Arkansas Blue MEDICARE
An Independent Licensee of the Blue Cross and Blue Shield Association

2024 Summary of Benefits

BlueMedicare Premier (HMO) H6158-001
BlueMedicare Independence (HMO) H6158-003

This Summary of Benefits

This is a summary of the benefits for:

- BlueMedicare Premier (HMO)
- BlueMedicare Independence (HMO)

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

If you'd like to learn more about the coverage and costs of Original Medicare, review the current "Medicare & You" handbook. You can find it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Plan Eligibility

To join, you must:

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

Service Area

The service area is the same for BlueMedicare Premier (HMO) and BlueMedicare Independence (HMO) and 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, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

BlueMedicare Premier (HMO) and BlueMedicare Independence (HMO) Are HMOs

An HMO is a health maintenance organization offered by a private insurance company. Our HMOs have a network of contracted healthcare providers and facilities. As a member of one of our HMOs, you'll be asked to choose a primary care provider (PCP) who will coordinate your care when you need to see a specialist or go to a facility. A referral from your PCP is not required for any service. Some services, however, require a prior authorization, which is approval from our plan in advance of you getting the service. Benefits mentioned in this document that require prior authorization are noted with an asterisk (*).

How to Contact Us

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

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

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

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

	BlueMedicare Premier (HMO) H6158-001	BlueMedicare Independence (HMO) H6158-003
Monthly Premium, Deductible, and Limits		
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	$0	$23.40
Medical Deductible	This plan does not have a deductible	This plan does not have a deductible
Annual Maximum Out-of-Pocket Costs It's the most you'll pay out of your own pocket (copays and/or coinsurance) for medical services for the year. Once you reach this amount, our plan will pay 100% of your medical costs for the rest of the plan year.	$5,000	$4,000

	BlueMedicare Premier (HMO) H6158-001	BlueMedicare Independence (HMO) H6158-003
Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Inpatient Hospital*	$360 copay per day for days 1–5; $0 copay per day for days 6–90	$300 copay per day for days 1–5; $0 copay per day for days 6–90
Outpatient Hospital		
Outpatient surgery/non-surgery	$295 copay	$275 copay
Outpatient observation*	$295 copay	$275 copay
Ambulatory Surgical Center (ASC) Services	$275 copay	$250 copay
Doctor Visits		
Primary care provider (PCP)	$0 copay	$0 copay
Specialist	$30 copay	$25 copay
Preventive Care	$0 copay	$0 copay

	BlueMedicare Premier (HMO) H6158-001	BlueMedicare Independence (HMO) H6158-003
Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Preventive Care – More Information Services include: Abdominal aortic aneurysm screening, alcohol misuse counseling, Annual Wellness Visit, barium enema, bone mass measurement, breast cancer screening (mammogram), cardiovascular disease (behavioral therapy), cardiovascular screening, cervical and vaginal cancer screening, colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, diabetes self-management training, digital rectal exam, electrocardiogram (EKG), glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare diabetes prevention program, obesity screening and counseling, prostate cancer screening (PSA), sexually transmitted infections screening and counseling, tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), vaccines (including flu, hepatitis B, and pneumococcal shots), and the "Welcome to Medicare" preventive visit (one-time). Any additional preventive services approved by Medicare during the plan year will be covered.		
Emergency Room (ER) If you're admitted to the hospital within 24 hours, you do not have to pay your ER copay.	$120 copay (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)	$120 copay (If you receive multiple services at the same location (e.g., the emergency room), you will pay the highest copay amount of all the services provided.)
Urgently Needed Services	$30 copay	$30 copay
Diagnostic Services/Labs/Imaging		
Diagnostic test – spirometry*	0% coinsurance	0% coinsurance
Diagnostic test – home-based sleep study*	0% coinsurance	0% coinsurance
All other diagnostic tests and procedures*	20% coinsurance	20% coinsurance
Lab services – genetic testing*	20% coinsurance	20% coinsurance
All other lab services (except genetic testing)*	0% coinsurance	0% coinsurance
Radiology – DEXA scan*	$0 copay	$0 copay
Radiology – diagnostic mammogram*	$25 copay	$25 copay
Radiology – ultrasound*	$25 copay	$25 copay
All other diagnostic radiology services*	$295 copay	$275 copay

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Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Radiation therapy*	20% coinsurance	20% coinsurance
X-rays*	$0 copay	$0 copay

Diagnostic Services/Labs/Imaging – More Information

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

Hearing Services		
Medicare-covered hearing exams	$30 copay	$25 copay
Routine hearing exam (1 per year)	$0 copay	$0 copay
Hearing aid fittings/evaluation (1 year of follow-up visits with hearing aid purchase)	$0 copay	$0 copay
Hearing aid allowance (up to 2 hearing aids per 3 years,1 per ear)	$1,000	$1,000

Hearing Services – More Information

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

Dental – Preventive Services		
Exams (up to 2 per calendar year)	$0 copay	$0 copay
Cleanings (2 per calendar year)	$0 copay	$0 copay
X-rays (1 per calendar year to every 3 calendar years depending on the service)	$0 copay	$0 copay
Fluoride treatments (1 to unlimited per calendar year depending on the service)	$0 copay	$0 copay
Dental – Comprehensive Services		
Medicare-covered dental services	$30 copay	$25 copay
Diagnostic services	Not covered	Not covered
Non-routine services	Not covered	Not covered
Restorative services (up to 2 per calendar year)	20% coinsurance	20% coinsurance

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Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Endodontics (1 per calendar year)	20% coinsurance	20% coinsurance
Periodontics (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	20% coinsurance
Extractions (unlimited per calendar year)	20% coinsurance	20% coinsurance
Prosthodontics/Other oral-maxillofacial surgery/Other services (up to 2 per calendar year to every 5 calendar years depending on the service)	20% coinsurance	20% coinsurance
Dental annual allowance (combined preventive and comprehensive services)	$2,000	$2,000
Dental – Dental Xtra℠ This program is for members who have diabetes, coronary artery disease (CAD), have suffered a stroke, or have been diagnosed with oral cancer, head and neck cancers, or Sjögren's syndrome. The program provides qualifying members with enhanced dental benefits. The benefits mentioned here are part of a special supplemental program for the chronically ill. Not all members qualify for them.	$0 copay	$0 copay

Dental Services – More Information

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

Vision Services		
Medicare-covered diabetic retinopathy screening	$0 copay	$0 copay
Medicare-covered glaucoma screening	$0 copay	$0 copay
All other Medicare-covered eye exams	$30 copay	$25 copay
Medicare-covered eyewear	$0 copay	$0 copay

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Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Routine eye exam (1 per year)	$0 copay	$0 copay
Routine eyewear – choice of a pair of contact lenses or eyeglasses (lenses and frames) (1 per year) and upgrades (up to the annual allowance)	$0 copay	$0 copay
Routine eyewear annual allowance	$150	$150
Mental Health		
Inpatient hospital*	$360 copay per day for days 1–5; $0 copay per day for days 6–90	$300 copay per day for days 1–5; $0 copay per day for days 6–90
Outpatient mental health specialty and psychiatric visits (individual and group therapy sessions)	$35 copay	$35 copay
Skilled Nursing Facility (SNF) Services*	$0 copay per day for days 1–20; $203 copay per day for days 21–100	$0 copay per day for days 1–20; $203 copay per day for days 21–100
Rehabilitation/Therapy Services		
Physical therapy*	$40 copay	$40 copay
Occupational therapy*	$35 copay	$35 copay
Speech therapy*	$40 copay	$40 copay
Ambulance Services		
Ground ambulance	$325 copay	$325 copay
Air ambulance	20% coinsurance	20% coinsurance
Transportation (health-related) (60 one-way trips per year)	Not covered	$0 copay
Medicare Part B Drugs		
Insulin products (e.g., for an insulin pump)	$35 copay	$35 copay
Chemotherapy/Radiation drugs*	0%–20% coinsurance	0%–20% coinsurance
Other Part B drugs*	0%–20% coinsurance	0%–20% coinsurance

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Prescription Drug Benefits		
Deductible Stage If your plan has a deductible, you'll begin in this stage when you fill your first prescription of the year if it's on a tier to which the deductible applies. You'll pay the full cost of these drugs until you reach the deductible amount. After that, you'll only pay your cost share. If your plan doesn't have a deductible, you'll start in the Initial Coverage Stage.		
Deductible	$100	$545
Deductible applies to these tiers	Tiers 4 and 5	Tiers 2–5
Initial Coverage Stage During this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You'll stay in this stage until your total yearly drug costs (total drug costs paid by you and our plan) reach $5,030. Once you reach this amount, you will enter the Coverage Gap Stage.		
Standard Retail Pharmacy Cost Shares	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$0 copay / $0 copay	$7 copay / $14 copay
Tier 2 (Generic)	$8 copay / $16 copay	$20 copay / $40 copay
Tier 3 (Preferred Brand)	$47 copay / $94 copay	$47 copay / $94 copay
Tier 4 (Non-Preferred Drug)	$100 copay / $300 copay	$100 copay / $300 copay
Tier 5 (Specialty Tier)	31% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	$0 copay / $0 copay	$0 copay / $0 copay
Mail-Order Pharmacy Cost Shares	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$0 copay / $0 copay	$7 copay / $14 copay
Tier 2 (Generic)	$8 copay / $0 copay	$20 copay / $40 copay
Tier 3 (Preferred Brand)	$47 copay / $94 copay	$47 copay / $94 copay
Tier 4 (Non-Preferred Drug)	$100 copay / $300 copay	$100 copay / $300 copay

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Prescription Drug Benefits		
Tier 5 (Specialty Tier)	31% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	$0 copay / $0 copay	$0 copay / $0 copay
Coverage Gap Stage Most Medicare Advantage drug plans have a Coverage Gap (also called the "donut hole"). In the Coverage Gap, there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after your total yearly drug costs (including what you have paid and what our plan has paid) reach $5,030. You stay in this stage until your total yearly drug costs reach $8,000. During the Coverage Gap, you pay 25% coinsurance for generic and brand drugs on all tiers, unless your plan offers additional gap coverage.		
Additional gap coverage (30-Day Supply / 100-Day Supply)	Tier 6 – $0 copay / $0 copay	Not covered
Catastrophic Coverage Stage After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacies and mail order) reach $8,000, you will enter the Catastrophic Coverage Stage.	You will have no cost sharing for the rest of the plan year	You will have no cost sharing for the rest of the plan year

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Prescription Drug Benefits		

Prescription Drug Coverage – More Information

- Cost shares for covered insulin products will not be more than a $20 copayment for a 30-day supply on BlueMedicare Premier (HMO) and a $35 copayment for a 30-day supply on BlueMedicare Independence (HMO) regardless of the tier. Additionally, the Part D deductible will not apply to any covered insulin products.
- Cost shares for covered ACIP-approved vaccines will be a $0 copayment regardless of the tier. Additionally, the Part D deductible will not apply to any covered ACIP-approved vaccine.
- For BlueMedicare Premier (HMO) only, Tier 2 includes coverage of certain excluded drugs for erectile dysfunction and weight loss, which are not covered by Medicare. Please see the Formulary and EOC for more details.
- Cost sharing may differ based on the pharmacy type (e.g., retail, mail order, long-term care (LTC)) or by fill amount (i.e., 30-day or 100-day supply).
- If you receive Extra Help, you may pay less for your Part D covered drugs depending on your level of Extra Help.
  - Deductible: $0
  - Generic drugs (on all tiers) – 30-day or 100-day supply: $0, $1.55, or $4.50 copayment
  - Brand drugs (on all tiers) – 30-day or 100-day supply: $0, $4.60, or $11.20 copayment
  - To see if you qualify for Extra Help, please call the Social Security Office at **1-800-772-1213** Monday–Friday, 8 a.m.–7 p.m. TTY users should call **1-800-325-0778**.

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Additional Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Podiatry Services (foot care)		
Medicare-covered services	$25 copay	$25 copay
Routine services (6 visits per year)	$25 copay	$25 copay
Medicare-Covered Chiropractic Services	$20 copay	$20 copay
Medical Equipment and Supplies		
Durable medical equipment (DME)*	20% coinsurance	20% coinsurance
Prosthetics*	20% coinsurance	20% coinsurance

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Additional Medical Benefits (benefits that may require prior authorization are noted with an "*")		
Medical supplies*	20% coinsurance	20% coinsurance
Diabetic supplies – testing supplies from our preferred manufacturers Lifescan and Roche	$0 copay (at a network pharmacy)	$0 copay (at a network pharmacy)
Diabetic supplies – continuous glucose monitors (CGMs) from our preferred manufacturers Dexcom and Freestyle*	$0 copay (at a network pharmacy)	$0 copay (at a network pharmacy)
Diabetic therapeutic shoes or inserts*	$0 copay	$0 copay
Additional Rehabilitation Services		
Cardiac rehabilitation*	$0 copay	$0 copay
Intensive cardiac rehabilitation*	$0 copay	$0 copay
Pulmonary rehabilitation*	$15 copay	$15 copay
Supervised exercise therapy for peripheral artery disease (PAD)*	$0 copay	$0 copay
Telehealth		
PCP, specialist, urgently needed, and outpatient mental health (individual and group therapy sessions) services	$0 copay	$0 copay

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Extra Benefits		
Walmart Wellness Benefits Card – OTC You'll be able to get over-the-counter (OTC) items from Walmart with our new and improved quarterly OTC benefit. Conveniently shop in-store at your local Walmart, online at **Walmart.com**, or through the Walmart app using your Walmart Wellness Benefits Card for OTC. (You can also call or mail in your order.) With thousands of products online and in store, an easy-to-use catalog, and a preloaded debit card, accessing your OTC benefit will be quick and easy. (Unused funds at the end of each quarter do not rollover to the next quarter.)	$75 (per quarter)	$150 (per quarter)
Walmart Wellness Benefits Card – Food & Produce If you have been diagnosed with a chronic health condition, you may be able to get the Walmart Wellness Benefits Card for food and produce. You can use the preloaded debit card to purchase healthy food and fresh produce from your local Walmart. (Only one debit card will be issued, which will have two separate "purses" on it – one for OTC and the other for food and produce.) This food and produce benefit is a monthly allowance, and unused funds at the end of each month do not rollover to the next month. The benefit mentioned here is part of a special supplemental program for the chronically ill. Not all members qualify for it.	Not covered	$25 (per month)
Blue Medicare Sapphire Card You'll receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses for covered dental, vision, and hearing services.	$500 (per year)	$500 (per year)

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Extra Benefits		
In-Home Support Services You can get a set number of hours per year for help with activities of daily living (ADLs) (e.g., bathing and dressing) and instrumental activities of daily living (IADLs) (e.g., errands and transportation to appointments). Scheduling your visits is easy and convenient (visits must be in two-hour or four-hour increments).	$0 copay (40 hours per year)	$0 copay (80 hours per year)
SilverSneakers® You'll have access to a fitness benefit at participating SilverSneakers facilities (instructor-led group exercise classes and exercise equipment), ways to get active outside of traditional gyms, and digital/ virtual options. In-home fitness kits are also available.	$0 copay	$0 copay
24-Hour Nurse Advice Line	$0 copay	$0 copay
Additional Physical Exam This is in addition to the Medicare-covered Annual Wellness Visit.	$0 copay	$0 copay
Meals Benefit Immediately following surgery or discharge from a hospital stay, you can get two nutritious meals per day for seven days (a total of 14 meals per year) delivered to your home.	$0 copay	$0 copay
Worldwide Emergency/Urgent Care Services Up to $15,000 per year combined for emergency and urgently needed services outside the U.S.	20% coinsurance	20% coinsurance

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

Pre-Enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- ☐ Reviewing/Completing this Pre-Enrollment Checklist will not affect your current or future coverage.