

Arkansas Blue  
**MEDICARE**

An Independent Licensee of the Blue Cross and Blue Shield Association



## 2021 Summary of Benefits

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

Our service area for **BlueMedicare Preferred (PFFS)** includes the following Arkansas counties:  
Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott,  
Sebastian, Washington, 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 **1-877-233-7022 (TTY: 711)**.

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### 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](http://www.arkbluemedicare.com)** or call **1-877-233-7022 (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.
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### 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 cost share for services received by non-contracted providers.
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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](http://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](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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**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 Preferred (PFFS)** includes the following Arkansas counties: Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, and Yell

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**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, you will pay a higher cost share for these services.

- You can see our plan's provider and pharmacy directories at our website ([www.arkbluemedicare.com](http://www.arkbluemedicare.com)), or you can call us and we will send you a copy of the provider and pharmacy directories.

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**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 **1-877-233-7022** (TTY: 711).
  - 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.
  - 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](http://www.arkbluemedicare.com)



## Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>Monthly plan premium</b>	<b>\$69</b>	
You must continue to pay your Medicare Part B premium.		
<b>Medical deductible</b>	<b>\$0</b>	<b>\$1,000</b>
<b>Pharmacy (Part D) deductible</b>	<b>\$420</b> for Tiers 2, 3, 4, and 5.	
<b>Maximum out-of-pocket responsibility</b>		<b>\$7,500</b> combined in- and out-of-network
The most you pay for copays, coinsurance and other costs for medical services for the year.		



## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Acute inpatient hospital care</b>	<b>\$390</b> copay per day for days 1-5 <b>\$0</b> copay per day for days 6-90	<b>40% of the cost</b>
<b>Outpatient hospital coverage</b>		
Outpatient surgery at Outpatient Hospital:	<b>\$340</b> copay	<b>40% of the cost</b>
Outpatient surgery at Ambulatory Surgical Center:	<b>\$340</b> copay	<b>40% of the cost</b>

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Doctor visits</b>	Primary care provider: <b>\$30</b> copay  Specialist: <b>\$50</b> copay  Telehealth: <ul style="list-style-type: none"> <li>• <b>\$0</b> copay primary care provider or urgently needed services</li> <li>• <b>\$0</b> copay mental health visit</li> <li>• <b>\$50</b> copay specialist</li> </ul>	Primary care provider: <b>40%</b> of the cost  Specialist: <b>40%</b> of the cost
<b>Preventive care</b>	<p><b>Our plan covers many preventive services at no cost when you see an in-network provider including:</b></p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Annual Wellness Visit</li> <li>• Barium enemas</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Digital rectal exam</li> <li>• Electrocardiogram</li> <li>• Glaucoma screening</li> <li>• HIV screening</li> <li>• Lung cancer screening</li> <li>• Medical nutrition therapy services</li> </ul>	<b>40%</b> of the cost


	IN-NETWORK	OUT-OF-NETWORK
<b>Preventive care (continued)</b>	<ul style="list-style-type: none"> <li>• Medicare diabetes prevention program</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Routine physical exam</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> </ul>	<b>40%</b> of the cost

**Any additional preventive services approved by Medicare during the contract year will be covered**

<b>EMERGENCY CARE</b>		
	IN-NETWORK	OUT-OF-NETWORK
<b>Emergency room</b>	<b>\$90</b> copay	<b>\$90</b> copay
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.	Worldwide emergency care services: <ul style="list-style-type: none"> <li>• <b>20%</b> of the cost</li> <li>• <b>\$15,000</b> annual limit</li> </ul>	Worldwide emergency care services: <ul style="list-style-type: none"> <li>• <b>20%</b> of the cost</li> <li>• <b>\$15,000</b> annual limit</li> </ul>
<b>Urgently needed services</b>	<b>\$50</b> copay	<b>\$50</b> copay

## OUTPATIENT CARE AND SERVICES

	IN-NETWORK	OUT-OF-NETWORK
<b>Diagnostic services, labs and imaging</b>	Diagnostic mammography: <b>\$0</b> copay	<b>40%</b> of the cost
	Diagnostic radiology – MRI: <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for DEXA scan</li> <li>• <b>\$50</b> copay at an urgent care facility</li> <li>• <b>\$50</b> copay at specialist or freestanding radiology clinic</li> <li>• <b>\$340</b> copay in outpatient hospital facility</li> </ul>	<b>40%</b> of the cost
	Outpatient lab services: <b>\$0</b> copay	<b>40%</b> of the cost
	Diagnostic tests and procedures: <ul style="list-style-type: none"> <li>• <b>20%</b> of the cost</li> <li>• <b>\$0</b> copay for spirometry</li> </ul>	<b>40%</b> of the cost
	X-Rays: <b>20%</b> of the cost	<b>40%</b> of the cost
	Radiation therapy: <b>20%</b> of the cost	<b>40%</b> of the cost
<b>Hearing</b>	Medicare-covered hearing exam: <b>\$50</b> copay	<b>40%</b> of the cost
	Routine hearing exam: <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for routine hearing exams, once per year</li> <li>• <b>\$0</b> copay for hearing aid fitting/evaluation up to 3 times per year</li> </ul>	Not covered
	TruHearing provider must be used.	Not covered

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
 <b>Comprehensive hearing</b>	<ul style="list-style-type: none"> <li>• <b>\$699</b> copay per aid for Advanced Aids (up to 1 hearing aid per ear per year)</li> <li>• <b>\$999</b> copay per aid for Premium Aids (up to 1 hearing aid per ear per year)</li> <li>• Includes 48 batteries per aid and 3 year warranty</li> </ul> <p>TruHearing provider must be used.</p>	Not covered
<b>Dental</b>	<p>Medicare-covered dental services:</p> <ul style="list-style-type: none"> <li>• <b>\$45</b> copay</li> </ul> <p>Routine dental: Comprehensive oral evaluation:</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay for comprehensive oral evaluation, 1 per lifetime per dentist</li> </ul> <p>Oral exam:</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay (up to 2 per year)</li> </ul> <p>Prophylaxis (cleaning):</p> <ul style="list-style-type: none"> <li>• <b>\$10</b> copay (up to 2 per year)</li> </ul> <p>X-Rays:</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay (limits vary per service)</li> </ul>	<p><b>40%</b> of the cost</p> <p><b>50%</b> of the cost</p> <p><b>50%</b> of the cost</p> <p><b>50%</b> of the cost</p> <p><b>50%</b> of the cost</p>
<b>Vision</b>	<p>Medicare-covered eye exam:</p> <ul style="list-style-type: none"> <li>• <b>\$50</b> copay</li> </ul> <p>Medicare-covered eyewear:</p> <ul style="list-style-type: none"> <li>• <b>\$50</b> copay</li> </ul> <p>Diabetic retinopathy:</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul> <p>Glaucoma screening:</p> <ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul>	<p><b>40%</b> of the cost</p> <p><b>40%</b> of the cost</p> <p><b>40%</b> of the cost</p> <p><b>40%</b> of the cost</p>





## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Mental health services</b>	Inpatient:	
	<ul style="list-style-type: none"> <li>• <b>\$320</b> copay per day for days 1-5</li> <li>• <b>\$0</b> copay per day for days 6-90</li> </ul>	<ul style="list-style-type: none"> <li>• <b>40%</b> of the cost</li> <li>• <b>40%</b> of the cost</li> </ul>
	Outpatient:	
	<ul style="list-style-type: none"> <li>• <b>\$40</b> copay for individual therapy sessions</li> <li>• <b>\$40</b> copay for group therapy sessions</li> </ul>	<ul style="list-style-type: none"> <li>• Individual therapy sessions: <b>40%</b> of the cost</li> <li>• Group therapy sessions: <b>40%</b> of the cost</li> </ul>
<b>Skilled nursing facility (SNF)</b>	Your plan covers up to 100 days in a SNF per benefit period. <ul style="list-style-type: none"> <li>• <b>\$0</b> copay per day for days 1-20</li> <li>• <b>\$184</b> copay per day for days 21-100</li> </ul>	<b>40%</b> of the cost for days 1-100
<b>Rehabilitation services</b>	Physical therapy: <b>\$40</b> copay	<b>40%</b> of the cost
	Occupational therapy: <b>\$40</b> copay	<b>40%</b> of the cost
	Speech therapy: <b>\$40</b> copay	<b>40%</b> of the cost
	Opioid treatment services: <b>\$50</b> copay	<b>40%</b> of the cost
	Cardiac rehabilitation: <b>\$45</b> copay	<b>40%</b> of the cost
	Pulmonary rehabilitation: <b>\$30</b> copay	<b>40%</b> of the cost
<b>Ambulance (ground)</b>	<b>\$265</b> copay	<b>\$265</b> copay
<b>Ambulance (air)</b>	<b>20%</b> of the cost	<b>20%</b> of the cost
<b>Transportation</b>	Not covered	Not covered
<b>Medicare Part B drugs</b>	Chemotherapy/Radiation drugs: <b>20%</b> of the cost	<b>40%</b> of the cost
	Other Medicare Part B drugs: <b>20%</b> of the cost	<b>40%</b> of the cost



# Prescription Drug Benefits

**Pharmacy (Part D) Deductible** This plan has a \$420 deductible for Tier 2, 3, 4, and 5 drugs. You pay the full cost of these drugs until you reach \$420. 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 2, 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.

## BlueMedicare Preferred (PFFS)

	Retail		Mail order
	30-day supply (Preferred Pharmacies)	30-day supply (Standard Pharmacies)	30-day supply
<b>Tier 1: Preferred Generic</b>	\$3	\$10	\$3
<b>Tier 2: Generic</b>	\$13	\$20	\$13
<b>Tier 3: Preferred Brand</b>	\$40	\$47	\$40
<b>Tier 4: Non-Preferred Drug</b>	40%	42%	40%
<b>Tier 5: Specialty Tier</b>	25%	25%	25%
	Up to 100-day supply (Preferred Pharmacies)	Up to 100-day supply (Standard Pharmacies)	Up to 100-day supply
<b>Tier 1: Preferred Generic</b>	\$7.50	\$25	\$7.50
<b>Tier 2: Generic</b>	\$32.50	\$50	\$32.50
<b>Tier 3: Preferred Brand</b>	\$100	\$117.50	\$100
<b>Tier 4: Non-Preferred Drug</b>	40%	42%	40%
<b>Tier 5: Specialty Tier</b>	25%	25%	25%

**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 out-of-pocket drug costs for the year reach **\$6,550**.

During the coverage gap:

- For drugs in all tiers, you pay 25% of the cost

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**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 Medical Benefits

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Chiropractic services</b>	<ul style="list-style-type: none"><li>• <b>\$15</b> copay for Medicare-covered services</li></ul>	<ul style="list-style-type: none"><li>• <b>40%</b> of the cost</li></ul>
<b>Diabetic supplies</b>	<ul style="list-style-type: none"><li>• <b>20%</b> of the cost for diabetic supplies</li><li>• <b>20%</b> of the cost for diabetic therapeutic shoes or inserts</li></ul>	<ul style="list-style-type: none"><li>• <b>20%</b> of the cost for diabetic supplies</li><li>• <b>20%</b> of the cost for diabetic therapeutic shoes or inserts</li></ul>
<b>Medical equipment / supplies</b>	<ul style="list-style-type: none"><li>• Durable medical equipment (like wheelchairs or oxygen): <b>20%</b> of the cost</li><li>• Medical supplies: <b>20%</b> of the cost</li><li>• Prosthetics (artificial limbs or braces): <b>20%</b> of the cost</li></ul>	<ul style="list-style-type: none"><li>• Durable medical equipment (like wheelchairs or oxygen): <b>20%</b> of the cost</li><li>• Medical supplies: <b>20%</b> of the cost</li><li>• Prosthetics (artificial limbs or braces): <b>20%</b> of the cost</li></ul>
<b>Outpatient substance abuse services</b>	<ul style="list-style-type: none"><li>• Individual therapy sessions: <b>\$40</b> copay</li><li>• Group therapy sessions: <b>\$40</b> copay</li></ul>	<ul style="list-style-type: none"><li>• Individual therapy sessions: <b>40%</b> of the cost</li><li>• Group therapy sessions: <b>40%</b> of the cost</li></ul>
<b>Podiatry</b>	<ul style="list-style-type: none"><li>• <b>\$50</b> copay for each Medicare-covered visit</li></ul>	<ul style="list-style-type: none"><li>• <b>40%</b> of the cost</li></ul>

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## 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.

### 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.

### Disclaimers

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

This information is not a complete description of benefits. Call 1-877-233-7022 (TTY: 711) for more information.

If you have any questions please contact Customer Service at 1-877-233-7022. (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).