Healthy Arkansas Preferred (PPO)

Summary of Benefits

January 1, 2027 – December 31, 2027

To be a member of our plan, you must be entitled to Medicare Part A, have Medicare Part B, and reside in our service area. The Service area for Healthy Arkansas Preferred (PPO) includes the following counties: Baxter, Benton, Boone, Carroll, Cleburne, Craighead, Crawford, Faulkner, Fulton, Garland, Grant, Hot Spring, Howard, Independence, Izard, Jefferson, Lawrence, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Newton, Poinsett, Pulaski, Saint Francis, Saline, Searcy, Sebastian, Sharp, Stone, Union, Washington, and White counties.

We're here to help

You may have questions as you read through this document, and that's OK. We are here to help. Please call us at 844-325-0275 (TTY users dial 711), 8:00 am – 8:00 pm CST 7 days a week from October 1 to March 31, and Monday through Friday from April 1 to September 30.

Comparing Coverage

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or you can use the Medicare Plan Finder on www.medicare.gov.

More about Original Medicare
If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare handbook.

View the handbook online at:
www.medicare.gov/medicare-and-you

Get a copy of the handbook by calling:
1-800-MEDICARE (1-800-633-4227),
24 hours a day, 7 days a week. TTY users should call 1-877-486-2048

About the Plan

Which doctors, hospitals, and pharmacies can I use?
The Healthy Arkansas Preferred (PPO) Plan has a network of doctors, hospitals, and other providers. As a PPO plan, you can use providers who are in our network (in-network) or providers who are not in our network (out-of-network). For all Medicare-covered services, you have out-of-network coverage, usually at a higher cost share. Please refer to your *Evidence of Coverage* (EOC) for more detailed information.

Our in-network providers have a tiering system. If you see a Tier 1 provider, you will have the lowest cost sharing. If you see a Tier 2 provider, you will have a higher cost sharing. You can check the tier of a provider on our website at www.healthy-ar.com, or you can call us at 844-325-0275 (TTY users dial 711), 8:00 am – 8:00 pm CST 7 days a week from October 1 to March 31, and Monday through Friday from April 1 to September 30.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

What do we cover?

- We cover all benefits covered by Original Medicare
- We also cover some benefits that Original Medicare does not cover. Some of these benefits are highlighted in this Summary of Benefits. For a complete list, please refer to your EOC.
- You can see the plan's Drug List, which is also called a formulary, which lists the Part D prescription drugs we cover, along with any restrictions on our website at www.healthy-ar.com
- You can also call us for a copy of the Drug List.

This benefit information is a brief summary of your benefits. It does not list every benefit, or every exclusion. To get a complete list, please refer to the EOC on our website at www.healthy-ar.com. You may also call us and ask us to mail you a copy of the EOC.

Benefits - Medical		
	In-network	Out-of-network
Monthly Plan premium	$0 per month You must continue to pay your Medicare Part B premium.	
Part B Premium Reduction (Part B buyback)	$105 per month Our plan will reduce your Medicare Part B Premiums up to $105 a month.	
Medical deductible	This plan has no medical deductible	
Maximum Out-of-pocket responsibility (MOOP)	$6,200. This is the most you will pay for in-network Medicare covered services[1] Combined in-network and out-of-network: $6,200[1] [1]*The MOOP does not apply to non-Medicare covered services.*	
Inpatient hospital – Acute‡	Tier 1: $0 copayment per stay Tier 2: $360 copayment per day, days 1-6; $0 copayment per day, days 7-90	40% coinsurance
Inpatient hospital – Mental health‡	Tier 1: $0 copayment per stay Tier 2: $318 copayment per day, days 1-5; $0 copayment per day, days 6-90	40% coinsurance
Outpatient observation‡	Tier 1: $0 copayment per stay Tier 2: $250 copayment per stay	40% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Outpatient hospital (surgery)‡	Tier 1: $0 copayment per surgery Tier 2: $250 copayment per surgery	40% coinsurance
Ambulatory surgical center (ASC)‡	Tier 1: $0 copayment per surgery Tier 2: $250 copayment per surgery	40% coinsurance
Primary care (PCP)	$0 copayment per visit	$20 copayment per visit
Specialist visit	Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit	$35 copayment per visit
Preventive care (annual wellness visit, breast cancer screening, certain vaccines)	$0 copayment for all Medicare-covered preventive services	
Emergency care	$115 copayment per visit. Copay is waived if admitted within 24 hours	
Urgently needed services	$45 copayment per visit	

Benefits - Medical		
	In-network	Out-of-network
Diagnostic services‡: Diagnostic tests and procedures‡ Lab services‡ Diagnostic radiology (CT, MRI)‡ Therapeutic radiology (radiation)‡ X-ray services‡	**Diagnostic procedures and tests‡:** Tier 1: $0 copayment per visit Tier 2: $50 copayment per visit **Labs‡:** $0 copayment per visit **Diagnostic radiology (CT, MRI):‡** Tier 1: $0 copayment per visit Tier 2: $200 copayment per visit **Therapeutic Radiology (Radiation):‡** Tier 1: $0 copayment per visit Tier 2: $50 copayment per visit **X-rays‡:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit	**Diagnostic procedures and tests‡:** 40% coinsurance **Labs‡:** 40% coinsurance **Diagnostic radiology (CT, MRI):‡** 40% coinsurance **Therapeutic Radiology (Radiation):‡** 40% coinsurance **X-rays‡:** 40% coinsurance
Hearing services: Medicare covered hearing services	**Medicare covered hearing services:** Tier 1: $0 copayment Tier 2: $25 copayment	**Medicare covered hearing services:** $35 copayment

Benefits - Medical		
	In-network	Out-of-network
Hearing services (continued) Non-Medicare covered hearing services: Routine hearing exam Hearing aid fitting/evaluation Prescription hearing aids	**Non-Medicare covered hearing services:** Routine hearing exams: $0 copayment for one exam per year Hearing aid fitting/evaluation: $0 copayment for one fitting/evaluation per year Prescription hearing aids: $0 copayment $1,950 hearing aid allowance, both ears combined, per year. Limited to two aids per year. The allowance is shared between in-network and out-of-network use.	**Non-Medicare covered hearing services:** 50% coinsurance $1,950 hearing aid allowance, both ears combined, per year. Limited to two aids per year. The allowance is shared between in-network and out-of-network use. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs
Dental services: Medicare covered dental services	**Medicare covered Dental services:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit	**Medicare covered Dental services:** $35 copayment per visit

Benefits - Medical		
	In-network	Out-of-network
Dental services (continued) Non-Medicare covered dental services: Routine dental visits Preventive services: Services include routine exams, x-rays, cleanings and fluoride treatment.	**Non-Medicare covered dental services:** $3,000 annual allowance for diagnostic, preventive, and comprehensive dental care. The allowance is shared between in-network and out-of-network use. $0 copayment for covered preventive dental services including: routine exams, x-rays, cleanings, and fluoride treatment until the annual maximum is met. Two visits per year for routine exams and cleanings, one visit per year for x-rays and fluoride treatment.	**Non-Medicare covered dental services:** 50% coinsurance $3,000 annual allowance for diagnostic, preventive, and comprehensive dental care. The allowance is shared between in-network and out-of-network use. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs
Comprehensive services: Services include restorative services, Endodontics, Periodontics, Prosthodontics: removable and fixed, Maxillofacial Prosthetics, Oral and Maxillofacial Surgery, and Adjunctive General Services. Please note Implants and Orthodontics are not covered.	$0 copayment for covered comprehensive dental services until the annual maximum is met.	50% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Vision services Medicare covered vision services	**Medicare covered diabetic retinal exam:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit **Medicare covered glaucoma screening:** $0 copayment **Medicare covered eye exam:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit **Medicare covered eyewear:** $0 copayment for Medicare covered standard frames and lenses after cataract surgery	**Medicare covered diabetic retinal exam:** $35 copayment per visit **Medicare covered glaucoma screening:** $0 copayment **Medicare covered eye exam:** $35 copayment per visit **Medicare covered eyewear:** $0 copayment for Medicare covered standard frames and lenses after cataract surgery

Benefits - Medical		
	In-network	Out-of-network
Non-Medicare covered vision services	**Non-Medicare covered vision services:** Routine Vision: $0 copayment for one routine eye exam per year $300 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one per year; all other categories are unlimited. The allowance is shared between in-network and out-of-network use.	**Non-Medicare covered vision services:** 50% coinsurance $300 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one per year; all other categories are unlimited. The allowance is shared between in-network and out-of-network use. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs

Benefits - Medical		
	In-network	Out-of-network
Outpatient mental health	**Mental health specialty outpatient services[2]:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit **Psychiatric services[2]:** Tier 1: $0 copayment per visit Tier 2: $25 copayment per visit [2] *Includes individual and group therapy sessions*	**Mental health specialty outpatient services[2]:** $25 copayment per visit **Psychiatric services[2]:** $30 copayment per visit [2] *Includes individual and group therapy sessions*
Skilled nursing facility (SNF)‡	Tier 1: $0 copayment per day, days 1-100 Tier 2: $0 copayment per day, days 1-20; $218 copayment per day, days 21-100	40% coinsurance, days 1-100
Diabetic supplies and services‡ Diabetic therapeutic shoes and inserts‡ Diabetic monitors (Continuous Glucose Monitors (CGMs) and Blood Glucose Monitors (BGMs))‡	**Diabetic supplies and services‡:** $0 copayment **Diabetic therapeutic shoes and inserts‡:** 20% coinsurance **Diabetic monitors (CGMs and BGMs) ‡:** 20% coinsurance	
Ambulance services (non-emergent)‡	**Ground and Air ambulance:** $285 copayment, per one-way trip	

Benefits - Medical		
	In-network	Out-of-network
Transportation	$0 per trip Up to 48 one-way trips per year Members can travel up to 75 miles each one-way trip Trip allowance is combined for in-network and out-of-network	50% coinsurance You can submit for reimbursement, less any applicable coinsurance, up 48 one-way trips Trip allowance is combined for in-network and out-of-network
Medicare Part B drugs‡	**Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) ‡:** 0% to 20% coinsurance **Part B insulin‡:** 0% to 20% coinsurance, up to a $35 maximum per one-month supply	**Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) ‡:** 0% to 20% coinsurance **Part B insulin‡:** 0% to 20% coinsurance, up to a $35 maximum per one-month supply
Outpatient rehabilitation including physical therapy, occupational therapy, and speech language therapy (PT, OT, ST)‡	**Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) ‡:** Tier 1: $0 copayment per visit Tier 2: $15 copayment per visit	**Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) ‡:** $30 copayment per visit

Benefits - Medical		
	In-network	Out-of-network
Over-the-counter (OTC)	$45 combined quarterly allowance All members receive this allowance for over-the-counter (OTC) items. It is a shared allowance with SSBCI (Special Supplemental Benefits for the Chronically Ill); members who qualify for SSBCI may also use the same allowance for eligible SSBCI benefits. Please see the SSBCI row in this chart for more details. If a member qualifies, this allowance may be used for both benefits. Unused amounts do not roll over to the next quarter.	50% coinsurance (applies to OTC only; *SSBCI has no out-of-network coverage) You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.
In-home support services	$0 copayment 108 hours per year for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Hours are shared between in-network and out-of-network services.	$0 copayment 108 hours per year for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Hours are shared between in-network and out-of-network services.

Benefits - Medical		
	In-network	Out-of-network
Fitness	$50 monthly allowance Unused amounts do not roll over to the next month. This allowance is combined for in-network and out-of-network services.	50% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.
Bathroom safety devices	$200 maximum allowance per year Unused amounts do not roll over to the next year. This allowance is combined for in-network and out-of-network services.	50% coinsurance $200 maximum allowance per year You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.

Special Supplemental Benefits		
If you are diagnosed with one or more of the chronic conditions listed within our EOC and meet the eligibility criteria, you may be eligible for additional benefits under our plan. Enrollment in our plan does not guarantee eligibility.		
	In-network	Out-of-network
SSBCI – Special Supplemental Benefits for the Chronically Ill† The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. The top five eligible chronic conditions include: Cardiovascular Disease, Chronic Kidney Disease, Diabetes, Chronic lung disorders, and Overweight, Obesity, and Metabolic Disorder. There are other chronic conditions eligible for this benefit. Please see your EOC for detailed information. To be eligible, members must have one or more qualifying chronic conditions, be at high risk of hospitalization or other adverse health outcomes and require intensive care coordination.	$45 combined quarterly allowance This is the same shared allowance described in the Over-the-counter (OTC) row. If you qualify, you may use this allowance for your SSBCI benefits, your OTC benefit, or both. SSBCI benefits include: Groceries (food and produce) General supports for living (utilities, rent, and mortgage assistance) Unused amounts do not roll over to the next quarter. †**Member must qualify to receive this benefit. Please refer to your *Evidence of Coverage* for more detailed information.**	Not covered

‡**Services marked with a double dagger (‡), may require prior authorization and is the responsibility of your provider**

<table>
<tr><th colspan="2">Prescription drug benefits</th></tr>
<tr><td>Deductible</td><td>Prescription drug deductible: You do not have a deductible</td></tr>
<tr><td>Initial coverage</td><td>In this stage, you pay the following until your yearly out-of-pocket costs reach $2,400.
You won’t pay more than $35 for a one-month supply of insulin at non-preferred pharmacies. You won’t pay more than $0 for a one-month supply of insulin at preferred pharmacies.

<table>
<tr><th colspan="5">Retail and Mail order cost sharing</th></tr>
<tr><th>Tier</th><th>Preferred 30 days</th><th>Non-preferred[§] 30 days</th><th>Preferred 100 days</th><th>Non-preferred[§] 100 days</th></tr>
<tr><td>Tier 1 - Preferred Generic</td><td>$0 copayment</td><td>$0 copayment</td><td>$0 copayment</td><td>$0 copayment</td></tr>
<tr><td>Tier 2 - Generic</td><td>$0 copayment</td><td>$0 copayment</td><td>$0 copayment</td><td>$0 copayment</td></tr>
<tr><td>Tier 3 - Preferred Brand</td><td>$0 copayment</td><td>$47 copayment</td><td>$0 copayment</td><td>$141 copayment</td></tr>
<tr><td>Tier 4 - Non-preferred Drug</td><td>$0 copayment</td><td>$100 copayment</td><td>$0 copayment</td><td>$300 copayment</td></tr>
<tr><td>Tier 5 - Specialty</td><td>28% coinsurance</td><td>28% coinsurance</td><td>Tier 5 is only covered up to a 30-day supply</td><td>Tier 5 is only covered up to a 30-day supply</td></tr>
</table>

[§]Out-of-network and Long-term care pharmacies follow non-preferred pharmacy copayments/coinsurance.</td></tr>
<tr><td>Catastrophic coverage</td><td>After your yearly out-of-pocket costs reach $2,400, the plan pays the full costs of your Part D drugs, and you pay nothing.</td></tr>
</table>

Healthy Arkansas Preferred (PPO) is a Medicare Advantage PPO with a Medicare Contract. Enrollment in Healthy Arkansas Preferred (PPO) Plan depends on contract renewal.

Benefits, features, and/or devices vary by plan/service area. Limitations, exclusions, and restrictions may apply. Contact the plan for more information. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

This information is not a complete description of benefits. Please see the EOC for a complete description of benefits, exclusions, limitations, and conditions of coverage.

The formulary, pharmacy network, and/or provider network can change at any time. You will receive notice when necessary.

Healthy Arkansas, Inc.'s pharmacy network includes limited lower-cost, preferred pharmacies in our service area, including in suburban and rural counties across Arkansas. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 844-325-0275, and TTY 711 or consult the online pharmacy directory at www.healthy-ar.com.

Out-of-network/non-contracted providers are under no obligation to treat Healthy Arkansas, Inc. members, except in emergency situations. Please call our Member Services number or see your EOC for more information.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.