2021 Summary of Benefits

BlueMedicare Value Choice (PPO) H3554-004

Our service area for **BlueMedicare Value Choice (PPO)** includes the following Arkansas counties: Baxter, Boone, Fulton, Izard, and Marion

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	☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
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/co-insurance may change on January 1, 2022. ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay 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, **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, 7 days a week. TTY users should call 1-877-486-2048.

Who can join?	To join, you must: ▪ be entitled to Medicare Part A; and ▪ be enrolled in Medicare Part B; and ▪ live in **our service area**. Our service area for **BlueMedicare Value Choice (PPO)** includes the following Arkansas counties: Baxter, Boone, Fulton, Izard, and Marion
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 at our website **(www.arkbluemedicare.com**), or you can call us and we will send you a copy of the provider and pharmacy directories.
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). o We are available October 1 to March 31, 7 days a week from 8:00 a.m. to 8:00 p.m. Central time, except for Thanksgiving and Christmas. o From April 1 to September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. Central time. ▪ Or visit our website at **www.arkbluemedicare.com**

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
Monthly plan premium You must continue to pay your Medicare Part B premium.	**$29**	
Medical deductible	**$0**	
Pharmacy (Part D) deductible	**$250** for Tiers 3, 4 and 5.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$6,700** in-network	**$11,300** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acute inpatient hospital care	**$360** copay per day for days 1-5 **$0** copay per day for days 6-90	**40% of the cost**
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		
Outpatient hospital coverage		
Outpatient surgery at Outpatient Hospital:	**$325** copay	**40%** of the cost
Outpatient surgery at Ambulatory Surgical Center:	**$300** copay **$0** copay diagnostic colonoscopy	**40%** of the cost
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		

	IN-NETWORK	OUT-OF-NETWORK
Doctor visits	Primary care provider: **$10** copay Specialist: **$45** copay Telehealth: • **$0** copay primary care provider or urgently needed • **$0** copay mental health visit • **$45** copay specialist	Primary care provider: **$25** copay Specialist: **40%** of the cost
Preventive care	**Our plan covers many preventive services at no cost when you see an in-network provider including:** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness Visit • Barium enemas • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Digital rectal exam • Electrocardiogram • Glaucoma screening • HIV screening • Lung cancer screening • Medical nutrition therapy services	**40%** of the cost

	IN-NETWORK	OUT-OF-NETWORK
Preventive care (continued)	• Medicare diabetes prevention program • Obesity screening and counseling • Prostate cancer screenings (PSA) • Routine physical exam • 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, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) **Any additional preventive services approved by Medicare during the contract year will be covered**	**40%** of the cost
EMERGENCY CARE		
	IN-NETWORK	**OUT-OF-NETWORK**
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay Worldwide emergency care services: • **20%** of the cost • **$15,000** annual limit	**$90** copay Worldwide emergency care services: • **20%** of the cost • **$15,000** annual limit
Urgently needed services	• **$10** copay at primary care physician office • **$30** copay at an urgent care facility • **$45** copay at specialist office	• **$10** copay at primary care physician office • **$30** copay at an urgent care facility • **$45** copay at specialist office

OUTPATIENT CARE AND SERVICES		
	IN-NETWORK	**OUT-OF-NETWORK**
Diagnostic services, labs and imaging	Diagnostic mammography: **$0** copay	**40%** of the cost
	Diagnostic radiology – MRI: • **$0** copay for DEXA scan • **$30** copay at an urgent care facility • **$45** copay at specialist or freestanding radiology clinic • **$325** copay in outpatient hospital facility	**40%** of the cost
	Outpatient lab services: **$0** copay	**40%** of the cost
	Diagnostic tests and procedures: • **$0** copay for preventive services • **$10** copay at primary care provider • **$30** copay at an urgent care facility • **$45** copay at specialist • **$325** copay in outpatient hospital facility • **$0** copay for spirometry • **$0** copay for home-based sleep study	**40%** of the cost
	X-Rays: • **$0** copay at primary care provider, urgent care facility, specialist or ER • **$25** copay at outpatient or freestanding facility	**40%** of the cost
	Radiation therapy: **20%** of the cost	**40%** of the cost
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		

	IN-NETWORK	OUT-OF-NETWORK
Hearing	Medicare-covered hearing exam: **$40** copay	**40%** of the cost
	Routine hearing exam: **$0** copay for routine hearing exams once per year	Not covered
	$0 copay for hearing aid fitting/evaluation up to 3 times per year TruHearing provider must be used.	Not covered
Comprehensive hearing	• Up to **$1,000** allowance toward the cost of 2 non-implantable hearing aids from the TruHearing Choice catalogue every 3 years (includes 48 batteries per aid and 3 year warranty) TruHearing provider must be used.	Not covered
Dental	Medicare-covered dental services: • **$45** copay	**40%** of the cost
	Routine dental: Comprehensive oral evaluation: • **$0** copay for comprehensive oral evaluation, 1 per lifetime per dentist	**50%** of the cost
	Oral exam: • **$0** copay (up to 2 per year)	**50%** of the cost
	Prophylaxis (cleaning): • **$0** copay (up to 2 per year)	**50%** of the cost
	X-Rays: • **$0** copay (limits vary per service)	**50%** of the cost

Comprehensive dental

Maximum benefit	Arkansas Blue Medicare pays up to **$2,000** per calendar year		
Covered Dental Services	In-Network* You Pay:	Out-of-Network** You Pay:	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	30%	50%	1 per year
Composite resin restorations (white fillings)	30%	50%	
Extractions	50%	50%	1 per year
Major Dental Services (Endodontics, Periodontics and Oral Surgery)			
Periodontal scaling and root planning (deep cleaning)	50%	50%	1 per quadrant every 2 years
Periodontal maintenance	50%	50%	2 per year
Complete or Partial dentures	50%	50%	1 set every 5 years
Complete and Partial denture adjustments	30%	50%	2 per year
Denture reline	50%	50%	1 every 3 years
Removal of impacted tooth	50%	50%	1 per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at 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.

Arkansas Blue Medicare members also have access to **Dental Xtra**, a program for members who are pregnant, have diabetes, coronary artery disease, have suffered a stroke or have been diagnosed with oral cancer, head and neck cancers or Sjögren's syndrome. It provides qualifying members with additional dental benefits, which are paid 100% when using a participating dentist. It won't count toward the maximum dollar amount your dental plan will cover for the calendar year and requires no copayment, coinsurance or deductible. To learn more, visit www.arkansasdentalblue.com.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Vision	Medicare-covered eye exam: **$40** copay Routine eye exam: **$0** copay (1 per year) Diabetic retinopathy: **$0** copay Glaucoma screening: **$0** copay	 **40%** of the cost **50%** of the cost **40%** of the cost **40%** of the cost
Comprehensive vision	Eye glasses (lenses and frames): • Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses are **covered in full** • **Covered in full*** up to the retail allowance of **$150** every 2 years ($15 copay may apply)	• Lenses: **50%** of the cost • Frames: **$150** allowance
	Contact lenses: • All contact lenses are in lieu of glasses (lenses and frames). Allowance up to **$100** (**$0 - $15** copay may apply).	• Contact lenses: **$100** allowance • Medically necessary contacts: **50%** of the cost

*Covered in full materials and services are less any applicable copay. Based on applicable laws, benefits and savings may vary by location.

To find an in-network vision provider, please visit www.arkbluemedicare.com.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Mental health services	Inpatient: • **$350** copay per day for days 1-5 • **$0** copay per day for days 6-90	 **40%** of the cost **40%** of the cost
	Outpatient: • **$40** copay for individual therapy sessions • **$30** copay for group therapy sessions	• Individual therapy sessions: **40%** of the cost • Group therapy sessions: **40%** of the cost

A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details

	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility (SNF)	Your plan covers up to 100 days in a SNF per benefit period. • **$0** copay per day for days 1-20 • **$184** copay per day for days 21-100	**40%** of the cost for days 1-100
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		
Rehabilitation services	Physical therapy: **$40** copay	**40%** of the cost
	Occupational therapy: **$40** copay	**40%** of the cost
	Speech therapy: **$40** copay	**40%** of the cost
	Opioid treatment services: **$45** copay	**40%** of the cost
	Cardiac rehabilitation: **$35** copay	**40%** of the cost
	Pulmonary rehabilitation: **$25** copay	**40%** of the cost
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		
Ambulance (ground)	**$265** copay	**$265** copay
Ambulance (air)	**20%** of the cost	**20%** of the cost
Transportation	Not covered	Not covered
Medicare Part B drugs	Chemotherapy/Radiation drugs: **20%** of the cost	**40%** of the cost
	Other Medicare Part B drugs: **20%** of the cost	**40%** of the cost

Prescription Drug Benefits

Pharmacy (Part D) Deductible	This plan has a $250 deductible for Tier 3, 4 and 5 drugs. You pay the full cost of these drugs until you reach $250. Then, you only pay your share of the cost. You begin in this stage when you fill your first prescription of the year in Tiers 3, 4, and 5.
Initial coverage stage (after you pay your deductible, if applicable)	During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You remain in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach **$4,130**. Once you reach this amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

	Retail		Mail order	
	30-day supply	**Up to 100-day supply**	**30-day supply**	**Up to 100-day supply**
Tier 1: Preferred Generic	$4	$8	$4	$0
Tier 2: Generic	$13	$26	$13	$0
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	50%	50%	50%	50%
Tier 5: Specialty Tier	28%	28%	28%	28%
Tier 6: Select Care Drugs Tier	$0	$0	$0	$0

Coverage gap stage	Most Medicare drug plans have a coverage gap (also called the "donut hole"). In the coverage gap, there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what you have paid and our plan has paid) reaches **$4,130.** You stay in this stage until your total year drug costs reach **$6,550**. During the coverage gap: • You pay the same copays that you paid in the initial coverage stage for drugs in Tier 6 (Select Care Drugs Tier) • For drugs in all other tiers, you pay 25% of the cost
Catastrophic coverage stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacies and mail order) reach **$6,550**, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drug Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Additional Drug Coverage

Tier 6 Drug Benefit	**$0** copays for specialized drugs aimed at improving medication adherence for certain chronic conditions, such as high blood pressure, high cholesterol, and diabetes. This tier also includes coverage for typically non-covered Medicare drugs for erectile dysfunction and weight loss.

Additional Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic services	• **$15** copay for Medicare-covered service	• **40%** of the cost
Diabetic supplies	• **$0** copay for diabetic supplies • **$0** copay for diabetic therapeutic shoes or inserts	• **20%** of the cost for diabetic supplies • **20%** of the cost for diabetic therapeutic shoes or inserts
Medical equipment / supplies	• Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost • Medical supplies: **20%** of the cost • Prosthetics (artificial limbs or braces): **20%** of the cost	• Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost • Medical supplies: **20%** of the cost • Prosthetics (artificial limbs or braces): **20%** of the cost
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		
Outpatient substance abuse services	• Individual therapy sessions: **$45** copay • Group therapy sessions: **$35** copay	• Individual therapy sessions: **40%** of the cost • Group therapy sessions: **40%** of the cost
Podiatry	• **$40** copay for each Medicare-covered visit • **$40** copay for routine foot care (up to 6 visits)	• **40%** of the cost • **40%** of the cost
Acupuncture	• **$0** copay (up to 6 visits)	• **40%** of the cost
A referral is not needed. Prior authorization may be required. See Evidence of Coverage for details		
Therapeutic massage	• **$0** copay (up to 6 visits)	Not covered

Get More with Arkansas Blue Medicare

Healthy Blue Rewards	You take care of your health, and we take care of you. When you complete select healthcare activities like getting your annual wellness visit or a flu shot, we'll send you gift card rewards.
Comprehensive hearing benefits	Your plan features expanded hearing benefits in addition to the hearing benefits covered by Original Medicare.
Comprehensive dental benefits	Your plan features expanded dental benefits in addition to the dental benefits covered by Original Medicare.
Comprehensive vision benefits	Your plan features expanded vision benefits in addition to the vision benefits covered by Original Medicare.
Nurse24	Arkansas Blue Medicare members get access to the Nurse24 nurse line, which gives you access to a registered nurse 24 hours a day, 7 days a week, 365 days a year. Nurses can provide information on home treatment of minor illnesses and injuries, how to prepare for doctor visits, understanding your prescription drugs and much more.
SilverSneakers® Fitness Program	You get a basic fitness center membership, including fitness classes, with no additional cost to you.
My Blueprint	As an Arkansas Blue Medicare member, you get access to My Blueprint, our digital member portal. With My Blueprint you can view claims information, find a doctor, view policy information, find a pharmacy or check prescription drug costs and access your SilverSneakers account.
The Wire	Sign up for the Wire, and we'll send you text messages that link you to your own personalized member feed. We'll tell you about cost-saving methods, preventive reminders, ways to maximize your benefits and much more. It's secure, HIPAA-compliant and there's nothing to download.
Over-the-counter benefit	Each quarter, we'll give you a $25 allowance to spend on over-the-counter drugs.
Meal benefit	Immediately following surgery or discharge from a Skilled Nursing Facility or inpatient hospital stay, maximum of two (2) meals a day for up to seven (7) days for a maximum of fourteen (14) meals, per enrollee per year as appropriate.

Disclaimers	Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers LPPO plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal. This information is not a complete description of benefits. Call 1-844-201-4934 (TTY: 711) for more information. If you have any questions please contact Customer Service at 1-844-201-4934. (TTY users should call 711.) Hours are 8:00 a.m. – 8:00 p.m. Central time, 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 time. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-844-662-2276 (TTY: 711).