2025

Outline of Medicare Supplement Coverage

For individuals who are eligible for coverage before January 1, 2020

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE —

COVER PAGE: Arkansas Blue Cross and Blue Shield offers Benefit Plans A, B, C, F, High Deductible F, G, and N.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Arkansas. Plans E, H, I, and J are no longer available for sale. **BASIC BENEFITS: Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance, (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments. **Blood:** First three pints of blood each year. **Hospice:** Part A coinsurance. **† INNOVATIVE BENEFIT:** Not part of standard benefit plan. **The SilverSneakers Fitness Program is an overall health and wellness program.**

A	B	C	D	F	F*	G	K**	L**	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance			Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							***Out-of-pocket limit $7,220; paid at 100% after limit reached	***Out-of-pocket limit $3,610; paid at 100% after limit reached		
SilverSneakers Fitness Program†	SilverSneakers Fitness Program†	SilverSneakers Fitness Program†		SilverSneakers Fitness Program†		SilverSneakers Fitness Program†				SilverSneakers Fitness Program†

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,875 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,875. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. **Plans K and L provide for different cost-sharing for items and services than Plans A-G. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You will be responsible for paying excess charges. ***The out-of-pocket annual limit will increase each year for inflation.

PREMIUM INFORMATION

We, Arkansas Blue Cross and Blue Shield, can only raise your premium if we raise the premium for all policies like yours in the same service area as yours.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY *VERY* CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Arkansas Blue Cross and Blue Shield, 601 Gaines Street, Little Rock, Arkansas 72203. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither Arkansas Blue Cross and Blue Shield nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for a new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLANS A, B, C, F, High Deductible F, G and N | **Medicare (Part A)** — Hospital Services — Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS							YOU PAY						
		A	B	C	F	HIGH DED F	G	N	A	B	C	F	HIGH DED F	G	N
HOSPITALIZATION* Semi-private room and board, general nursing, and miscellaneous services and supplies															
First 60 days	All but $1,676 /benefit period	$-0-	$1,676	$1,676	$1,676	$1,676	$1,676	$1,676	$1,676	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
61st through 90th day	All but $419 a day	$419	$419	$419	$419	$419	$419	$419	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
91st day and after															
– While using 60 lifetime reserve days	All but $838 a day	$838	$838	$838	$838	$838	$838	$838	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
– Once lifetime reserve days are used: – Additional 365 days	$-0-	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	100% of Medicare-Eligible Expenses	$-0-**	$-0-**	$-0-**	$-0-**	$-0-**	$-0-**	$-0-**
– Beyond the Additional 365 days	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs
SKILLED NURSING FACILITY CARE*															
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.															
First 20 days	All approved amounts	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
21st through 100th day	All but $209.50 a day	$-0-	$-0-	Up to $209.50 a day	Up to $209.50 a day	Up to $209.50 a day	Up to $209.50 a day	Up to $209.50 a day	Up to $209.50 a day	Up to $209.50 a day	$-0-	$-0-	$-0-	$-0-	$-0-
101st day and after	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs
BLOOD															
First three pints	$-0-	3 Pints	3 Pints	3 Pints	3 Pints	3 Pints	3 Pints	3 Pints	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
Additional amounts	100%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
HOSPICE CARE															
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS							YOU PAY						
		A	B	C	F	HIGH DED F	G	N	A	B	C	F	HIGH DED F	G	N
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment															
First $257 of Medicare-Approved Amounts	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	$-0-	$-0-	$-0-	$-0-	100%	100%	100%	$-0-	All Costs	All Costs	All Costs	$-0-	$-0-	$-0-	All Costs
BLOOD															
First three pints	$-0-	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
Next $257 of Medicare-Approved Amounts*	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	20%	20%	20%	20%	20%	20%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
– Durable medical equipment – First $257 of Medicare-Approved Amounts*	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)	$-0-	$-0-	$-0-	$257 (Part B Deductible)	$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	20%	20%	20%	20%	20%	20%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-

* Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS							YOU PAY						
		A	B	C	F	HIGH DED F	G	N	A	B	C	F	HIGH DED F	G	N
FOREIGN TRAVEL — NOT COVERED BY MEDICARE															
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA															
First $250 each calendar year	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	All Costs	All Costs	$250	$250	$250	$250	$250
Remainder of Charges	$-0-	$-0-	$-0-	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	All Costs	All Costs	20% and amounts over the $50,000 lifetime max.	20% and amounts over the $50,000 lifetime max.	20% and amounts over the $50,000 lifetime max.	20% and amounts over the $50,000 lifetime max.	20% and amounts over the $50,000 lifetime max.
SILVERSNEAKERS FITNESS PROGRAM	$-0-	100%	100%	100%	100%	100%	100%	100%	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-	$-0-
Vision care: asymptomatic eye exam*	$-0-	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	All Costs	No Costs	No Costs	No Costs	No Costs	No Costs	No Costs	No Costs
TruHearing program coverage	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$699/$999 per aid	$699/$999 per aid	$699/$999 per aid	$699/$999 per aid	$699/$999 per aid	$699/$999 per aid	$699/$999 per aid

Service Area 1 Counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clay, Cleveland, Columbia, Craighead, Crawford, Crittenden, Desha, Drew, Franklin, Fulton, Grant, Greene, Jefferson, Johnson, Lafayette, Lee, Lincoln, Logan, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Newton, Phillips, Poinsett, Polk, Pope, Prairie, Randolph, Scott, Searcy, Sebastian, St. Francis, Stone, Union, Washington, White, Woodruff, Yell

Service Area 2 Counties: Clark, Cleburne, Conway, Cross, Dallas, Faulkner, Garland, Hempstead, Hot Spring, Howard, Independence, Izard, Jackson, Lawrence, Little River, Lonoke, Nevada, Ouachita, Perry, Pike, Pulaski, Saline, Sevier, Sharp, Van Buren

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* See Medi-Pak Vision Care Program brochure/certificate for benefit details. The benefits provided under this program are in addition to, and not instead of, your benefits under Medicare or the Medi-Pak Medicare supplement certificate.

Medi-Pak insurance plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

Service Area 1 Premiums

	A	B	C	F	HIGH DED F	G	N
Monthly	$144.30	$1,300.10	$317.40	$302.00	$51.10	$198.00	$155.70
Quarterly	$432.90	$3,900.30	$952.20	$906.00	$153.30	$594.00	$467.10

Service Area 2 Premiums

Monthly	$165.50	$1,300.10	$357.60	$340.00	$57.60	$222.40	$174.00
Quarterly	$496.50	$3,900.30	$1,072.80	$1,020.00	$172.80	$667.20	$522.00