered eyewear	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Routine eye exam	Not covered		Not covered		Not covered	
Routine eyewear	Not covered		Not covered		Not covered	
Routine eyewear annual allowance	Not covered		Not covered		Not covered	
<b>Mental Health</b>						
Inpatient hospital	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance	\$385 copay per day for days 1–5; \$0 copay per day for days 6–90	40% coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The \$1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
Outpatient mental health specialty and psychiatric visits (individual and group therapy sessions)	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance
<b>Skilled Nursing Facility (SNF) Services</b>	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance	\$0 copay per day for days 1–20; \$203 copay per day for days 21–100	40% coinsurance
<b>Rehabilitation/Therapy Services</b>						
Physical therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance
Occupational therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance
Speech therapy	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance	\$40 copay	40% coinsurance
<b>Ambulance Services</b>						
Ground ambulance	\$325 copay	\$325 copay	\$325 copay	\$325 copay	\$325 copay	\$325 copay
Air ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Medical Benefits</b>						
<b>Transportation (health-related)</b>	Not covered		Not covered		Not covered	
<b>Medicare Part B Drugs</b>						
Insulin products (e.g., for an insulin pump)	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance	\$35 copay	40% coinsurance
Chemotherapy/Radiation drugs	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance
Other Part B drugs	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance

	<b>BlueMedicare Preferred (PFFS) H4213-017-001</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-005</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-006</b>
<b>Prescription Drug Benefits</b>			
<b>Deductible Stage</b> If your plan has a deductible, you'll begin in this stage when you fill your first prescription of the year if it's on a tier to which the deductible applies. You'll pay the full cost of these drugs until you reach the deductible amount. After that, you'll only pay your cost share. If your plan doesn't have a deductible, you'll start in the Initial Coverage Stage.  Deductible  Deductible applies to these tiers	\$545  Tiers 2–5	\$545  Tiers 2–5	\$545  Tiers 2–5
<b>Initial Coverage Stage</b> During this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You'll stay in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach \$5,030. Once you reach this amount, you will enter the Coverage Gap Stage.			
<b>Standard Retail Pharmacy Cost Shares</b>	<b>30-Day / 100-Day Supply</b>	<b>30-Day / 100-Day Supply</b>	<b>30-Day / 100-Day Supply</b>
Tier 1 (Preferred Generic)	\$15 copay / \$37.50 copay	\$15 copay / \$37.50 copay	\$15 copay / \$37.50 copay
Tier 2 (Generic)	\$20 copay / \$50 copay	\$20 copay / \$50 copay	\$20 copay / \$50 copay
Tier 3 (Preferred Brand)	\$47 copay / \$117.50 copay	\$47 copay / \$117.50 copay	\$47 copay / \$117.50 copay

	<b>BlueMedicare Preferred (PFFS) H4213-017-001</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-005</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-006</b>
<b>Prescription Drug Benefits</b>			
Tier 4 (Non-Preferred Drug)	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered	25% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	\$0 copay / \$0 copay	\$0 copay / \$0 copay	\$0 copay / \$0 copay
<b>Mail-Order Pharmacy Cost Shares</b>	<b>30-Day / 100-Day Supply</b>	<b>30-Day / 100-Day Supply</b>	<b>30-Day / 100-Day Supply</b>
Tier 1 (Preferred Generic)	\$15 copay / \$37.50 copay	\$15 copay / \$37.50 copay	\$15 copay / \$37.50 copay
Tier 2 (Generic)	\$20 copay / \$50 copay	\$20 copay / \$50 copay	\$20 copay / \$50 copay
Tier 3 (Preferred Brand)	\$47 copay / \$117.50 copay	\$47 copay / \$117.50 copay	\$47 copay / \$117.50 copay
Tier 4 (Non-Preferred Drug)	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered	25% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	\$0 copay / \$0 copay	\$0 copay / \$0 copay	\$0 copay / \$0 copay

	<b>BlueMedicare Preferred (PFFS) H4213-017-001</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-005</b>	<b>BlueMedicare Preferred (PFFS) H4213-017-006</b>
<b>Prescription Drug Benefits</b>			
<p><b>Coverage Gap Stage</b>            Most Medicare Advantage drug plans have a Coverage Gap (also called the "donut hole"). In the Coverage Gap, there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after your total yearly drug costs (including what you have paid and what our plan has paid) reach \$5,030. You stay in this stage until your total yearly drug costs reach \$8,000. During the Coverage Gap, you pay 25% coinsurance for generic and brand drugs on all tiers, unless your plan offers additional gap coverage.</p> <p>Additional gap coverage</p>	Not covered	Not covered	Not covered
<p><b>Catastrophic Coverage Stage</b>            After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach \$8,000, you will enter the Catastrophic Coverage Stage.</p>	You will have no cost sharing for the rest of the plan year	You will have no cost sharing for the rest of the plan year	You will have no cost sharing for the rest of the plan year

**BlueMedicare  
Preferred (PFFS)  
H4213-017-001**

**BlueMedicare  
Preferred (PFFS)  
H4213-017-005**

**BlueMedicare  
Preferred (PFFS)  
H4213-017-006**

**Prescription Drug Benefits**

**Prescription Drug Coverage – More Information**

- Cost shares for covered insulin products will not be more than a \$35 copayment for a 30-day supply regardless of the tier. Additionally, the Part D deductible will not apply to any covered insulin products.
- Cost shares for covered ACIP-approved vaccines will be a \$0 copayment regardless of the tier. Additionally, the Part D deductible will not apply to any covered ACIP-approved vaccine.
- Cost sharing may differ based on the pharmacy type (e.g., retail, mail order, long-term care (LTC)) or by fill amount (i.e., 30-day or 100-day supply).
- If you receive Extra Help, you may pay less for your Part D covered drugs depending on your level of Extra Help.
  - Deductible: \$0
  - Generic drugs (on all tiers) – 30-day or 100-day supply: \$0, \$1.55, or \$4.50 copayment
  - Brand drugs (on all tiers) – 30-day or 100-day supply: \$0, \$4.60, or \$11.20 copayment
  - To see if you qualify for Extra Help, please call the Social Security Office at **1-800-772-1213** Monday–Friday, 8 a.m.–7 p.m. TTY users should call **1-800-325-0778**.

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**BlueMedicare  
Preferred (PFFS)  
H4213-017-001**

**BlueMedicare  
Preferred (PFFS)  
H4213-017-005**

**BlueMedicare  
Preferred (PFFS)  
H4213-017-006**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**In-Network  
or Out-of-  
Network  
(out of AR)**

**Out-of-  
Network  
(in AR)**

**Additional Medical Benefits**

**Podiatry Services (foot care)**



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<b>Additional Medical Benefits</b>						
Medicare-covered services	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance	\$50 copay	40% coinsurance
Routine services	Not covered		Not covered		Not covered	
<b>Medicare-Covered Chiropractic Services</b>	\$15 copay	40% coinsurance	\$15 copay	40% coinsurance	\$15 copay	40% coinsurance
<b>Medical Equipment and Supplies</b>						
Durable medical equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetics	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Medical supplies	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic supplies – testing supplies from our preferred manufacturers Lifescan and Roche	\$0 copay (at a network pharmacy)	20% coinsurance	\$0 copay (at a network pharmacy)	20% coinsurance	\$0 copay (at a network pharmacy)	20% coinsurance

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<b>In-Network or Out-of-Network (out of AR)</b>	<b>Out-of-Network (in AR)</b>	<b>In-Network or Out-of-Network (out of AR)</b>	<b>Out-of-Network (in AR)</b>	<b>In-Network or Out-of-Network (out of AR)</b>	<b>Out-of-Network (in AR)</b>

**Additional Medical Benefits**

Diabetic supplies – continuous glucose monitors (CGMs) from our preferred manufacturers Dexcom and Freestyle	\$0 copay (at a network pharmacy)	20% coinsurance	\$0 copay (at a network pharmacy)	20% coinsurance	\$0 copay (at a network pharmacy)	20% coinsurance
Diabetic therapeutic shoes or inserts	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

**Additional Rehabilitation Services**

Cardiac rehabilitation	\$30 copay	40% coinsurance	\$30 copay	40% coinsurance	\$30 copay	40% coinsurance
Intensive cardiac rehabilitation	\$55 copay	40% coinsurance	\$55 copay	40% coinsurance	\$55 copay	40% coinsurance
Pulmonary rehabilitation	\$15 copay	40% coinsurance	\$15 copay	40% coinsurance	\$15 copay	40% coinsurance
Supervised exercise therapy for peripheral artery disease (PAD)	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance	\$25 copay	40% coinsurance

**Telehealth**

PCP, specialist, urgently needed, and outpatient mental health (individual and group therapy sessions) services	\$0 copay	Not covered	\$0 copay	Not covered	\$0 copay	Not covered
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	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<p><b>Walmart Wellness Benefits Card – OTC</b>            You'll be able to get over-the-counter (OTC) items from Walmart with our new and improved quarterly OTC benefit. Conveniently shop in-store at your local Walmart, online at <b>Walmart.com</b>, or through the Walmart app using your Walmart Wellness Benefits Card for OTC. (You can also call or mail in your order.) With thousands of products online and in store, an easy-to-use catalog, and a preloaded debit card, accessing your OTC benefit will be quick and easy. (Unused funds at the end of each quarter do not rollover to the next quarter.)</p>	Not covered		Not covered		Not covered	

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<b>Extra Benefits</b>						
<p><b>Walmart Wellness Benefits Card – Food &amp; Produce</b></p> <p>If you have been diagnosed with a chronic health condition, you may be able to get the Walmart Wellness Benefits Card for food and produce. You can use the preloaded debit card to purchase healthy food and fresh produce from your local Walmart. (Only one debit card will be issued, which will have two separate “purses” on it – one for OTC and the other for food and produce.) This food and produce benefit is a monthly allowance, and unused funds at the end of each month do not rollover to the next month.</p> <p>The benefit mentioned here is part of a special supplemental program for the chronically ill. Not all members qualify for it.</p>	Not covered		Not covered		Not covered	
<p><b>Blue Medicare Sapphire Card</b></p> <p>You’ll receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses (in-network and out-of-network) for <u>covered</u> dental, vision, and hearing services. The annual allowance is combined for in-network and out-of-network services.</p>	Not covered		Not covered		Not covered	

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	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)	In-Network or Out-of-Network (out of AR)	Out-of-Network (in AR)
<b>Extra Benefits</b>						
<b>In-Home Support Services</b> You can get a set number of hours per year for help with activities of daily living (ADLs) (e.g., bathing and dressing) and instrumental activities of daily living (IADLs) (e.g., errands and transportation to appointments). Scheduling your visits is easy and convenient (visits must be in two-hour or four-hour increments).	Not covered		Not covered		Not covered	
<b>SilverSneakers®</b> You'll have access to a fitness benefit at participating SilverSneakers facilities (instructor-led group exercise classes and exercise equipment), ways to get active outside of traditional gyms, and digital/ virtual options. In-home fitness kits are also available.	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used
<b>24-Hour Nurse Advice Line</b>	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used	\$0 copay	Only the in-network benefit can be used
<b>Additional Physical Exam</b> This is in addition to the Medicare-covered Annual Wellness Visit.	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance	\$0 copay	40% coinsurance

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<b>Extra Benefits</b>						
<b>Meals Benefit</b> Immediately following surgery or discharge from a hospital stay, you can get two nutritious meals per day for seven days (a total of 14 meals per year) delivered to your home.	Not covered		Not covered		Not covered	
<b>Worldwide Emergency/Urgent Care Services</b> Up to \$15,000 per year combined for emergency and urgently needed services outside the U.S.	20% coinsurance		20% coinsurance		20% coinsurance	

Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal.

## Pre-Enrollment Checklist

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Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-855-591-9794** (TTY: 711).

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.arkbluemedicare.com** or call **1-855-591-9794** (TTY: 711) to view a copy of the EOC.
- Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the Formulary to make sure your drugs are covered.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- Reviewing/Completing this Pre-Enrollment Checklist will not affect your current or future coverage.



## Multi-Language Insert

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-463-1088. Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-463-1088. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-463-1088。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-463-1088。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-463-1088. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-463-1088. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-844-463-1088 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-463-1088. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.





**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-463-1088 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-463-1088. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-463-1088. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-463-1088 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-463-1088. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-463-1088. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-463-1088. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który - pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-463-1088. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-844-463-1088 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

## IMPORTANT INFORMATION:

### 2024 Medicare Star Ratings



Official U.S.  
Government  
Medicare  
Information



### Arkansas Blue Medicare - H4213

For 2024, Arkansas Blue Medicare - H4213 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★★★★  
**Health Services Rating:** ★★★★★  
**Drug Services Rating:** ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

### Questions about this plan?

Contact Arkansas Blue Medicare 7 days a week from 8:00 a.m. to 8:00 p.m. Central time at 888-605-0322 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. Current members please call 877-233-7022 (toll-free) or 711 (TTY).

## INFORMACION IMPORTANTE:

### Calificación 2024 de Medicare con Estrellas

Información  
oficial de  
Medicare del  
gobierno de los  
Estados Unidos



#### Arkansas Blue Medicare - H4213

En el 2024, Arkansas Blue Medicare - H4213 recibió las siguientes calificaciones de Medicare con estrellas:

Calificación general por estrellas: ★★★★★☆

Calificación de los Servicios de Salud: ★★★★★☆

Calificación de los Servicios de Medicamentos: ★★★★★☆

Cada año, Medicare evalúa los planes basándose en un Sistema de Calificación por 5 estrellas.

#### Por qué la Calificación por Estrellas es importante

Medicare califica los planes en base a sus servicios de salud y medicamentos.

Esto le permite comparar fácilmente los planes en base a su calidad y desempeño.

La Calificación por Estrellas se basa en factores que incluyen:

- Opiniones y comentarios de miembros sobre el cuidado y el servicio que proporciona el plan
- El número de miembros que cancelaron o continuaron con el plan
- La cantidad de quejas que recibió Medicare sobre el plan
- Información proporcionada por médicos y hospitales que trabajan con el plan

Más estrellas significan un mejor plan – por ejemplo, los miembros pueden obtener un mejor cuidado y un mejor y más rápido servicio al cliente.

El número de estrellas indica qué tan bien funciona el plan.

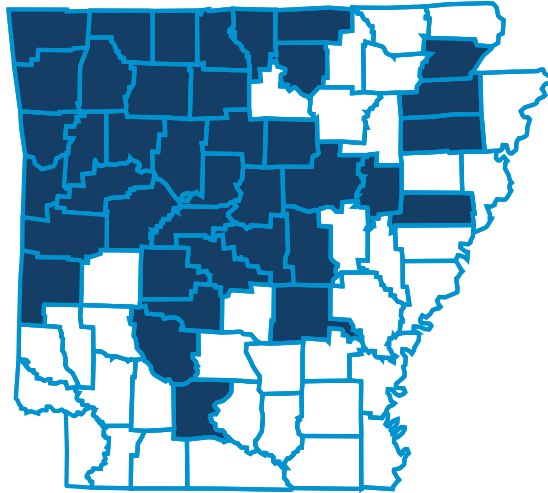
- ★★★★★ EXCELENTE
- ★★★★☆ SUPERIOR AL PROMEDIO
- ★★★☆☆ PROMEDIO
- ★★☆☆☆ DEBAJO DEL PROMEDIO
- ★☆☆☆☆ DEFICIENTE

#### Obtenga más información sobre la Calificación por Estrellas en línea

Compare la Calificación por Estrellas de este y otros planes en línea en [es.medicare.gov/plan-compare](https://es.medicare.gov/plan-compare).

#### ¿Preguntas sobre este plan?

Comuníquese con Arkansas Blue Medicare 7 días a la semana de 8:00 a.m. a 8:00 p.m. hora Central a 888-605-0322 (número gratuito) o al 711 (teléfono de texto) del 1 de octubre al 31 de marzo. Nuestro horario de atención de 1 de abril al 30 de septiembre es lunes a viernes de 8:00 a.m. a 8:00 p.m. hora Central. Miembros actuales favor de llamar 877-233-7022 (número gratuito) o al 711 (teléfono de texto).



### **Arkansas Blue Medicare PFFS counties served:**

**H4213-016-001/H4213-017-001:** Baxter, Boone, Clark, Conway, Craighead, Fulton, Garland, Greene, Hot Spring, IZard, Marion, Newton, Ouachita, Poinsett, Polk, Searcy, St. Francis, Van Buren, Woodruff

**H4213-016-003/H4213-017-005:** Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, Yell

**H4213-016-004/H4213-017-006:** Cleburne, Jefferson, Lonoke, Pulaski, Saline, White

We do not offer every plan available in your area. Please contact [Medicare.gov](https://www.medicare.gov), 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options. USABLE Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association. Arkansas Blue Medicare is the marketing name for USABLE PPO Insurance Company and USABLE HMO, Inc. USABLE PPO Insurance Company and USABLE HMO, Inc. are affiliates of Arkansas Blue Cross. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal. © 2023 Arkansas Blue Cross and Blue Shield. All rights reserved.