Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2023 PPO
Medicare Advantage Plans

Blue is choices

available in
67 counties

ARKANSANS CARING FOR ARKANSANS
BLUE MEDICARE

BlueMedicare Saver Choice (PPO)

BlueMedicare Value Choice (PPO)

BlueMedicare Premier Choice (PPO)

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BlueMedicare Saver Choice (PPO)
BlueMedicare Value Choice (PPO)
BlueMedicare Premier Choice (PPO)
BlueMedicare Freedom Giveback (PPO)

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BLUE MEDICARE PPO BENEFITS

Health & Wellness Coverage

Plan Benefits	BlueMedicare Saver Choice (PPO) H3554-002	BlueMedicare Value Choice (PPO) H3554-004	BlueMedicare Premier Choice (PPO) H3554-007	BlueMedicare Freedom Giveback (PPO) H3554-011
Monthly Premium	$0	$29	$49	$0
In-Network Max Out-of-Pocket	$5,000	$6,000	$5,700	$4,500
Part B Deductible	$0	$0	$0	$0
Monthly Part B Giveback	No	No	No	$50
PCP	$0 copay	$0 copay	$0 copay	$0 copay
Specialist	$30 copay	$40 copay	$35 copay	$35 copay
Inpatient Hospital	$375 copay per day, days 1–5	$345 copay per day, days 1–5	$315 copay per day, days 1–5	$350 copay per day, days 1–5
ER	$110 copay	$110 copay	$110 copay	$110 copay
Outpatient Hospital	$275 copay	$275 copay	$250 copay	$275 copay
Labs	$0 copay	$0 copay	$0 copay	$0 copay
X-Rays	$0 copay	$25 copay	$25 copay	$15 copay
Diabetic Supplies	$0 copay (at a network pharmacy)	$0 copay (at a network pharmacy)	$0 copay (at a network pharmacy)	$0 copay (at a network pharmacy)
Blue Medicare Sapphire Card	$500 per year	$500 per year	$500 per year	$300 per year
Dental (Preventive & Restorative)	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
Vision (Eyewear)	$100 per year	$150 per year	$200 per year	$150 per year
Hearing Aids	$699/$999 copay	$1,000 per 3 years	$1,500 per 3 years	$1,000 per 3 years
Quarterly Over-the-Counter (OTC)	$40	$40	$40	$50
Transportation	No	No	No	No
Post-Acute Meals	$0 copay (14 meals per year)	$0 copay (14 meals per year)	$0 copay (14 meals per year)	$0 copay (14 meals per year)
SilverSneakers®	$0 copay	$0 copay	$0 copay	$0 copay
In-Home Support Services	No	No	No	$0 copay (40 hours per year)

Want to learn more? Call 855-591-9794 (TTY: 711) | Visit Choosebluemedicare.com

Consult the Summary of Benefits (SB) for more information. These are in-network benefits. You pay these amounts if 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 if the services are performed by a provider who participates in the Blue Cross and Blue Shield Association PPO Network Sharing Group.

Prescription Drug Coverage

Plan Benefits	BlueMedicare Saver Choice (PPO) H3554-002	BlueMedicare Value Choice (PPO) H3554-004	BlueMedicare Premier Choice (PPO) H3554-007	BlueMedicare Freedom Giveback (PPO) H3554-011
Part D Deductible	$250 (T4 & T5)	$150 (T4 & T5)	$0	No Part D coverage
Tier 1 (30-day fill)	$0 copay	$1 copay	$1 copay	
Tier 2 (30-day fill)	$15 copay	$13 copay	$10 copay	
Tier 3 (30-day fill)	$47 copay	$47 copay	$47 copay	
Tier 4 (30-day fill)	$100 copay	$100 copay	$100 copay	
Tier 5 (30-day fill)	29% coinsurance	30% coinsurance	33% coinsurance	
Tier 6 (30-day fill)	$0 copay	$0 copay	$0 copay	
Gap Coverage	Yes	Yes	Yes	
ED/Weight-Loss Drugs	Yes	Yes	Yes	
$0 Select Insulin for Diabetic Members*	$0 copay (Tier 3 and Tier 4)	$0 copay (Tier 3 and Tier 4)	$0 copay (Tier 3 and Tier 4)	
Prescription Drug Coverage Periods				
Deductible Stage	You begin in this stage when you fill your first Tier 4 or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach $250. After that, you only pay your share.	You begin in this stage when you fill your first Tier 4 or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach $150. After that, you only pay your share.	This plan does not have a deductible; therefore, this stage does not apply.	No Part D coverage
Initial Coverage Stage	You remain in this stage until your total yearly drug costs (total drug costs paid by you and by the plan) reach $4,660.			
Coverage Gap Stage	Tier 6: You pay the same copay as in the Initial Coverage Stage. All other tiers: You pay 25% coinsurance.		Tier 1 and Tier 6: You pay the same copay as in the Initial Coverage Stage. All other tiers: You pay 25% coinsurance.	
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of 5% coinsurance or a $4.15 copay for generic drugs and a $10.35 copay for brand drugs			

*Select Insulin on Tier 3 and Tier 4 are at a $0 copay for 30-day and 100-day supplies through the Deductible, Initial Coverage and Coverage Gap Stages. If you receive LIS/Extra Help, your LIS/Extra Help cost sharing will apply.

Arkansas Blue Medicare PPO members get up to $2,000 per calendar year for dental benefits.

Our Blue Medicare PPO plans provide expanded benefits in addition to the dental benefits covered by Original Medicare. You get real value and savings while limiting out-of-pocket cost surprises.

PREVENTIVE SERVICES:

- Oral exams: $0 copay (2 per year)
- Cleanings: $0 copay (2 per year)
- X-rays: $0 copay (limits vary per service)
- Fluoride treatments: Coverage varies by plan

COMPREHENSIVE BASIC SERVICES:

(RESTORATIVE SERVICES)

- Silver and white fillings: Coverage varies by plan
- Extractions: Coverage and cost sharing vary by plan

COMPREHENSIVE MAJOR SERVICES:

(ENDODONTICS, PERIODONTICS, PROSTHODONTICS AND ORAL SURGERY)

- Root canals: Coverage varies by plan
- Crowns: Coverage varies by plan
- Deep cleanings: 50% coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)
- Periodontal maintenance: 50% coinsurance (2 per year)
- Complete or partial dentures: Coverage varies by plan
- Complete or partial denture adjustments: Coverage and cost sharing vary by plan
- Complete or partial denture reline: 50% coinsurance (1 upper and 1 lower every 3 years)
- Complete denture rebase: Coverage varies by plan
- Denture repairs (after 6 months of placement): 50% coinsurance (2 per year/up to 5 total in 5 years)

Consult the Summary of Benefits (SB) for more information. These are in-network benefits.

FIND AN IN-NETWORK DENTAL PROVIDER

Visit arkbluemedicare.com

HEARING

Arkansas Blue Medicare PPO members receive coverage of non-implantable hearing aids.

HEARING EXAM SERVICES:

- Routine hearing exam: $0 copay (1 per year)
- Hearing aid fitting and evaluation: $0 copay (includes 1st year of follow-up provider visits)

HEARING AIDS (coverage varies by plan):

- $699 copay per hearing aid per year for 2 non-implantable Advanced hearing aids (1 per ear) or $999 copay per hearing aid per year for 2 non-implantable Premium hearing aids (1 per ear).
- Up to $1,000 or $1,500 every 3 years towards the cost of 2 non-implantable hearing aids (1 per ear) from the TruHearing Choice catalog.
- Included with hearing aids - 80 batteries per aid for non-rechargeable models, 1st year of follow-up provider visits, 60-day trial period and 3-year warranty.

TruHearing providers and hearing aids must be used.

VISION

Arkansas Blue Medicare PPO members get up to $100, $150 or $200 per calendar year for eyewear, depending on the plan.

EYE EXAM SERVICES (in-network):

- Routine eye exam: $0 copay (1 per year)
- Diabetic retinopathy: $0 copay (for the 1st exam, then the specialist copay will apply for additional exams)
- Glaucoma screening: $0 copay (1 per year)

EYEWEAR:

- Eyeglasses (lenses and frames) or contacts and any upgrades (special lens coatings): Up to a total of $100, $150 or $200 per year, depending on the plan

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FIND AN IN-NETWORK VISION PROVIDER Visit arkbluemedicare.com

BLUE MEDICARE SAPPHIRE CARD

Arkansas Blue Medicare PPO members will receive a $300 or $500 pre-loaded Mastercard debit card to help reduce out-of-pocket dental, vision and hearing costs.

- Use your card funds to offset any **COVERED** out-of-pocket expenses at dental, vision and hearing providers who accept Mastercard.
- If you join the plan after January 1, 2023, you'll receive your card with the full amount – there's no proration.
- Card funds may not be converted to cash, and funds will not be approved for cosmetic procedures.
- Member reimbursement is available if the dental, vision or hearing provider does not accept debit cards or in the unlikely event of card failure.
- Reimbursement requests must include an itemized receipt from the provider and be submitted to the plan within 90 days of the transaction date.
- Unused funds at the end of the benefit year return to the plan, including if you leave the plan before the end of the benefit year.

TO LEARN MORE Visit arkbluemedicare.com

IN-HOME SUPPORT SERVICES

BlueMedicare Freedom Giveback (PPO) members receive up to 40 hours per year of in-home support services.

Papa, Inc. will provide up to 40 hours per year of in-home support services **with no required event** for help with things like learning and using technology, scheduling and attending medical visits, accessing telehealth support, transportation to the doctor/pharmacy, running errands, light housekeeping, chores, meal prep, and even help with pets.

COMPANIONSHIP:

- Play board games
- Watch a movie
- Take a walk

TRANSPORTATION:

- Doctor appointments
- Errands
- Grocery/pharmacy shopping

TECHNOLOGY:

- How to use computers, smartphones and tablets
- Help with software
- How to access telehealth services

HOUSEHOLD NEEDS:

- Light housekeeping
- Meal prep
- Organization
- Pet help

"Papa Pals" are enthusiastic and compassionate. They go through a strict vetting process, including background checks, and are covered through Papa, Inc.'s liability insurance.

TO LEARN MORE Visit arkbluemedicare.com

OVER-THE-COUNTER (OTC)

Get $40 or $50 worth of healthcare products* every quarter, shipped directly to your front door at no additional cost.

Order items such as mobility aids, compression garments, incontinence products, toothpaste, lotions, cleansers and much more from familiar brands including Curad®, Biotene® and Remedy®.

TIPS TO MAKE THE MOST OF YOUR BENEFIT:

- OTC dollars are available to use at the start of each calendar quarter (1/1, 4/1, 7/1 and 10/1).
- The dollars must be used by the end of each calendar quarter (3/31, 6/30, 9/30 and 12/31) or you'll lose them.
- You'll receive an OTC catalog in your new member kit.

WE HAVE 3 EASY WAYS TO ORDER YOUR OTC ITEMS:

- Telephone (toll-free)
- Place an online order via secure website
- Complete and mail an order form (included in the catalog)

* This benefit applies to over-the-counter items purchased through Medline only and may not be used elsewhere.

TO LEARN MORE Visit arkbluemedicare.com

$0 SELECT INSULIN FOR DIABETIC MEMBERS

Our BlueMedicare Saver Choice, Value Choice and Premier Choice PPO plans provide insulin users with real savings.

- Diabetic members have access to Select Insulin on Tier 3 and Tier 4 at a $0 copay for 30-day and 100-day supplies through the Deductible, Initial Coverage and Coverage Gap Stages.
- The covered insulin types include injectable rapid-acting, short-acting, intermediate-acting and long-acting.

(If you receive LIS/Extra Help, your LIS/Extra Help cost sharing will apply.)

Rx/Insulin	Member Cost Share
	Retail & Mail
	30- & 100-days
Basaglar	$0 copay
Humalog & Humalog Mix	$0 copay
Humulin, Humulin N & Humulin R	$0 copay
Lantus	$0 copay
Levemir	$0 copay
Lyumjev	$0 copay
Soliqua	$0 copay
Toujeo	$0 copay
Tresiba	$0 copay

TO LEARN MORE Visit arkbluemedicare.com

DIABETIC SUPPLIES

Save on preferred diabetic supplies and continuous glucose monitors.

$0 copays for preferred diabetic supplies at network pharmacies:

- Blood sugar monitors
- Test strips
- Lancet devices
- Lancet supplies

PREFERRED MANUFACTURERS

- Continuous glucose monitors (CGMs) (limit 1 per year):
  - Dexcom
  - FreeStyle
- Test strips (limit 204 per 31 days):
  - **OneTouch Verio Reflect** or **OneTouch Verio Flex** (Lifescan) meters, test strips and lancets are covered at $0 at network pharmacies
  - **Contour Next One** or **Contour Next EZ** (Ascensia) meters, test strips and lancets are covered at $0 at network pharmacies

NOTE: Using a DME provider instead of getting supplies at a network pharmacy may result in a 20% DME coinsurance charge.

TO LEARN MORE Visit arkbluemedicare.com

NOTES

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Arkansas Blue Medicare PPO counties served:

Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell

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

Visit **arkbluemedicare.com**

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact **Medicare.gov** or 1-800-MEDICARE to get information on all of your options. Arkansas Blue Medicare is the marketing name for USAble Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield, USAble PPO Insurance Company, and USAble HMO, Inc. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal. Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2023

Summary of Benefits

BlueMedicare Saver Choice (PPO) H3554-002

The service area for **BlueMedicare Saver Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Pre-Enrollment Checklist

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 **1-844-201-4934** (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 **1-844-201-4934** (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

- ☐ 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, 2024.
- ☐ 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 cost share for services received by non-contracted providers.

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us, and ask for the “Evidence of Coverage.” You may also view the “Evidence of Coverage” for this plan on our website at **www.arkbluemedicare.com**.

If you want to know more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Who can join?

To join, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

The service area for **BlueMedicare Saver Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Which doctors, hospitals, and pharmacies can I use?

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

You can see our plan's Provider and Pharmacy Directories and Formulary (Drug List) on our website at **www.arkbluemedicare.com**, or you can call us, and we will send you a copy of the Provider and Pharmacy Directories and Formulary.

Have questions? Call us.

If you are not a member of this plan, call us at **1-855-591-9794** (TTY: **711**).

If you are a member of this plan, call us at **1-844-201-4934** (TTY: **711**).

October 1 to March 31: We are 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 are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can visit our website at **www.arkbluemedicare.com**.

Monthly Premium, Deductible, and Limits	
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	**$0**
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**$250** for Tier 4 and Tier 5
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance, and other costs for medical services for the year.	In-network: **$5,000** Combined in- and out-of-network: **$8,950**

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Acute Inpatient Hospital Coverage	**$375** copay per day for days 1–5 **$0** copay per day for days 6–90 **$0** copay per day for days 91 and beyond Prior authorization may be required. See the Evidence of Coverage (EOC) for details.	**40%** coinsurance
Outpatient Hospital Coverage		
Outpatient surgery/non-surgery at an outpatient hospital:	**$275** copay	**40%** coinsurance
Outpatient observation:	**$275** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Ambulatory Surgical Center (ASC) Services	**$0** copay for a diagnostic colonoscopy at an ASC **$225** copay for all other services	**40%** coinsurance **40%** coinsurance
Doctor Visits Primary care provider (PCP): Specialist:	 **$0** copay **$30** copay	 **$30** copay **40%** coinsurance
Preventive Care Abdominal aortic aneurysm screening, alcohol misuse counseling, the 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,	**$0** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
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 shots, hepatitis B shots, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency Care If you are admitted to the hospital within 24 hours, you do not have to pay your ER copay (does not apply to worldwide ER or worldwide urgent care services). Worldwide emergency or urgent care services:	**$110** copay **$90** copay **$15,000** annual coverage limit	**$110** copay **$90** copay **$15,000** annual coverage limit
Urgently Needed Services Worldwide emergency or urgent care services:	**$30** copay **$90** copay **$15,000** annual coverage limit	**$30** copay **$90** copay **$15,000** annual coverage limit

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Diagnostic Services/Labs/Imaging		
Diagnostic tests and procedures:	**$0** copay for a spirometry test **$0** copay for a home-based sleep study **$20** copay for all other tests and procedures	**40%** coinsurance
Lab services:	**$0** copay	**40%** coinsurance
Diagnostic radiology:	**$0** copay for a diagnostic mammogram **$0** copay for a DEXA scan **$30** copay for services in a professional office or freestanding radiology clinic **$275** copay for services in an outpatient location	**40%** coinsurance
Therapeutic (radiation) radiology:	**20%** coinsurance	**40%** coinsurance
X-rays:	**$0** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Hearing Services		
Medicare-covered hearing exam:	**$30** copay	**40%** coinsurance
Routine hearing exam:	**$0** copay (1 per year)	**$0** copay (1 per year)
Hearing aid fittings/evaluation:	**$0** copay (includes first year of follow-up provider visits)	**$0** copay (includes first year of follow-up provider visits)
Hearing aids:	**$699** copay per hearing aid for Advanced hearing aids (up to 1 hearing aid per ear per year) **$999** copay per hearing aid for Premium hearing aids (up to 1 hearing aid per ear per year)	**$699** copay per hearing aid for Advanced hearing aids (up to 1 hearing aid per ear per year) **$999** copay per hearing aid for Premium hearing aids (up to 1 hearing aid per ear per year)
	Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty	Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty
Hearing Services – More Information TruHearing providers and hearing aids must be used.		

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Dental Services – Preventive Dental		
Comprehensive oral evaluation:	**$0** copay (1 per lifetime per dentist)	**50%** coinsurance (1 per lifetime per dentist)
Oral exams:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
Cleanings:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
X-rays:	**$0** copay (limits vary per service)	**50%** coinsurance (limits vary per service)
Fluoride treatments:	Not covered	Not covered
Dental Services – Comprehensive Dental		
Medicare-covered dental services:	**$30** copay	**40%** coinsurance
Fillings (white and silver):	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Extractions:	**$20** copay (2 per year)	**50%** coinsurance (2 per year)
Root canals:	Not covered	Not covered
Crowns:	Not covered	Not covered
Re-cementation of crowns:	Not covered	Not covered
Deep cleanings:	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Periodontal maintenance:	**50%** coinsurance (2 per year)	**50%** coinsurance (2 per year)
Complete or partial dentures:	Not covered	Not covered
Complete or partial denture adjustments:	**$20** copay (2 per year)	**50%** coinsurance (2 per year)
Complete or partial denture reline:	**50%** coinsurance (1 upper and 1 lower every 3 years)	**50%** coinsurance (1 upper and 1 lower every 3 years)
Complete or partial denture rebase:	Not covered	Not covered
Denture repairs (after 6 months of placement):	**50%** coinsurance (2 per year with up to 5 total in 5 years) The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.	**50%** coinsurance (2 per year with up to 5 total in 5 years) The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.
Dental Services – Dental XtraSM A program 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 that provides	**$0** copay	**$0** copay

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
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.		
Dental Services – More Information Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see the EOC for details. 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. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Arkansas Blue Medicare to the provider. To find an in-network dental provider, please visit **www.arkbluemedicare.com**.		
Vision Services		
Medicare-covered diabetic retinopathy:	**$0** copay (for the 1st exam, then the specialist copay will apply for additional exams)	**40%** coinsurance
Medicare-covered glaucoma screening:	**$0** copay	**40%** coinsurance
All other Medicare-covered eye exams:	**$30** copay	**40%** coinsurance
Routine eye exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
Medicare-covered eyewear:	**$0** copay	**40%** coinsurance
Routine eyewear – contact lenses:	**$0** copay (1 per year)	**$0** copay (1 per year)

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Routine eyewear – eyeglasses (lenses and frames):	**$0** copay (1 per year)	**$0** copay (1 per year)
Routine eyewear – upgrades:	**$0** copay (included in coverage amount) The plan covers up to **$100** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.	**$0** copay (included in coverage amount) The plan covers up to **$100** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.
Vision Services – More Information To find an in-network vision provider, please visit **www.arkbluemedicare.com**.		
Mental Health Services		
Inpatient psychiatric hospital coverage:	**$350** copay per day for days 1–5 **$0** copay per day for days 6–90	**40%** coinsurance
Partial hospitalization:	**$55** copay	**40%** coinsurance
Outpatient mental health specialty and psychiatry individual sessions:	**$35** copay	**40%** coinsurance
Outpatient mental health specialty and psychiatry group sessions:	**$35** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Skilled Nursing Facility (SNF)	**$0** copay per day for days 1–20 **$196** copay per day for days 21–100 Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Rehabilitation/Therapy Services		
Cardiac rehabilitation:	**$10** copay	**40%** coinsurance
Intensive cardiac rehabilitation:	**$10** copay	**40%** coinsurance
Pulmonary rehabilitation:	**$20** copay	**40%** coinsurance
Supervised exercise therapy (SET) for peripheral artery disease (PAD):	**$10** copay	**40%** coinsurance
Occupational therapy:	**$35** copay	**40%** coinsurance
Physical therapy:	**$40** copay	**40%** coinsurance
Speech therapy:	**$40** copay	**40%** coinsurance
Opioid treatment services:	**$50** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Ambulance Services		
Ground ambulance:	**$265** copay	**$265** copay
Air ambulance:	**20%** coinsurance	**20%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Transportation	Not covered	Not covered
Medicare Part B Drugs Chemotherapy/Radiation drugs: Other Medicare Part B drugs:	 **20%** coinsurance **20%** coinsurance Prior authorization may be required. See the EOC for details.	 **40%** coinsurance **40%** coinsurance

Prescription Drug Benefits				
Deductible Stage				
$250 deductible for Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs You begin in this stage when you fill your first Tier 4 or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach $250. After that, you only pay your share of the total cost. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Initial Coverage Stage (after you pay your deductible, if applicable)				
During this stage, the plan pays its share of the total cost of your drugs, and you pay your share of the total cost. You remain in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach $4,660. Once you reach this amount, you will enter the Coverage Gap. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Standard Retail and Mail-Order Pharmacy Cost Shares				
	Standard Retail Pharmacy		**Mail-Order Pharmacy**	
	30-Day Supply	100-Day Supply	30-Day Supply	100-Day Supply
Tier 1 (Preferred Generic):	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Tier 2 (Generic):	**$15** copay	**$30** copay	**$15** copay	**$0** copay

Prescription Drug Benefits				
Tier 3 (Preferred Brand):	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.
Tier 4 (Non-Preferred Drug):	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.
Tier 5 (Specialty Tier):	**29%** coinsurance	Not covered	**29%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Coverage Gap Stage				
Most Medicare 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 $4,660. You stay in this stage until your total yearly drug costs reach $7,400. During the Coverage Gap, you pay the same copays you paid in the Initial Coverage Stage for Tier 6 drugs and 25% coinsurance for generic and brand drugs on all other tiers. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Catastrophic Coverage Stage				
After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach $7,400, you pay the greater of: • **5%** coinsurance, or • a **$4.15** copay for generics (including brand drugs treated as generic) and a **$10.35** copay for all other drugs.				

Prescription Drug Benefits

Prescription Drug Benefits – More Information

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $0 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Tier 6 includes coverage of certain excluded drugs for erectile dysfunction and weight loss (generics), which are not covered by Medicare. Please see the Formulary and EOC for more details.

Cost sharing may differ based on pharmacy type (e.g., retail, mail-order, long-term care (LTC)) or by fill amount (i.e., 30- or 100-day supply).

Additional Benefits		
	In-Network	**Out-of-Network**
Chiropractic Services	**$20** copay	**40%** coinsurance
Medical Equipment/Supplies		
Durable medical equipment (DME):	**20%** coinsurance	**20%** coinsurance
Prosthetics:	**20%** coinsurance	**20%** coinsurance
Medical supplies:	**20%** coinsurance	**20%** coinsurance
Diabetic supplies:	**$0** copay for preferred supplies at a network pharmacy (Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are our preferred manufacturers for diabetic supplies)	**20%** coinsurance
Continuous glucose monitors (CGMs):	**$0** copay (Dexcom and Freestyle are our preferred manufacturers for CGMs)	**20%** coinsurance
Diabetic therapeutic shoes or inserts:	**20%** coinsurance Prior authorization may be required. See the EOC for details.	**20%** coinsurance
Outpatient Substance Abuse Services		
Individual sessions:	**$40** copay	**40%** coinsurance
Group sessions:	**$40** copay	**40%** coinsurance

Additional Benefits		
	In-Network	**Out-of-Network**
Podiatry		
Medicare-covered care:	**$35** copay	**40%** coinsurance
Routine care:	**$35** copay (6 visits per year)	**40%** coinsurance (6 visits per year)
Home Health Services	**$0** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Telehealth Services		
PCP, urgently needed, and mental health (individual or group sessions) services:	**$0** copay	Not covered
Specialist services:	**$0** copay	Not covered

Additional Benefits		
	In-Network	**Out-of-Network**
Wellness Programs		
Additional physical exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
SilverSneakers® fitness program:	**$0** copay You'll have access to a fitness benefit virtually and at participating SilverSneakers facilities, giving you access to instructor-led group exercise classes, exercise equipment, and options to get active outside of traditional gyms, as well as virtual options.	Only SilverSneakers participating facilities can be used.
Nurse24:	**$0** copay You'll have access to the Nurse24 nurse advice line 24 hours a day, seven days a week, 365 days a year. Registered nurses can provide information on home treatment of minor illnesses and injuries, how to prepare for doctor visits, how to understand your prescription drugs, and much more.	Only the Nurse24 nurse line can be used.
Over-the-Counter (OTC) Items	**$0** copay **$40** per calendar quarter We have three easy ways to order your items from the convenience and comfort of your home.	Only the in-network benefit can be used.

Additional Benefits		
	In-Network	**Out-of-Network**
Meals Benefit	**$0** copay (14 meals per year) Immediately following surgery or discharge from an inpatient hospital stay, you can get two nutritious meals per day for seven days delivered to your home.	Only the in-network benefit can be used.
Blue Medicare Sapphire Card	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.

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 if the services are performed by a provider who participates in the Blue Cross and Blue Shield Association PPO Network Sharing Group.

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

If you have any questions, please contact our Customer Service at **1-844-201-4934** (TTY users should call **711**). Hours are 8:00 a.m.–8:00 p.m. Central, seven days a week, from October 1–March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday–Friday, 8:00 a.m.–8:00 p.m. Central.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-844-201-4934** (TTY: **711**).

Notes

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2023

Summary of Benefits

BlueMedicare Value Choice (PPO) H3554-004

The service area for **BlueMedicare Value Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Pre-Enrollment Checklist

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 **1-844-201-4934** (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 **1-844-201-4934** (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, 2024.
- ☐ 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 cost share for services received by non-contracted providers.

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us, and ask for the “Evidence of Coverage.” You may also view the “Evidence of Coverage” for this plan on our website at **www.arkbluemedicare.com**.

If you want to know more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Who can join?

To join, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

The service area for **BlueMedicare Value Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Which doctors, hospitals, and pharmacies can I use?

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

You can see our plan's Provider and Pharmacy Directories and Formulary (Drug List) on our website at **www.arkbluemedicare.com**, or you can call us, and we will send you a copy of the Provider and Pharmacy Directories and Formulary.

Have questions? Call us.

If you are not a member of this plan, call us at **1-855-591-9794** (TTY: **711**).

If you are a member of this plan, call us at **1-844-201-4934** (TTY: **711**).

October 1 to March 31: We are 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 are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can visit our website at **www.arkbluemedicare.com**.

Monthly Premium, Deductible, and Limits	
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	**$29**
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**$150** for Tier 4 and Tier 5
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance, and other costs for medical services for the year.	In-network: **$6,000** Combined in- and out-of-network: **$8,950**

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Acute Inpatient Hospital Coverage	**$345** copay per day for days 1–5 **$0** copay per day for days 6–90 **$0** copay per day for days 91 and beyond Prior authorization may be required. See the Evidence of Coverage (EOC) for details.	**40%** coinsurance
Outpatient Hospital Coverage		
Outpatient surgery/non-surgery at an outpatient hospital:	**$275** copay	**40%** coinsurance
Outpatient observation:	**$275** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Ambulatory Surgical Center (ASC) Services	**$0** copay for a diagnostic colonoscopy at an ASC **$225** copay for all other services	**40%** coinsurance **40%** coinsurance
Doctor Visits Primary care provider (PCP): Specialist:	 **$0** copay **$40** copay	 **$25** copay **40%** coinsurance
Preventive Care Abdominal aortic aneurysm screening, alcohol misuse counseling, the 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,	**$0** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
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 shots, hepatitis B shots, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency Care If you are admitted to the hospital within 24 hours, you do not have to pay your ER copay (does not apply to worldwide ER or worldwide urgent care services). Worldwide emergency or urgent care services:	**$110** copay **$90** copay **$15,000** annual coverage limit	**$110** copay **$90** copay **$15,000** annual coverage limit
Urgently Needed Services Worldwide emergency or urgent care services:	**$30** copay **$90** copay **$15,000** annual coverage limit	**$30** copay **$90** copay **$15,000** annual coverage limit

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Diagnostic Services/Labs/Imaging		
Diagnostic tests and procedures:	**$0** copay for a spirometry test **$0** copay for a home-based sleep study **$20** copay for all other tests and procedures	**40%** coinsurance
Lab services:	**$0** copay	**40%** coinsurance
Diagnostic radiology:	**$0** copay for a diagnostic mammogram **$0** copay for a DEXA scan **$40** copay for services in a professional office or freestanding radiology clinic **$275** copay for services in an outpatient location	**40%** coinsurance
Therapeutic (radiation) radiology:	**20%** coinsurance	**40%** coinsurance
X-rays:	**$25** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Hearing Services		
Medicare-covered hearing exam:	**$40** copay	**40%** coinsurance
Routine hearing exam:	**$0** copay (1 per year)	**$0** copay (1 per year)
Hearing aid fittings/evaluation:	**$0** copay (includes first year of follow-up provider visits)	**$0** copay (includes first year of follow-up provider visits)
Hearing aids:	Up to **$1,000** every 3 years towards the cost of 2 non-implantable hearing aids (limit 1 hearing aid per ear) Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty	Up to **$1,000** every 3 years towards the cost of 2 non-implantable hearing aids (limit 1 hearing aid per ear) Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty
Hearing Services – More Information TruHearing providers and hearing aids must be used.		

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Dental Services – Preventive Dental		
Comprehensive oral evaluation:	**$0** copay (1 per lifetime per dentist)	**50%** coinsurance (1 per lifetime per dentist)
Oral exams:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
Cleanings:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
X-rays:	**$0** copay (limits vary per service)	**50%** coinsurance (limits vary per service)
Fluoride treatments:	Not covered	Not covered
Dental Services – Comprehensive Dental		
Medicare-covered dental services:	**$40** copay	**40%** coinsurance
Fillings (white and silver):	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Extractions:	**$20** copay (2 per year)	**50%** coinsurance (2 per year)
Root canals:	Not covered	Not covered
Crowns:	Not covered	Not covered
Re-cementation of crowns:	Not covered	Not covered
Deep cleanings:	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Periodontal maintenance:	**50%** coinsurance (2 per year)	**50%** coinsurance (2 per year)
Complete or partial dentures:	Not covered	Not covered
Complete or partial denture adjustments:	**$20** copay (2 per year)	**50%** coinsurance (2 per year)
Complete or partial denture reline:	**50%** coinsurance (1 upper and 1 lower every 3 years)	**50%** coinsurance (1 upper and 1 lower every 3 years)
Complete or partial denture rebase:	Not covered	Not covered
Denture repairs (after 6 months of placement):	**50%** coinsurance (2 per year with up to 5 total in 5 years) The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.	**50%** coinsurance (2 per year with up to 5 total in 5 years) The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.
Dental Services – Dental XtraSM A program 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 that provides	**$0** copay	**$0** copay

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
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.		
Dental Services – More Information Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see the EOC for details. 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. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Arkansas Blue Medicare to the provider. To find an in-network dental provider, please visit **www.arkbluemedicare.com**.		
Vision Services		
Medicare-covered diabetic retinopathy:	**$0** copay (for the 1st exam, then the specialist copay will apply for additional exams)	**40%** coinsurance
Medicare-covered glaucoma screening:	**$0** copay	**40%** coinsurance
All other Medicare-covered eye exams:	**$40** copay	**40%** coinsurance
Routine eye exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
Medicare-covered eyewear:	**$0** copay	**40%** coinsurance
Routine eyewear – contact lenses:	**$0** copay (1 per year)	**$0** copay (1 per year)

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Routine eyewear – eyeglasses (lenses and frames):	**$0** copay (1 per year)	**$0** copay (1 per year)
Routine eyewear – upgrades:	**$0** copay (included in coverage amount) The plan covers up to **$150** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.	**$0** copay (included in coverage amount) The plan covers up to **$150** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.
Vision Services – More Information To find an in-network vision provider, please visit **www.arkbluemedicare.com**.		
Mental Health Services		
Inpatient psychiatric hospital coverage:	**$325** copay per day for days 1–5 **$0** copay per day for days 6–90	**40%** coinsurance
Partial hospitalization:	**$55** copay	**40%** coinsurance
Outpatient mental health specialty and psychiatry individual sessions:	**$35** copay	**40%** coinsurance
Outpatient mental health specialty and psychiatry group sessions:	**$35** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Skilled Nursing Facility (SNF)	**$0** copay per day for days 1–20 **$196** copay per day for days 21–100 Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Rehabilitation/Therapy Services		
Cardiac rehabilitation:	**$10** copay	**40%** coinsurance
Intensive cardiac rehabilitation:	**$10** copay	**40%** coinsurance
Pulmonary rehabilitation:	**$20** copay	**40%** coinsurance
Supervised exercise therapy (SET) for peripheral artery disease (PAD):	**$10** copay	**40%** coinsurance
Occupational therapy:	**$35** copay	**40%** coinsurance
Physical therapy:	**$35** copay	**40%** coinsurance
Speech therapy:	**$35** copay	**40%** coinsurance
Opioid treatment services:	**$50** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Ambulance Services		
Ground ambulance:	**$265** copay	**$265** copay
Air ambulance:	**20%** coinsurance	**20%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Transportation	Not covered	Not covered
Medicare Part B Drugs Chemotherapy/Radiation drugs: Other Medicare Part B drugs:	 **20%** coinsurance **20%** coinsurance Prior authorization may be required. See the EOC for details.	 **40%** coinsurance **40%** coinsurance

Prescription Drug Benefits				
Deductible Stage				
$150 deductible for Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs You begin in this stage when you fill your first Tier 4 or Tier 5 prescription of the year. You pay the full cost of these drugs until you reach $150. After that, you only pay your share of the total cost. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Initial Coverage Stage (after you pay your deductible, if applicable)				
During this stage, the plan pays its share of the total cost of your drugs, and you pay your share of the total cost. You remain in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach $4,660. Once you reach this amount, you will enter the Coverage Gap. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Standard Retail and Mail-Order Pharmacy Cost Shares				
	Standard Retail Pharmacy		**Mail-Order Pharmacy**	
	30-Day Supply	100-Day Supply	30-Day Supply	100-Day Supply
Tier 1 (Preferred Generic):	**$1** copay	**$2** copay	**$1** copay	**$0** copay
Tier 2 (Generic):	**$13** copay	**$26** copay	**$13** copay	**$0** copay

Prescription Drug Benefits				
Tier 3 (Preferred Brand):	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.
Tier 4 (Non-Preferred Drug):	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.
Tier 5 (Specialty Tier):	**30%** coinsurance	Not covered	**30%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Coverage Gap Stage				
Most Medicare 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 $4,660. You stay in this stage until your total yearly drug costs reach $7,400. During the Coverage Gap, you pay the same copays you paid in the Initial Coverage Stage for Tier 6 drugs and 25% coinsurance for generic and brand drugs on all other tiers. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Catastrophic Coverage Stage				
After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach $7,400, you pay the greater of: • **5%** coinsurance, or • a **$4.15** copay for generics (including brand drugs treated as generic) and a **$10.35** copay for all other drugs.				

Prescription Drug Benefits

Prescription Drug Benefits – More Information

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $0 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Tier 6 includes coverage of certain excluded drugs for erectile dysfunction and weight loss (generics), which are not covered by Medicare. Please see the Formulary and EOC for more details.

Cost sharing may differ based on pharmacy type (e.g., retail, mail-order, long-term care (LTC)) or by fill amount (i.e., 30- or 100-day supply).

Additional Benefits		
	In-Network	**Out-of-Network**
Chiropractic Services	**$20** copay	**40%** coinsurance
Medical Equipment/Supplies		
Durable medical equipment (DME):	**20%** coinsurance	**20%** coinsurance
Prosthetics:	**20%** coinsurance	**20%** coinsurance
Medical supplies:	**20%** coinsurance	**20%** coinsurance
Diabetic supplies:	**$0** copay for preferred supplies at a network pharmacy (Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are our preferred manufacturers for diabetic supplies)	**20%** coinsurance
Continuous glucose monitors (CGMs):	**$0** copay (Dexcom and Freestyle are our preferred manufacturers for CGMs)	**20%** coinsurance
Diabetic therapeutic shoes or inserts:	**20%** coinsurance Prior authorization may be required. See the EOC for details.	**20%** coinsurance
Outpatient Substance Abuse Services		
Individual sessions:	**$40** copay	**40%** coinsurance
Group sessions:	**$40** copay	**40%** coinsurance

Additional Benefits		
	In-Network	**Out-of-Network**
Podiatry		
Medicare-covered care:	**$35** copay	**40%** coinsurance
Routine care:	**$35** copay (6 visits per year)	**40%** coinsurance (6 visits per year)
Home Health Services	**$0** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Telehealth Services		
PCP, urgently needed, and mental health (individual or group sessions) services:	**$0** copay	Not covered
Specialist services:	**$20** copay	Not covered

Additional Benefits		
	In-Network	**Out-of-Network**
Wellness Programs		
Additional physical exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
SilverSneakers® fitness program:	**$0** copay You'll have access to a fitness benefit virtually and at participating SilverSneakers facilities, giving you access to instructor-led group exercise classes, exercise equipment, and options to get active outside of traditional gyms, as well as virtual options.	Only SilverSneakers participating facilities can be used.
Nurse24:	**$0** copay You'll have access to the Nurse24 nurse advice line 24 hours a day, seven days a week, 365 days a year. Registered nurses can provide information on home treatment of minor illnesses and injuries, how to prepare for doctor visits, how to understand your prescription drugs, and much more.	Only the Nurse24 nurse line can be used.
Over-the-Counter (OTC) Items	**$0** copay **$40** per calendar quarter We have three easy ways to order your items from the convenience and comfort of your home.	Only the in-network benefit can be used.

Additional Benefits		
	In-Network	**Out-of-Network**
Meals Benefit	**$0** copay (14 meals per year) Immediately following surgery or discharge from an inpatient hospital stay, you can get two nutritious meals per day for seven days delivered to your home.	Only the in-network benefit can be used.
Blue Medicare Sapphire Card	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.

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 if the services are performed by a provider who participates in the Blue Cross and Blue Shield Association PPO Network Sharing Group.

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

If you have any questions, please contact our Customer Service at **1-844-201-4934** (TTY users should call **711**). Hours are 8:00 a.m.–8:00 p.m. Central, seven days a week, from October 1–March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday–Friday, 8:00 a.m.–8:00 p.m. Central.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-844-201-4934** (TTY: **711**).

Notes

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2023

Summary of Benefits

BlueMedicare Premier Choice (PPO) H3554-007

The service area for **BlueMedicare Premier Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Pre-Enrollment Checklist

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 **1-844-201-4934** (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 **1-844-201-4934** (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, 2024.
- ☐ 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 cost share for services received by non-contracted providers.

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us, and ask for the “Evidence of Coverage.” You may also view the “Evidence of Coverage” for this plan on our website at **www.arkbluemedicare.com**.

If you want to know more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Who can join?

To join, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

The service area for **BlueMedicare Premier Choice (PPO)** includes the following Arkansas counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Which doctors, hospitals, and pharmacies can I use?

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

You can see our plan's Provider and Pharmacy Directories and Formulary (Drug List) on our website at **www.arkbluemedicare.com**, or you can call us, and we will send you a copy of the Provider and Pharmacy Directories and Formulary.

Have questions? Call us.

If you are not a member of this plan, call us at **1-855-591-9794** (TTY: **711**).

If you are a member of this plan, call us at **1-844-201-4934** (TTY: **711**).

October 1 to March 31: We are 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 are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Central.

You can visit our website at **www.arkbluemedicare.com**.

Monthly Premium, Deductible, and Limits	
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	**$49**
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance, and other costs for medical services for the year.	In-network: **$5,700** Combined in- and out-of-network: **$8,950**

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Acute Inpatient Hospital Coverage	**$315** copay per day for days 1–5 **$0** copay per day for days 6–90 **$0** copay per day for days 91 and beyond Prior authorization may be required. See the Evidence of Coverage (EOC) for details.	**40%** coinsurance
Outpatient Hospital Coverage		
Outpatient surgery/non-surgery at an outpatient hospital:	**$250** copay	**40%** coinsurance
Outpatient observation:	**$250** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Ambulatory Surgical Center (ASC) Services	**$0** copay for a diagnostic colonoscopy at an ASC **$195** copay for all other services	**40%** coinsurance **40%** coinsurance
Doctor Visits Primary care provider (PCP): Specialist:	 **$0** copay **$35** copay	 **$20** copay **40%** coinsurance
Preventive Care Abdominal aortic aneurysm screening, alcohol misuse counseling, the 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,	**$0** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
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 shots, hepatitis B shots, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency Care If you are admitted to the hospital within 24 hours, you do not have to pay your ER copay (does not apply to worldwide ER or worldwide urgent care services). Worldwide emergency or urgent care services:	**$110** copay **$90** copay **$15,000** annual coverage limit	**$110** copay **$90** copay **$15,000** annual coverage limit
Urgently Needed Services Worldwide emergency or urgent care services:	**$30** copay **$90** copay **$15,000** annual coverage limit	**$30** copay **$90** copay **$15,000** annual coverage limit

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Diagnostic Services/Labs/Imaging		
Diagnostic tests and procedures:	**$0** copay for a spirometry test **$0** copay for a home-based sleep study **$20** copay for all other tests and procedures	**40%** coinsurance
Lab services:	**$0** copay	**40%** coinsurance
Diagnostic radiology:	**$0** copay for a diagnostic mammogram **$0** copay for a DEXA scan **$35** copay for services in a professional office or freestanding radiology clinic **$250** copay for services in an outpatient location	**40%** coinsurance
Therapeutic (radiation) radiology:	**20%** coinsurance	**40%** coinsurance
X-rays:	**$25** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Hearing Services		
Medicare-covered hearing exam:	**$35** copay	**40%** coinsurance
Routine hearing exam:	**$0** copay (1 per year)	**$0** copay (1 per year)
Hearing aid fittings/evaluation:	**$0** copay (includes first year of follow-up provider visits)	**$0** copay (includes first year of follow-up provider visits)
Hearing aids:	Up to **$1,500** every 3 years towards the cost of 2 non-implantable hearing aids (limit 1 hearing aid per ear) Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty	Up to **$1,500** every 3 years towards the cost of 2 non-implantable hearing aids (limit 1 hearing aid per ear) Included with hearing aids: First year of provider follow-up visits, 80 batteries per hearing aid for non-rechargeable models, 60-day trial period, and 3-year warranty
Hearing Services – More Information TruHearing providers and hearing aids must be used.		

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Dental Services – Preventive Dental		
Comprehensive oral evaluation:	**$0** copay (1 per lifetime per dentist)	**50%** coinsurance (1 per lifetime per dentist)
Oral exams:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
Cleanings:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
X-rays:	**$0** copay (limits vary per service)	**50%** coinsurance (limits vary per service)
Fluoride treatments:	**$0** copay (2 per year)	**50%** coinsurance (2 per year)
Dental Services – Comprehensive Dental		
Medicare-covered dental services:	**$35** copay	**40%** coinsurance
Fillings (white and silver):	**50%** coinsurance (2 per year)	**50%** coinsurance (2 per year)
Extractions:	**50%** coinsurance (2 per year)	**50%** coinsurance (2 per year)
Root canals:	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Crowns:	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Re-cementation of crowns:	**50%** coinsurance (unlimited)	**50%** coinsurance (unlimited)

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Deep cleanings:	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)	**50%** coinsurance (1 per quadrant every 2 years, not to exceed 4 unique quadrants every 2 years)
Periodontal maintenance:	**50%** coinsurance (2 per year)	**50%** coinsurance (2 per year)
Complete or partial dentures:	**50%** coinsurance (1 upper and 1 lowers every 5 years)	**50%** coinsurance (1 upper and 1 lowers every 5 years)
Complete denture adjustments:	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Complete or partial denture reline:	**50%** coinsurance (1 upper and 1 lower every 3 years)	**50%** coinsurance (1 upper and 1 lower every 3 years)
Complete denture rebase:	**50%** coinsurance (1 per year)	**50%** coinsurance (1 per year)
Denture repairs (after 6 months of placement):	**50%** coinsurance (2 per year with up to 5 total in 5 years)	**50%** coinsurance (2 per year with up to 5 total in 5 years)
	The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.	The plan covers up to **$2,000** combined for in-network and out-of-network for preventive and comprehensive dental per year.

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Dental Services – Dental Xtra[SM] A program 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 that 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	**$0** copay
Dental Services – More Information Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see the EOC for details. 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. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Arkansas Blue Medicare to the provider. To find an in-network dental provider, please visit **www.arkbluemedicare.com**.		
Vision Services		
Medicare-covered diabetic retinopathy:	**$0** copay (for the 1st exam, then the specialist copay will apply for additional exams)	**40%** coinsurance
Medicare-covered glaucoma screening:	**$0** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
All other Medicare-covered eye exams:	**$35** copay	**40%** coinsurance
Routine eye exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
Medicare-covered eyewear:	**$0** copay	**40%** coinsurance
Routine eyewear – contact lenses:	**$0** copay (1 per year)	**$0** copay (1 per year)
Routine eyewear – eyeglasses (lenses and frames):	**$0** copay (1 per year)	**$0** copay (1 per year)
Routine eyewear – upgrades:	**$0** copay (included in coverage amount) The plan covers up to **$200** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.	**$0** copay (included in coverage amount) The plan covers up to **$200** combined in-network and out-of-network for contact lenses, eyeglasses (lenses and frames), and upgrades per year.
Vision Services – More Information To find an in-network vision provider, please visit **www.arkbluemedicare.com**.		
Mental Health Services		
Inpatient psychiatric hospital coverage:	**$295** copay per day for days 1–5 **$0** copay per day for days 6–90	**40%** coinsurance
Partial hospitalization:	**$55** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Outpatient mental health specialty and psychiatry individual sessions:	**$35** copay	**40%** coinsurance
Outpatient mental health specialty and psychiatry group sessions:	**$35** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Skilled Nursing Facility (SNF)	**$0** copay per day for days 1–20 **$196** copay per day for days 21–100 Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Rehabilitation/Therapy Services		
Cardiac rehabilitation:	**$0** copay	**40%** coinsurance
Intensive cardiac rehabilitation:	**$0** copay	**40%** coinsurance
Pulmonary rehabilitation:	**$20** copay	**40%** coinsurance
Supervised exercise therapy (SET) for peripheral artery disease (PAD):	**$0** copay	**40%** coinsurance
Occupational therapy:	**$35** copay	**40%** coinsurance
Physical therapy:	**$30** copay	**40%** coinsurance
Speech therapy:	**$30** copay	**40%** coinsurance

Covered Medical and Hospital Benefits		
	In-Network	**Out-of-Network**
Opioid treatment services:	**$50** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Ambulance Services		
Ground ambulance:	**$265** copay	**$265** copay
Air ambulance:	**20%** coinsurance	**20%** coinsurance
Transportation	Not covered	Not covered
Medicare Part B Drugs		
Chemotherapy/Radiation drugs:	**20%** coinsurance	**40%** coinsurance
Other Medicare Part B drugs:	**20%** coinsurance Prior authorization may be required. See the EOC for details.	**40%** coinsurance

Prescription Drug Benefits				
Deductible Stage				
This plan does not have a deductible; therefore, this stage does not apply.				
Initial Coverage Stage				
During this stage, the plan pays its share of the total cost of your drugs, and you pay your share of the total cost. You remain in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach $4,660. Once you reach this amount, you will enter the Coverage Gap. During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)				
Standard Retail and Mail-Order Pharmacy Cost Shares				
	Standard Retail Pharmacy		**Mail-Order Pharmacy**	
	30-Day Supply	100-Day Supply	30-Day Supply	100-Day Supply
Tier 1 (Preferred Generic):	**$1** copay	**$2** copay	**$1** copay	**$0** copay
Tier 2 (Generic):	**$10** copay	**$20** copay	**$10** copay	**$0** copay
Tier 3 (Preferred Brand):	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.	**$47** copay Select Insulin will have a $0 copay.	**$141** copay Select Insulin will have a $0 copay.

Prescription Drug Benefits				
Tier 4 (Non-Preferred Drug):	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.	**$100** copay Select Insulin will have a $0 copay.	**$300** copay Select Insulin will have a $0 copay.
Tier 5 (Specialty Tier):	**33%** coinsurance	Not covered	**33%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$0** copay	**$0** copay	**$0** copay	**$0** copay

Coverage Gap Stage

Most Medicare 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 $4,660. You stay in this stage until your total yearly drug costs reach $7,400.

During the Coverage Gap, you pay the same copays you paid in the Initial Coverage Stage for Tier 1 and Tier 6 drugs, and 25% coinsurance for generic and brand drugs on all other tiers.

During this stage, your out-of-pocket cost for Select Insulin will be a $0 copay. (If you receive Extra Help, your Extra Help cost sharing will apply.)

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach $7,400, you pay the greater of:

- **5%** coinsurance, or
- a **$4.15** copay for generics (including brand drugs treated as generic) and a **$10.35** copay for all other drugs.

Prescription Drug Benefits – More Information

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Prescription Drug Benefits
Important Message About What You Pay for Insulin – You won't pay more than $0 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. Tier 6 includes coverage of certain excluded drugs for erectile dysfunction and weight loss (generics), which are not covered by Medicare. Please see the Formulary and EOC for more details. Cost sharing may differ based on pharmacy type (e.g., retail, mail-order, long-term care (LTC)) or by fill amount (i.e., 30- or 100-day supply).

Additional Benefits		
	In-Network	**Out-of-Network**
Chiropractic Services	**$20** copay	**40%** coinsurance
Medical Equipment/Supplies		
Durable medical equipment (DME):	**20%** coinsurance	**20%** coinsurance
Prosthetics:	**20%** coinsurance	**20%** coinsurance
Medical supplies:	**20%** coinsurance	**20%** coinsurance
Diabetic supplies:	**$0** copay for preferred supplies at a network pharmacy (Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are our preferred manufacturers for diabetic supplies)	**20%** coinsurance
Continuous glucose monitors (CGMs):	**$0** copay (Dexcom and Freestyle are our preferred manufacturers for CGMs)	**20%** coinsurance
Diabetic therapeutic shoes or inserts:	**$0** copay Prior authorization may be required. See the EOC for details.	**20%** coinsurance
Outpatient Substance Abuse Services		
Individual sessions:	**$40** copay	**40%** coinsurance
Group sessions:	**$40** copay	**40%** coinsurance

Additional Benefits		
	In-Network	**Out-of-Network**
Podiatry		
Medicare-covered care:	**$25** copay	**40%** coinsurance
Routine care:	**$25** copay (6 visits per year)	**40%** coinsurance (6 visits per year)
Home Health Services	**$0** copay Prior authorization may be required. See the EOC for details.	**40%** coinsurance
Telehealth Services		
PCP, urgently needed, and mental health (individual or group sessions) services:	**$0** copay	Not covered
Specialist services:	**$10** copay	Not covered

Additional Benefits		
	In-Network	**Out-of-Network**
Wellness Programs		
Additional physical exam:	**$0** copay (1 per year)	**40%** coinsurance (1 per year)
SilverSneakers® fitness program:	**$0** copay You'll have access to a fitness benefit virtually and at participating SilverSneakers facilities, giving you access to instructor-led group exercise classes, exercise equipment, and options to get active outside of traditional gyms, as well as virtual options.	Only SilverSneakers participating facilities can be used.
Nurse24:	**$0** copay You'll have access to the Nurse24 nurse advice line 24 hours a day, seven days a week, 365 days a year. Registered nurses can provide information on home treatment of minor illnesses and injuries, how to prepare for doctor visits, how to understand your prescription drugs, and much more.	Only the Nurse24 nurse line can be used.
Over-the-Counter (OTC) Items	**$0** copay **$40** per calendar quarter We have three easy ways to order your items from the convenience and comfort of your home.	Only the in-network benefit can be used.

Additional Benefits		
	In-Network	**Out-of-Network**
Meals Benefit	**$0** copay (14 meals per year) Immediately following surgery or discharge from an inpatient hospital stay, you can get two nutritious meals per day for seven days delivered to your home.	Only the in-network benefit can be used.
Blue Medicare Sapphire Card	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.	**$500** per year You will receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for in-network and out-of-network covered dental, vision, and hearing services.

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 if the services are performed by a provider who participates in the Blue Cross and Blue Shield Association PPO Network Sharing Group.

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

If you have any questions, please contact our Customer Service at **1-844-201-4934** (TTY users should call **711**). Hours are 8:00 a.m.–8:00 p.m. Central, seven days a week, from October 1–March 31, except for Thanksgiving and Christmas. From April 1 to September 30, we are open Monday–Friday, 8:00 a.m.–8:00 p.m. Central.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-844-201-4934** (TTY: **711**).

Notes

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Changes to the Blue Medicare HMO, PPO, and PFFS Plans

This is important information about upcoming changes to your Blue Medicare HMO, PPO, or PFFS plan coverage.

This notice is to let you know about changes to two benefits. Please keep this information for your reference. You can also find this notice on our website at **www.arkbluemedicare.com**.

Changes to Your Benefits

Impacted Plans	Effective Date of Benefit Change	Benefit Change	What Does This Mean for You?
All Blue Medicare HMO, PPO, and PFFS plans	April 1, 2023	Cost sharing for a Part B rebatable drug cannot exceed the coinsurance amount set by Original Medicare. If Original Medicare adjusts the coinsurance of a rebatable Part B drug, we will adjust our cost sharing. It will not exceed the adjusted coinsurance. This includes chemotherapy/ radiation drugs and other drugs covered under Part B of Original Medicare	• Our plan's cost sharing for covered Part B drugs will not be higher than the coinsurance you would pay if on Original Medicare. • If the price is not adjusted at the time you pay for the Part B drug and you overpay, you will be reimbursed for the overpaid amount.
All Blue Medicare HMO, PPO, and PFFS plans	July 1, 2023	The cost share for a 30-day supply of insulin provided under the Part B drug benefit through covered durable medical equipment (DME) will not exceed $35. If the plan has a deductible, it will not apply to this insulin.	• If you're diabetic and on an insulin pump, your cost share for a 30-day supply of the insulin for your pump will not be higher than $35. • Plus, if you're on one of our Blue Medicare PFFS plans, your medical deductible will not apply to this insulin.

You do not need to take any action in response to this document. If you have any questions, please call us at the toll-free phone number on the back of your member ID card. Our hours are 8:00 a.m. to 8:00 p.m. Central, Monday through Friday (April 1 through September 30). From October 1 through March 31, our hours are 8:00 a.m. to 8:00 p.m. Central, seven days a week.

Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal.

Arkansas Blue MEDICARE

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Cambios en los beneficios de los planes HMO, PPO y PFFS de Blue Medicare

Esta es información importante sobre los próximos cambios en su cobertura del plan HMO, PPO o PFFS de Blue Medicare.

Este aviso es para informarle sobre los cambios en dos beneficios. Guarde esta información para futura referencia. También puede encontrar esta información en nuestro sitio web en **www.arkbluemedicare.com**.

Cambios en sus beneficios

Planes afectados	Fecha de entrada en vigencia del cambio en el beneficio	Cambio en el beneficio	¿Qué significa esto para usted?
Todos los planes HMO, PPO y PFFS de Blue Medicare	1.° de abril de 2023	El costo compartido de un medicamento reembolsable de la Parte B no puede exceder el monto del coseguro establecido por Original Medicare. Si Original Medicare ajusta el coseguro de un medicamento reembolsable de la Parte B, ajustaremos nuestros costos compartidos. No excederá el coseguro ajustado. Esto incluye quimioterapia/radioterapia y otros medicamentos cubiertos por la Parte B de Original Medicare.	• El costo compartido de nuestro plan para los medicamentos cubiertos de la Parte B no será mayor que el coseguro que pagaría si recibiera Original Medicare. • Si el precio no se ajusta en el momento en que usted paga el medicamento de la Parte B y paga en exceso, se le reembolsará el monto pagado en exceso.
Todos los planes HMO, PPO y PFFS de Blue Medicare	1.° de julio de 2023	Los costos compartidos de un suministro de insulina para 30 días proporcionado en virtud del beneficio de medicamentos de la Parte B a través de equipos médicos duraderos (DME) cubiertos no superará los $35. Si el plan tiene un deducible, no se aplicará a esta insulina.	• Si es diabético y usa una bomba de insulina, sus costos compartidos de un suministro de insulina para 30 días para su bomba no será superior a $35. • Además, si está en uno de nuestros planes Blue Medicare PFFS, su deducible médico no se aplicará a esta insulina.

No es necesario que realice ninguna acción en respuesta a este documento. Si tiene alguna pregunta, llámenos al número gratuito que aparece en el reverso de su tarjeta de identificación de miembro. Nuestro horario de atención es de 8:00 a. m. a 8:00 p. m., hora del centro, de lunes a viernes (desde el 1.º de abril hasta el 30 de septiembre). Desde el 1.º de octubre hasta el 31 de marzo, nuestro horario es de 8:00 a. m. a 8:00 p. m., hora del centro, los siete días de la semana.

Arkansas Blue Medicare ofrece planes HMO, PFFS, PPO y PDP que tiene contratos con Medicare.
La inscripción a Arkansas Blue Medicare depende de la renovación del contrato.

Arkansas Blue MEDICARE

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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 1-844-201-4934. Someone who speaks English/Language 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 1-844-201-4934. 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 1-844-201-4934。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 1-844-201-4934。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 1-844-201-4934. 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 1-844-201-4934. 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 quí vị cần thông dịch viên xin gọi 1-844-201-4934 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-201-4934. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-201-4934번으로 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 1-844-201-4934. 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 1-844-201-4934. 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 1-844-201-4934 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 1-844-201-4934. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-844-201-4934. 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 1-844-201-4934. 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 1-844-201-4934. 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ございます。通訳をご用命になるには、1-844-201-4934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:

2023 Medicare Star Ratings

Arkansas Blue Medicare - H3554

Official U.S. Government Medicare Information

For 2023, Arkansas Blue Medicare - H3554 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
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.

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 844-201-4934 (toll-free) or 711 (TTY).

Y0083_H3554_23BM_STARS_M

INFORMACION IMPORTANTE:

Calificación 2023 de Medicare con Estrellas

Información oficial de Medicare del gobierno de los Estados Unidos

Arkansas Blue Medicare - H3554

En el 2023, Arkansas Blue Medicare - H3554 recibió las siguientes calificaciones de Medicare con estrellas:

Calificación general por estrellas:	★★★½☆
Calificación de los Servicios de Salud:	★★★½☆
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.

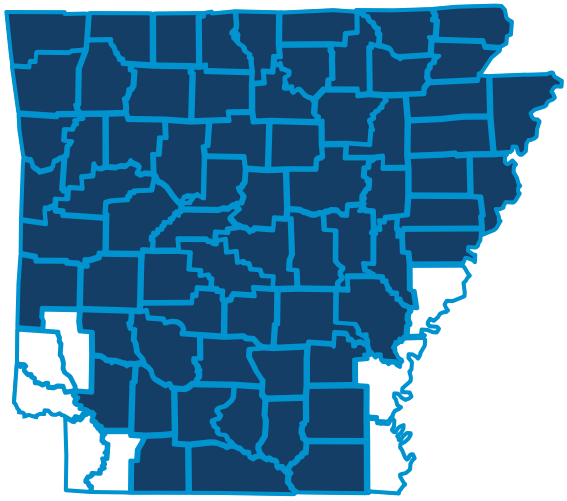
★★★★★	EXCELENTE
★★★★☆	SUPERIOR AL PROMEDIO
★★★☆☆	PROMEDIO
★★☆☆☆	DEBAJO DEL PROMEDIO
★☆☆☆☆	DEFICIENTE

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.

¿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 septiembre es lunes a viernes de 8:00 a.m. a 8:00 p.m. hora Central. Miembros actuales favor de llamar 844-201-4934 (número gratuito) o al 711 (teléfono de texto).



Arkansas Blue Medicare PPO counties served:

Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hempstead, Hot Spring, Independence, Izard, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options. Arkansas Blue Medicare is the marketing name for USAble Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield, USAble PPO Insurance Company, and USAble HMO, Inc. Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal. Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.