



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

Covered Medical and Hospital Benefits		
	In-Network	Out-of-Network
<p>Acute Inpatient Hospital Coverage</p>	<p>\$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</p> <p>Prior authorization may be required. See the Evidence of Coverage (EOC) for details.</p>	40% coinsurance
<p>Outpatient Hospital Coverage</p> <p>Outpatient surgery/non-surgery at an outpatient hospital:</p> <p>Outpatient observation:</p>	<p>\$275 copay</p> <p>\$275 copay</p> <p>Prior authorization may be required. See the EOC for details.</p>	<p>40% coinsurance</p> <p>40% coinsurance</p>

Covered Medical and Hospital Benefits		
	In-Network	Out-of-Network
Ambulatory Surgical Center (ASC) Services	<p>\$0 copay for a diagnostic colonoscopy at an ASC</p> <p>\$225 copay for all other services</p>	<p>40% coinsurance</p> <p>40% coinsurance</p>
Doctor Visits		
<p>Primary care provider (PCP):</p> <p>Specialist:</p>	<p>\$0 copay</p> <p>\$30 copay</p>	<p>\$30 copay</p> <p>40% coinsurance</p>
Preventive Care	\$0 copay	40% coinsurance
<p>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,</p>		

Covered Medical and Hospital Benefits		
	In-Network	Out-of-Network
<p>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)</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>		
<p>Emergency Care</p> <p>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).</p> <p>Worldwide emergency or urgent care services:</p>	<p>\$110 copay</p> <p>\$90 copay \$15,000 annual coverage limit</p>	<p>\$110 copay</p> <p>\$90 copay \$15,000 annual coverage limit</p>
<p>Urgently Needed Services</p> <p>Worldwide emergency or urgent care services:</p>	<p>\$30 copay</p> <p>\$90 copay \$15,000 annual coverage limit</p>	<p>\$30 copay</p> <p>\$90 copay \$15,000 annual coverage limit</p>

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	40% coinsurance
	Prior authorization may be required. See the EOC for details.	

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:	<p>\$699 copay per hearing aid for Advanced hearing aids (up to 1 hearing aid per ear per year)</p> <p>\$999 copay per hearing aid for Premium hearing aids (up to 1 hearing aid per ear per year)</p> <p>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</p>	<p>\$699 copay per hearing aid for Advanced hearing aids (up to 1 hearing aid per ear per year)</p> <p>\$999 copay per hearing aid for Premium hearing aids (up to 1 hearing aid per ear per year)</p> <p>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</p>

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 relines:	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)	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.
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
<p>qualifying members with enhanced dental benefits.</p> <p>The benefits mentioned here are part of a special supplemental program for the chronically ill. Not all members qualify for them.</p>		
<p>Dental Services – More Information</p> <p>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.</p> <p>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.</p> <p>To find an in-network dental provider, please visit www.arkbluemedicare.com.</p>		
<p>Vision Services</p> <p>Medicare-covered diabetic retinopathy:</p> <p>Medicare-covered glaucoma screening:</p> <p>All other Medicare-covered eye exams:</p> <p>Routine eye exam:</p> <p>Medicare-covered eyewear:</p> <p>Routine eyewear – contact lenses:</p>	<p>\$0 copay (for the 1st exam, then the specialist copay will apply for additional exams)</p> <p>\$0 copay</p> <p>\$30 copay</p> <p>\$0 copay (1 per year)</p> <p>\$0 copay</p> <p>\$0 copay (1 per year)</p>	<p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance (1 per year)</p> <p>40% coinsurance</p> <p>\$0 copay (1 per year)</p>

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)	<p>\$0 copay per day for days 1–20 \$196 copay per day for days 21–100</p> <p>Prior authorization may be required. See the EOC for details.</p>	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	40% coinsurance
	Prior authorization may be required. See the EOC for details.	
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:	20% coinsurance	40% coinsurance
Other Medicare Part B drugs:	20% coinsurance	40% coinsurance
	Prior authorization may be required. See the EOC for details.	

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				
<p>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.</p> <p>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.</p> <p>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.)</p>				
Catastrophic Coverage Stage				
<p>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:</p> <ul style="list-style-type: none"> • 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	<p>\$0 copay (14 meals per year)</p> <p>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.</p>	Only the in-network benefit can be used.
Blue Medicare Sapphire Card	<p>\$500 per year</p> <p>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.</p>	<p>\$500 per year</p> <p>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.</p>

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**).

