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

2026 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.	$58	$48	$78
Medical Deductible	$1,000 (out-of-network in Arkansas (AR) only)	$1,000 (out-of-network in Arkansas (AR) only)	$1,000 (out-of-network in Arkansas (AR) only)
Annual Maximum Out-of-Pocket Costs It's the most you'll pay out of your own pocket (copays and/or coinsurance) for covered medical services for the year. Once you reach this amount, our plan will pay 100% of your covered 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)	$10 copay	40% coinsurance	$10 copay	40% coinsurance	$10 copay	40% coinsurance
Specialist	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance

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Medical Benefits						
Preventive Care	$0 copay	40% coinsurance (the out-of-network deductible doesn't apply)	$0 copay	40% coinsurance (the out-of-network deductible doesn't apply)	$0 copay	40% coinsurance (the out-of-network deductible doesn't apply)

Preventive Care – More Information

Services include: Abdominal aortic aneurysm screening, alcohol misuse counseling, Annual Wellness Visit, bone mass measurement, breast cancer screening (mammogram), cardiovascular disease (behavioral therapy), cardiovascular screening, cervical and vaginal cancer screening, colorectal cancer screening (colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, diabetes self-management training, digital rectal exam, glaucoma screening, Hepatitis C Virus infection screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare diabetes prevention program, obesity screening and counseling, Pre-exposure prophylaxis (PrEP) for HIV prevention, 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.

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Medical Benefits						
Emergency Room (ER)	$115 copay (the out-of-network deductible doesn't apply) (if you receive multiple services at the same location (e.g., the emergency room) on the same day, you will pay the highest copay amount of all the services provided)		$115 copay (the out-of-network deductible doesn't apply) (if you receive multiple services at the same location (e.g., the emergency room) on the same day, you will pay the highest copay amount of all the services provided)		$115 copay (the out-of-network deductible doesn't apply) (if you receive multiple services at the same location (e.g., the emergency room) on the same day, you will pay the highest copay amount of all the services provided)	
Urgently Needed Services	$40 copay (the out-of-network deductible doesn't apply)		$40 copay (the out-of-network deductible doesn't apply)		$40 copay (the out-of-network deductible doesn't apply)	

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Medical Benefits						
Diagnostic Services/Labs/Imaging						
Diagnostic test – spirometry	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance	0% coinsurance	40% coinsurance
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 (the out-of-network deductible doesn't apply)	20% coinsurance	40% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	40% coinsurance (the out-of-network deductible doesn't apply)
All other lab services (except genetic testing)	0% coinsurance	40% coinsurance (the out-of-network deductible doesn't apply)	0% coinsurance	40% coinsurance (the out-of-network deductible doesn't apply)	0% coinsurance	40% coinsurance (the out-of-network deductible doesn't apply)
Radiology – diagnostic mammogram	$25 copay	40% coinsurance	$25 copay	40% coinsurance	$25 copay	40% coinsurance

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Medical Benefits						
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

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) on the same day, 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.

Medicare-Covered Hearing Exams	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance
Extra Hearing Services	The out-of-network cost shares for the following **Extra Hearing Services** apply to both out of AR and in AR.					
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

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Medical Benefits						
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	

Extra Hearing Services – More Information

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

Medicare-Covered Dental Services	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Extra Dental – Preventive Services	The out-of-network cost shares for the following **Extra Dental – Preventive Services** apply to both out of AR and in AR.					
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	
Extra Dental – Comprehensive Services	The out-of-network cost shares for the following **Extra Dental – Comprehensive Services** apply to both out of AR and in AR.					
Diagnostic services	Not covered		Not covered		Not covered	

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Medical Benefits						
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
Adjunctive general services	Not covered		Not covered		Not covered	
Prosthodontics, removable (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)	$3,000		$3,000		$3,000	

Extra 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						
Medicare-Covered Vision Services						
Medicare-covered diabetic retinopathy screening	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
All other Medicare-covered eye exams	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Medicare-covered eyewear	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 copay	40% coinsurance
Extra Vision Services	The out-of-network cost shares for the following **Extra Vision Services** apply to both out of AR and in AR.					
Routine eye exam (1 per year)	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance
Routine eyewear – contact lenses and eyeglasses (lenses and frames) (unlimited up to the annual allowance) and upgrades (up to the annual allowance)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Routine eyewear annual allowance (combined contact lenses, eyeglasses, and upgrades)	$100		$100		$100	

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Medical Benefits						
Mental Health						
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 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; $218 copay per day for days 21–100	40% coinsurance	$0 copay per day for days 1–20; $218 copay per day for days 21–100	40% coinsurance	$0 copay per day for days 1–20; $218 copay per day for days 21–100	40% coinsurance
Rehabilitation/Therapy Services						
Physical therapy	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance
Occupational therapy	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance
Speech therapy	$35 copay	40% coinsurance	$35 copay	40% coinsurance	$35 copay	40% coinsurance

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Medical Benefits						
Ambulance Services						
Ground ambulance	$325 copay	$325 copay (the out-of-network deductible doesn't apply)	$325 copay	$325 copay (the out-of-network deductible doesn't apply)	$325 copay	$325 copay (the out-of-network deductible doesn't apply)
Air ambulance	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)
Transportation (non-emergency)	Not covered		Not covered		Not covered	

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Medical Benefits						
Medicare Part B Drugs						
Insulin products (e.g., for an insulin pump)	$35 copay	40% coinsurance (the out-of-network deductible doesn't apply)	$35 copay	40% coinsurance (the out-of-network deductible doesn't apply)	$35 copay	40% coinsurance (the out-of-network deductible doesn't apply)
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	$615	$615	$615
Deductible applies to these tiers	Tier 2, Tier 3, Tier 4, and Tier 5	Tier 2, Tier 3, Tier 4, and Tier 5	Tier 2, Tier 3, Tier 4, and Tier 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 out-of-pocket costs (your payments only) reach $2,100. Once you reach this amount, you will enter the Catastrophic Coverage Stage.			

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Prescription Drug Benefits			
Standard Retail Pharmacy Cost Shares	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$5 copay / $12.50 copay	$5 copay / $12.50 copay	$5 copay / $12.50 copay
Tier 2 (Generic)	$12 copay / $30 copay	$12 copay / $30 copay	$12 copay / $30 copay
Tier 3 (Preferred Brand)	20% coinsurance / 20% coinsurance	20% coinsurance / 20% coinsurance	20% coinsurance / 20% coinsurance
Tier 4 (Non-Preferred Drug)	30% coinsurance / 30% coinsurance	30% coinsurance / 30% coinsurance	30% coinsurance / 30% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered	25% coinsurance / Not covered	25% coinsurance / Not covered
Catastrophic Coverage Stage After your yearly out-of-pocket drug costs (your payments only) reach $2,100, 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 be the lesser of a $35 copay or a 20% coinsurance for Tier 3 and 25% coinsurance for Tier 4 and Tier 5 for a 30-day supply.
- The Part D deductible will not apply to any covered insulin products.
- Cost shares for covered ACIP-approved vaccines will be a $0 copay 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, 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, $1.60, or $5.10 copay
  - Brand drugs (on all tiers) – 30-day or 100-day supply: $0, $4.90, or $12.65 copay
  - To see if you qualify for "Extra Help," please call the Social Security Office at **1-800-772-1213** Monday–Friday, 8:00 a.m.–7:00 p.m. TTY users should call **1-800-325-0778**.

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						
Podiatry Services (foot care)						
Medicare-covered services	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 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 (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)
Prosthetics	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)

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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						
Medical supplies	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)	20% coinsurance	20% coinsurance (the out-of-network deductible doesn't apply)
Diabetic Supplies	The out-of-network cost shares for the following **Diabetic Supplies** apply to both out of AR and in AR.					
Testing supplies from our preferred manufacturer Roche (i.e., Accu-Check) - testing supplies from other manufacturers are not covered	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)
Continuous glucose monitors (CGMs) from our preferred brand Dexcom - CGMs from other brands are not covered	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)	$0 copay (at a network pharmacy)	20% coinsurance (the out-of-network deductible doesn't apply)
Diabetic Therapeutic Shoes or Inserts	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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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						
Additional Rehabilitation Services						
Cardiac rehabilitation	$30 copay	40% coinsurance	$30 copay	40% coinsurance	$30 copay	40% coinsurance
Intensive cardiac rehabilitation	$40 copay	40% coinsurance	$40 copay	40% coinsurance	$40 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)	$20 copay	40% coinsurance	$20 copay	40% coinsurance	$20 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

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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)**
Extra Benefits						
OTC You'll be able to get over-the-counter (OTC) items from NationsBenefits with our quarterly OTC benefit. Conveniently shop in-store at a participating retailer, online at **ArkBlueMedicare.NationsBenefits.com**, or through the Benefits Pro™ app using your Benefits Mastercard® Prepaid 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.	$25 (per quarter)		$25 (per quarter)		$25 (per quarter)	
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

	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						
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 (the out-of-network deductible doesn't apply)	$0 copay	40% coinsurance (the out-of-network deductible doesn't apply)	$0 copay	40% coinsurance (the out-of-network deductible doesn't apply)
Worldwide Emergency/Urgent Care Services Up to $15,000 per year combined for emergency and urgently needed services outside the U.S.	20% coinsurance (the out-of-network deductible doesn't apply)		20% coinsurance (the out-of-network deductible doesn't apply)		20% coinsurance (the out-of-network deductible doesn't apply)	

Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers HMO, PFFS, 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 (Drug List) 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, 2027.
- ☐ 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.
- ☐ Effect on current coverage: If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap policy, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.