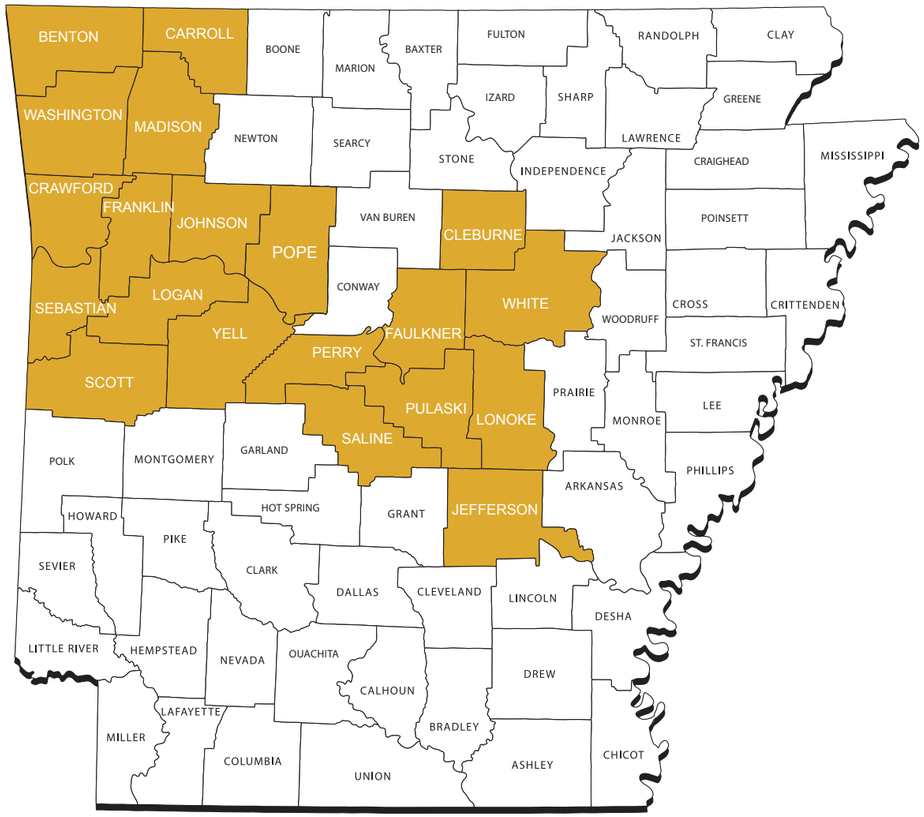
Service Area

The premiums vary by the county in which you permanently reside. Rates are based on the use and cost of healthcare in each service area. You must continue to pay your Medicare Part B premium.

Benton	Franklin	Madison	Scott
Carroll	Jefferson	Perry	Sebastian
Cleburne	Johnson	Pope	Washington
Crawford	Logan	Pulaski	White
Faulkner	Lonoke	Saline	Yell



This information is not a complete description of benefits. Call 1-844-298-2444/711 for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurances may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFITS AT A GLANCE

2020 MEDI-PAK® ADVANTAGE (PFFS)

Become a member of Arkansas Blue Cross and Blue Shield's Medi-Pak Advantage (PFFS) plan and get the care you want when you need it. It's the right choice if you're looking for complete coverage both in or out-of-network. You'll get:

- Choice of plans with low monthly premiums and prescription drug coverage
- $0 Fitness program
- Affordable copays
- Preventive services
- No in-network referrals needed
- Worldwide emergency/urgent care
- 24-Hour nurse line
- Nationwide coverage when you travel

Enroll Your Way

We want you to pick the plan that's best for you. We're ready to help.

- Enroll online at: **arkansasbluecross.com/Medicare**
- Complete and mail in an enrollment form
- Call us toll-free at the phone number listed below
- Contact your agent

1-844-298-2444, TTY users call 711

8 a.m. to 8 p.m. Central time, Monday through Friday, April 1 through September 30

8 a.m. to 8 p.m., Central time, seven days a week, October 1 through March 31

Arkansas Blue Cross and Blue Shield is a PFFS plan with a Medicare contract. Enrollment in Arkansas Blue Cross and Blue Shield depends on contract renewal.

2020 Medi-Pak Advantage (PFFS) Benefit Comparison

Summary of most frequently used benefits.
A complete description is available at **arkansasbluecross.com/Medicare** or by calling **1-844-298-2444**.

Covered Services	Medical coverage only (MA)		Medical and prescription drug coverage (MA-PD)	
	In-network	Out-of-network	In-network	Out-of-network
Monthly plan premium	You pay $22-$59	You pay $22-$59	You pay $57-$89.90	You pay $57-89.90
Out-of-pocket maximum for Medicare-covered medical services	$6,700			
Medical deductible	$1,000 per year for out-of-network services Out of network deductible applies to out of network Medicare-covered plan services inside Arkansas.			
Inpatient acute hospital care	Days 1-5: $372 copay per day, Days 6-90+: $0 copay per day;	Days 1-5: $372 copay per day; Days 6-90+: $0 copay per day; or 40% of the cost per day for days 1 through 90 after deductible	Days 1-5: $372 copay per day; Days 6-90+: $0 copay per day;	Days 1-5: $372 copay per day; Days 6-90+: $0 copay per day; or 40% of the cost per day for days 1 through 90 after deductible
Skilled nursing facility (in a Medicare-certified skilled nursing facility)	Days 1-20: $0 copay per day, Days 21-100: $178 copay per day	Days 1-20: $0 copay per day, Days 21-100: $178 copay per day after deductible or 40% coinsurance after deductible per day	Days 1-20: $0 copay per day, Days 21-100: $178 copay per day	Days 1-20: $0 copay per day, Days 21-100: $178 copay per day after deductible or 40% coinsurance after deductible per day
Outpatient hospital (non-surgical) services	$340 copay	$340 copay or 40% coinsurance after deductible	$340 copay	$340 copay or 40% coinsurance after deductible
Office visits: primary care physicians	$30 copay	$30 copay or 40% coinsurance after deductible	$30 copay	$30 copay or 40% coinsurance after deductible
Office visits: specialists	$50 copay	$50 copay or 40% coinsurance after deductible	$50 copay	$50 copay or 40% coinsurance after deductible
Outpatient surgery	$340 copay ambulatory surgical center or hospital	$340 copay ambulatory surgical center or hospital or 40% coinsurance after deductible	$340 copay ambulatory surgical center or hospital	$340 copay ambulatory surgical center or hospital or 40% coinsurance after deductible
Ambulance services	Ground $265 copay, Air: 20% coinsurance			
Urgent care within the U.S.	$50 copay			
Emergency care within the U.S.	$90 copay			
Emergency and urgent care outside the U.S. (worldwide)	20% coinsurance; $15,000 annual limit			
Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Annual physical exams: one per year	$0	$0 or 40% coinsurance after deductible	$0	$0 or 40% coinsurance after deductible
Chiropractic care	Medicare-covered services only; $20 copay	Medicare-covered services only; $20 copay or 40% coinsurance after deductible	Medicare-covered services only; $20 copay	Medicare-covered services only; $20 copay or 40% coinsurance after deductible
Podiatry	Medicare-covered services only; $50 copay	Medicare-covered services only; $50 copay or 40% coinsurance after deductible	Medicare-covered services only; $50 copay	Medicare-covered services only; $50 copay or 40% coinsurance after deductible
Dental	Medicare-covered services only; $50 copay $300 annual maximum reimbursement benefit for covered services	Medicare-covered services only; $50 copay $300 annual maximum reimbursement benefit for covered services	Medicare-covered services only; $50 copay $300 annual maximum reimbursement benefit for covered services	Medicare-covered services only; $50 copay $300 annual maximum reimbursement benefit for covered services
Vision	Medicare-covered services only; $0-$50 copay ($0 diabetic retinopathy exams)	Medicare-covered services only; $0-$50 copay or 40% coinsurance after deductible ($0 diabetic retinopathy exams)	Medicare-covered services only; $0-$50 copay ($0 diabetic retinopathy exams)	Medicare-covered services only; $0-$50 copay or 40% coinsurance after deductible ($0 diabetic retinopathy exams)
Hearing	Medicare-covered services only: $50 copay $0 copay for routine hearing exam once every 12 months; $699 or $999 copay for one hearing aid per ear per year (depends on type of hearing aid)	Medicare-covered services only: $50 copay $0 copay for routine hearing exam once every 12 months; $699 or $999 copay for one hearing aid per ear per year (depends on type of hearing aid)	Medicare-covered services only: $50 copay $0 copay for routine hearing exam once every 12 months; $699 or $999 copay for one hearing aid per ear per year (depends on type of hearing aid)	Medicare-covered services only: $50 copay $0 copay for routine hearing exam once every 12 months; $699 or $999 copay for one hearing aid per ear per year (depends on type of hearing aid)
SilverSneakers Fitness program	$0			
24 Hour nurse hotline	$0 copay			

Benefit for Medicare-Covered Services	Medical coverage only (MA) Medical and prescription drug coverage (MA-PD)
Preventive Services	$0 copay in-network; 40% coinsurance for out-of-network after deductible. Abdominal aortic aneurysm screening, Alcohol misuse screenings & counseling, Barium Enemas, Bone mass measurements (bone density), Cardiovascular disease screenings, Cardiovascular disease (behavioral therapy), Cervical & vaginal cancer screening, Colorectal cancer screenings, Depression screenings, Diabetes screenings, Diabetes self-management training, Diabetes prevention program, Digital Rectal Exams, EKG, Glaucoma tests, Hepatitis C screening test, HIV screening, Immunizations (including flu, pneumonia and Hepatitis B vaccines), Lung cancer screening, Mammograms (screening), Nutrition therapy services, Obesity screenings & counseling, One-time "Welcome to Medicare" preventive visit, Prostate cancer screenings, Sexually transmitted infections screening & counseling, Tobacco use cessation counseling and Annual "Wellness" visit.

Prescription Drug Coverage		
Formulary Tiers	Copayment/Coinsurance - (MA-PD) ONLY	
	Rx Deductible: $325 for Tiers 2, 3, 4, 5	
	Preferred Pharmacy	Standard Pharmacy
Tier 1 Preferred generic	$3	$10
Tier 2 Generic	$13	$20
Tier 3 Preferred brand	$40	$47
Tier 4 Non-preferred	48%	50%
Tier 5 Specialty	27%	27%

Coverage Periods	Copayment/Coinsurance - (MA-PD) ONLY
Initial coverage limit	You pay copays and coinsurances until your total yearly drug costs reach $4,020.
Gap coverage	Generic Drugs - 25% copay of the plan's cost Brand Name Drugs - 25% copay of the plan's cost
Catastrophic coverage	$6,350: $3.60 copay for generic drugs $8.95 copay for all other covered drugs or 5% coinsurance