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

2024 Summary of Benefits

BlueMedicare Preferred (PFFS) H4213-017-001
BlueMedicare Preferred (PFFS) H4213-017-005
BlueMedicare Preferred (PFFS) H4213-017-006

This Summary of Benefits

This is a summary of the benefits for:

- BlueMedicare Preferred (PFFS) H4213-017-001
- BlueMedicare Preferred (PFFS) H4213-017-005
- BlueMedicare Preferred (PFFS) H4213-017-006

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 for BlueMedicare Preferred (PFFS) H4213-017-001 includes the following Arkansas counties: Baxter, Boone, Clark, Conway, Craighead, Fulton, Garland, Greene, Hot Spring, Izard, Marion, Newton, Ouachita, Poinsett, Polk, Searcy, St. Francis, Van Buren, and Woodruff.
- The service area for BlueMedicare Preferred (PFFS) H4213-017-005 includes the following Arkansas counties: Benton, Carroll, Crawford, Faulkner, Franklin, Johnson, Logan, Madison, Perry, Pope, Scott, Sebastian, Washington, and Yell.
- The service area for BlueMedicare Preferred (PFFS) H4213-017-006 includes the following Arkansas counties: Cleburne, Jefferson, Lonoke, Pulaski, Saline, and White.

BlueMedicare Preferred (PFFS) H4213-017-001/-005/-006 Are PFFS Plans

A PFFS plan is a private fee-for-service health plan offered by a private insurance company. Our PFFS plans have a network of contracted healthcare providers and facilities – these are in-network providers. Providers and facilities who are not contracted with our plan are considered out-of-network. As a PFFS member, you'll have the choice of going to an in-network or out-of-network provider or facility. Generally, your out-of-pocket costs for an out-of-network provider will be higher than for one who is in-network. Additionally, the out-of-network provider must agree to accept our plan's payment terms and conditions.

BlueMedicare Preferred (PFFS) does not require members or their providers to get prior authorization or a referral from the plan as a condition for covering medically necessary covered services. If you have any questions about if we'll cover a medical service or care you're considering, call us in advance and ask if it'll be covered.

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 Preferred (PFFS) H4213-017-001	BlueMedicare Preferred (PFFS) H4213-017-005	BlueMedicare Preferred (PFFS) H4213-017-006
Monthly Premium, Deductible, and Limits			
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	$50	$60	$90
Medical Deductible	$1,000 (out-of-network only)	$1,000 (out-of-network only)	$1,000 (out-of-network only)
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. Combined in- and out-of-network	$7,500	$7,500	$7,500

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
Medical Benefits						
Inpatient Hospital	$390 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance	$390 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance	$390 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance
Outpatient Hospital						
Outpatient surgery/non-surgery	$340 copay	40% coinsurance	$340 copay	40% coinsurance	$340 copay	40% coinsurance
Outpatient observation	$340 copay	40% coinsurance	$340 copay	40% coinsurance	$340 copay	40% coinsurance
Ambulatory Surgical Center (ASC) Services	$340 copay	40% coinsurance	$340 copay	40% coinsurance	$340 copay	40% coinsurance
Doctor Visits						
Primary care provider (PCP)	$20 copay	40% coinsurance	$20 copay	40% coinsurance	$20 copay	40% coinsurance
Specialist	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Preventive Care	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance

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Medical Benefits						
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)	$95 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.)		$95 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.)		$95 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	$50 copay		$50 copay		$50 copay	
Diagnostic Services/Labs/Imaging						
Diagnostic test – spirometry	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance

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Medical Benefits						
Diagnostic test – home-based sleep study	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other diagnostic tests and procedures	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Lab services – genetic testing	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
All other lab services (except genetic testing)	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance
Radiology – DEXA scan	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
Radiology – diagnostic mammogram	$25 copay	40% coinsurance	$25 copay	40% coinsurance	$25 copay	40% coinsurance
Radiology – ultrasound	$25 copay	40% coinsurance	$25 copay	40% coinsurance	$25 copay	40% coinsurance
All other diagnostic radiology services	$340 copay	40% coinsurance	$340 copay	40% coinsurance	$340 copay	40% coinsurance
Radiation therapy	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
X-rays	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance

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Medical Benefits						
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	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Routine hearing exam (1 per year)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Hearing aid fittings/evaluation (1 year of follow-up visits with hearing aid purchase)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Hearing aids (Advanced / Premium – up to 2 hearing aids per year, 1 per ear)	$699 / $999 copay per hearing aid		$699 / $999 copay per hearing aid		$699 / $999 copay per hearing aid	
Hearing Services – More Information • TruHearing providers must be used for the routine hearing exam. • TruHearing hearing aids must also be used.						
Dental – Preventive Services						

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The $1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).	**BlueMedicare Preferred (PFFS) H4213-017-001**		**BlueMedicare Preferred (PFFS) H4213-017-005**		**BlueMedicare Preferred (PFFS) H4213-017-006**	
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Medical Benefits						
Exams (up to 2 per calendar year)	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Cleanings (2 per calendar year)	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
X-rays (1 per calendar year to every 3 calendar years depending on the service)	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Fluoride treatments	Not covered		Not covered		Not covered	
Dental – Comprehensive Services						
Medicare-covered dental services	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Diagnostic services	Not covered		Not covered		Not covered	
Non-routine services	Not covered		Not covered		Not covered	
Restorative services (1 per calendar year)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Endodontics	Not covered		Not covered		Not covered	
Periodontics (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Extractions (unlimited per calendar year)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance

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Medical Benefits						
Prosthodontics/Other oral-maxillofacial surgery/Other services (up to 2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Dental annual allowance (combined preventive and comprehensive services, in-network and out-of-network)	$2,000		$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	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance

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.

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Medical Benefits						
Vision Services						
Medicare-covered diabetic retinopathy screening	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
Medicare-covered glaucoma screening	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
All other Medicare-covered eye exams	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Medicare-covered eyewear	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Routine eye exam	Not covered		Not covered		Not covered	
Routine eyewear	Not covered		Not covered		Not covered	
Routine eyewear annual allowance	Not covered		Not covered		Not covered	
Mental Health						
Inpatient hospital	$385 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance	$385 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance	$385 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance

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Medical Benefits						
Outpatient mental health specialty and psychiatric visits (individual and group therapy sessions)	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance
Skilled Nursing Facility (SNF) Services	$0 copay per day for days 1–20; $203 copay per day for days 21–100	40% coinsurance	$0 copay per day for days 1–20; $203 copay per day for days 21–100	40% coinsurance	$0 copay per day for days 1–20; $203 copay per day for days 21–100	40% coinsurance
Rehabilitation/Therapy Services						
Physical therapy	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Occupational therapy	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Speech therapy	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Ambulance Services						
Ground ambulance	$325 copay	$325 copay	$325 copay	$325 copay	$325 copay	$325 copay
Air ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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Medical Benefits						
Transportation (health-related)	Not covered		Not covered		Not covered	
Medicare Part B Drugs						
Insulin products (e.g., for an insulin pump)	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance
Chemotherapy/Radiation drugs	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance
Other Part B drugs	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% coinsurance	0%–20% coinsurance	40% 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	$545	$545	$545
Deductible applies to these tiers	Tiers 2–5	Tiers 2–5	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**	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$15 copay / $37.50 copay	$15 copay / $37.50 copay	$15 copay / $37.50 copay
Tier 2 (Generic)	$20 copay / $50 copay	$20 copay / $50 copay	$20 copay / $50 copay
Tier 3 (Preferred Brand)	$47 copay / $117.50 copay	$47 copay / $117.50 copay	$47 copay / $117.50 copay

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Prescription Drug Benefits			
Tier 4 (Non-Preferred Drug)	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered	25% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	$0 copay / $0 copay	$0 copay / $0 copay	$0 copay / $0 copay
Mail-Order Pharmacy Cost Shares	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$15 copay / $37.50 copay	$15 copay / $37.50 copay	$15 copay / $37.50 copay
Tier 2 (Generic)	$20 copay / $50 copay	$20 copay / $50 copay	$20 copay / $50 copay
Tier 3 (Preferred Brand)	$47 copay / $117.50 copay	$47 copay / $117.50 copay	$47 copay / $117.50 copay
Tier 4 (Non-Preferred Drug)	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance	32% coinsurance / 32% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered	25% coinsurance / Not covered	25% coinsurance / Not covered
Tier 6 (Select Care Drugs)	$0 copay / $0 copay	$0 copay / $0 copay	$0 copay / $0 copay

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Prescription Drug Benefits			
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	Not covered	Not covered	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	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 $35 copayment for a 30-day supply 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.
- 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						
Podiatry Services (foot care)						

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
Additional Medical Benefits						
Medicare-covered services	$50 copay	40% coinsurance	$50 copay	40% coinsurance	$50 copay	40% coinsurance
Routine services	Not covered		Not covered		Not covered	
Medicare-Covered Chiropractic Services	$15 copay	40% coinsurance	$15 copay	40% coinsurance	$15 copay	40% coinsurance
Medical Equipment and Supplies						
Durable medical equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetics	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Medical supplies	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic supplies – testing supplies from our preferred manufacturers Lifescan and Roche	$0 copay (at a network pharmacy)	20% coinsurance	$0 copay (at a network pharmacy)	20% coinsurance	$0 copay (at a network pharmacy)	20% coinsurance

For members who travel and live out-of-state for part of the year, we cover out-of-network out-of-Arkansas services at in-network cost sharing. The $1,000 out-of-network deductible only applies to services received within Arkansas from non-contracted providers (providers not in our network).	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
Additional Medical Benefits						
Diabetic supplies – continuous glucose monitors (CGMs) from our preferred manufacturers Dexcom and Freestyle	$0 copay (at a network pharmacy)	20% coinsurance	$0 copay (at a network pharmacy)	20% coinsurance	$0 copay (at a network pharmacy)	20% coinsurance
Diabetic therapeutic shoes or inserts	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Additional Rehabilitation Services						
Cardiac rehabilitation	$30 copay	40% coinsurance	$30 copay	40% coinsurance	$30 copay	40% coinsurance
Intensive cardiac rehabilitation	$55 copay	40% coinsurance	$55 copay	40% coinsurance	$55 copay	40% coinsurance
Pulmonary rehabilitation	$15 copay	40% coinsurance	$15 copay	40% coinsurance	$15 copay	40% coinsurance
Supervised exercise therapy for peripheral artery disease (PAD)	$25 copay	40% coinsurance	$25 copay	40% coinsurance	$25 copay	40% coinsurance
Telehealth						
PCP, specialist, urgently needed, and outpatient mental health (individual and group therapy sessions) services	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
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.)	Not covered		Not covered		Not covered	

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
Extra Benefits						
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		Not covered		Not covered	
Blue Medicare Sapphire Card You'll receive a pre-loaded Mastercard debit card to help reduce out-of-pocket expenses (in-network and out-of-network) for covered dental, vision, and hearing services. The annual allowance is combined for in-network and out-of-network services.	Not covered		Not covered		Not covered	

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
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).	Not covered		Not covered		Not covered	
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	Only the in-network benefit can be used	$0 copay	Only the in-network benefit can be used	$0 copay	Only the in-network benefit can be used
24-Hour Nurse Advice Line	$0 copay	Only the in-network benefit can be used	$0 copay	Only the in-network benefit can be used	$0 copay	Only the in-network benefit can be used
Additional Physical Exam This is in addition to the Medicare-covered Annual Wellness Visit.	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance

	BlueMedicare Preferred (PFFS) H4213-017-001		BlueMedicare Preferred (PFFS) H4213-017-005		BlueMedicare Preferred (PFFS) H4213-017-006	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**	**In-Network or Out-of-Network (out of AR)**	**Out-of-Network (in AR)**
Extra Benefits						
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.	Not covered		Not covered		Not covered	
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		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.
- ☐ 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 copay for services received by non-contracted providers.
- ☐ Reviewing/Completing this Pre-Enrollment Checklist will not affect your current or future coverage.