Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2027 Summary of Benefits

BlueMedicare Preferred (PFFS) H4213-020

This Summary of Benefits

This is a summary of the benefits for:

- BlueMedicare Preferred (PFFS)

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) includes the following Arkansas counties: Baxter, Benton, Boone, Carroll, Clark, Cleburne, Conway, Craighead, Crawford, Faulkner, Franklin, Fulton, Garland, Greene, Hot Spring, Izard, Jefferson, Johnson, Logan, Lonoke, Madison, Marion, Newton, Ouachita, Perry, Poinsett, Polk, Pope, Pulaski, Saline, Scott, Searcy, Sebastian, St. Francis, Van Buren, Washington, White, Woodruff, and Yell.

BlueMedicare Preferred (PFFS) Is a PFFS Plan

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 this plan, call us at **1-844-463-1088** (TTY: **711**). If you're not a member of this plan, 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) H4213-020
Monthly Premium, Deductible, and Limits	
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	$78
Medical Deductible	$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

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) H4213-020**	
	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 after deductible
Outpatient Hospital		
Outpatient surgery/non-surgery	$340 copay	40% coinsurance after deductible
Outpatient observation	$340 copay	40% coinsurance after deductible
Ambulatory Surgical Center (ASC) Services	$340 copay	40% coinsurance after deductible
Doctor Visits		
Primary care provider (PCP)	$10 copay	40% coinsurance after deductible
Specialist	$40 copay	40% coinsurance after deductible
Preventive Care	$0 copay	40% coinsurance (deductible doesn't apply)

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
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.		
Emergency Room (ER)	$115 copay (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 (deductible doesn't apply)	

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
Diagnostic Services/Labs/Imaging		
Diagnostic test – spirometry	0% coinsurance	40% coinsurance after deductible
Diagnostic test – home-based sleep study	20% coinsurance	40% coinsurance after deductible
All other diagnostic tests and procedures	20% coinsurance	40% coinsurance after deductible
Lab services – genetic testing	20% coinsurance	40% coinsurance (deductible doesn't apply)
All other lab services (except genetic testing)	0% coinsurance	40% coinsurance (deductible doesn't apply)
Radiology – diagnostic mammogram	$25 copay	40% coinsurance after deductible
Radiology – ultrasound	$25 copay	40% coinsurance after deductible
All other diagnostic radiology services	$340 copay	40% coinsurance after deductible
Radiation therapy	20% coinsurance	40% coinsurance after deductible

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
X-rays	20% coinsurance	40% coinsurance after deductible

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	$30 copay	40% coinsurance after deductible
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 (deductible doesn't apply)
Hearing aid fittings/evaluation (1 year of follow-up visits with hearing aid purchase)	$0 copay	$0 copay (deductible doesn't apply)
Hearing aids (Advanced / Premium – up to 2 hearing aids per year, 1 per ear)	$699 / $999 copay per hearing aid (deductible doesn't apply)	

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
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 after deductible
Extra Dental – Diagnostic/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 (2 per calendar year)	$0 copay	50% coinsurance (deductible doesn't apply)
Cleanings (2 per calendar year)	$0 copay	50% coinsurance (deductible doesn't apply)
X-rays (1 per calendar year to every 3 calendar years depending on the X-ray type)	$0 copay	50% coinsurance (deductible doesn't apply)
Fluoride treatments	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.	
Restorative services (1 per calendar year)	20% coinsurance	50% coinsurance (deductible doesn't apply)

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
Endodontics	Not covered	
Periodontics (2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance (deductible doesn't apply)
Extractions (unlimited per calendar year)	20% coinsurance	50% coinsurance (deductible doesn't apply)
Adjunctive general services	Not covered	
Prosthodontics, removable (2 per calendar year to every 3 calendar years depending on the service)	20% coinsurance	50% coinsurance (deductible doesn't apply)
Dental annual maximum coverage amount applies to comprehensive services only, in-network and out-of-network. Preventive dental services (oral exams and cleanings) do not count toward the annual dental maximum.	$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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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
Medicare-Covered Vision Services		
Medicare-covered diabetic retinopathy screening	$0 copay	40% coinsurance after deductible
All other Medicare-covered eye exams	$40 copay	40% coinsurance after deductible
Medicare-covered eyewear	$40 copay	40% coinsurance after deductible
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 (deductible doesn't apply)
Routine eyewear – contact lenses, eyeglasses (lenses and frames), and upgrades (unlimited up to the annual allowance)	$0 copay	$0 copay (deductible doesn't apply)
Routine eyewear annual allowance (combined for contact lenses, eyeglasses, and upgrades)	$100	

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
Mental Health		
Inpatient hospital	$390 copay per day for days 1–5; $0 copay per day for days 6–90	40% coinsurance after deductible
Outpatient mental health specialty and psychiatric visits (individual and group therapy sessions)	$35 copay	40% coinsurance after deductible
Skilled Nursing Facility (SNF) Services	$0 copay per day for days 1–20; $221 copay per day for days 21–100	40% coinsurance after deductible
Rehabilitation/Therapy Services		
Physical therapy	$35 copay	40% coinsurance after deductible
Occupational therapy	$35 copay	40% coinsurance after deductible
Speech therapy	$35 copay	40% coinsurance after deductible
Ambulance Services		
Ground ambulance	$325 copay	$325 copay (deductible doesn't apply)
Air ambulance	20% coinsurance	20% coinsurance (deductible doesn't apply)

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Medical Benefits		
Transportation (non-emergency)	Not covered	
Medicare Part B Drugs		
Insulin products (e.g., for an insulin pump)	$35 copay	40% coinsurance (deductible doesn't apply)
Chemotherapy/Radiation drugs	0%–20% coinsurance	40% coinsurance after deductible
Other Part B drugs	0%–20% coinsurance	40% coinsurance after deductible

	BlueMedicare Preferred (PFFS) H4213-020
Medical 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	$700
Deductible applies to these tiers	Tier 2, Tier 3, Tier 4, and Tier 5
Initial Coverage Stage During this stage, your 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 reach $2,400. Once you reach this amount, you will enter the Catastrophic Coverage Stage.	

	BlueMedicare Preferred (PFFS) H4213-020
Medical Benefits	
Standard Retail Pharmacy Cost Shares	**30-Day / 100-Day Supply**
Tier 1 (Preferred Generic)	$7 copay / $21 copay
Tier 2 (Generic)	$12 copay / $36 copay
Tier 3 (Preferred Brand)	20% coinsurance / 20% coinsurance
Tier 4 (Non-Preferred Drug)	41% coinsurance / 41% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance / Not covered
Mail-Order Pharmacy Cost Shares	**100-Day Supply Only**
Tier 1 (Preferred Generic)	$14 copay
Tier 2 (Generic)	$24 copay
Tier 3 (Preferred Brand)	20% coinsurance
Tier 4 (Non-Preferred Drug)	41% coinsurance
Tier 5 (Specialty Tier)	Not covered

	BlueMedicare Preferred (PFFS) H4213-020
Medical Benefits	
Catastrophic Coverage Stage After your yearly out-of-pocket drug costs reach $2,400, you will enter the Catastrophic Coverage Stage.	You will have no cost sharing for the rest of the plan year.

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, 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, $1.65, or $5.80 copay
  - Brand drugs (on all tiers) – 30-day or 100-day supply: $0, $5, or $14.40 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**.

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	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 after deductible
Routine services	Not covered	
Medicare-Covered Chiropractic Services	$15 copay	40% coinsurance after deductible
Medical Equipment and Supplies		
Durable medical equipment (DME)	20% coinsurance	20% coinsurance (deductible doesn't apply)
Prosthetics	20% coinsurance	20% coinsurance (deductible doesn't apply)
Medical supplies	20% coinsurance	20% coinsurance (deductible doesn't apply)

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	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Additional Medical Benefits		
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	20% coinsurance (deductible doesn't apply)
Diabetic Therapeutic Shoes/Inserts	20% coinsurance	20% coinsurance after deductible
Diabetic Monitors	The out-of-network cost shares for the following **Diabetic Monitors** apply to both out of AR and in AR.	
Continuous glucose monitors (CGMs) from our preferred brand, Dexcom - CGMs from other brands are not covered.	$0 copay	20% coinsurance (deductible doesn't apply)

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	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 after deductible
Intensive cardiac rehabilitation	$40 copay	40% coinsurance after deductible
Pulmonary rehabilitation	$25 copay	40% coinsurance after deductible
Supervised exercise therapy for peripheral artery disease (PAD)	$20 copay	40% coinsurance after deductible
Telehealth		
PCP, specialist, urgently needed, and outpatient mental health (individual and group therapy sessions) services	$0 copay	Not covered

	BlueMedicare Preferred (PFFS) H4213-020	
	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)	
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	Participating SilverSneakers facilities only
24-Hour Nurse Advice Line	$0 copay	Only the in-network benefit can be used.

	BlueMedicare Preferred (PFFS) H4213-020	
	In-Network or Out-of-Network (out of AR)	**Out-of-Network (in AR)**
Extra Benefits		
Additional Physical Exam This is in addition to the Medicare-covered Annual Wellness Visit.	$0 copay	40% coinsurance (deductible doesn't apply)
Worldwide Emergency/Urgent Care Services Up to $50,000 per year combined for emergency and urgently needed services outside the U.S.	20% coinsurance (deductible doesn't apply)	

Arkansas Blue Medicare offers HMO, PFFS, and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal. USAble Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association. Arkansas Blue Medicare is the marketing name for USAble HMO, Inc. USAble HMO, Inc. is an affiliate of Arkansas Blue Cross. © 2026 Arkansas Blue Cross and Blue Shield. All rights reserved.

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**). October 1 through March 31, our hours are 8:00 a.m. to 8:00 p.m. Central, seven days a week. April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. Central, Monday through Friday.

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, 2028.
- ☐ 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 Medicare Supplement (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.