2027 Summary of Benefits

Secure Blue℠ Courage (PPO)

H1302-004-000
January 1, 2027 – December 31, 2027

Blue Cross of Idaho Health Service, Inc. is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in Blue Cross of Idaho Health Service, Inc. depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-888-494-2583 (TTY: 711) and request the "Evidence of Coverage" or access it online at ***bcidaho.com/PPOMemberResources.***

To join Secure Blue℠ Courage (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties in Idaho: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Canyon, Cassia, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Madison, Minidoka, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley, and Washington.

You can use out-of-network providers in emergency situations for the same copay as in-network providers. For all other care, services from out-of-network providers may lead to higher copays and/or coinsurance on the full cost of services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at ***medicare.gov*** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print or audio.

Free language interpreter services are available for non-English speakers.

For more information, please call customer service at: 1-888-494-2583 (TTY: 711)

8 a.m. – 8 p.m.
Oct. – Mar.: seven days a week
Apr. – Sept.: Mon. – Fri.

Or please visit us at ***medicare.bcidaho.com***.

	IN-NETWORK	OUT-OF-NETWORK
Monthly Plan Premium You must continue to pay your Medicare Part B premium	$0: you pay nothing	
Part B Premium Buydown	$45	
Medical Deductible This plan does not have a medical deductible	$0: you pay nothing	
Maximum Out-of-Pocket Responsibility The most you pay for covered Part A and Part B medical services. Doesn't include monthly premium.	$5,200 in-network	$7,000 combined in- and out-of-network
Inpatient Hospital Coverage[◊†]	$350 daily: days 1 - 5; $0 daily: days 6 - 90	$350: days 1 - 10; $0: days 11 - 90
Outpatient Hospital[◊†]	$325 copay; $0 diagnostic colonoscopy	20% of cost
Observation Coverage[◊†]	$325 copay	20% of cost
Ambulatory Surgery Center[◊†]	$225 copay; $0 diagnostic colonoscopy	20% of cost
Doctor Visits Primary care	$0: you pay nothing	$45 copay
Specialists[†]	$40 copay	$45 copay
Preventive Care	$0: you pay nothing	
Emergency Care Copay waived if admitted to the hospital within 24 hours	$130 copay	
Urgent Care	$50 copay	
Worldwide Emergency and Urgent Coverage	$0 emergency room care copay; $0 urgent care copay; $0 ambulance	
Diagnostic Tests and Procedures[†]	$30 copay; 10% of cost for sleep studies	25% of cost
Lab Services[◊†]	$0: you pay nothing	25% of cost
Diagnostic Radiology (MRI, CT, PET)[◊†]	$200 copay in hospital; $100 copay non-hospital; $0 diagnostic mammogram	25% of cost
X-rays[◊†]	$15 copay	25% of cost
Medicare-Covered Hearing Services[†]	$20 copay	$45 copay
TruHearing® Hearing Exam Benefit is one exam per year	$0: you pay nothing	90% of cost

[◊]Your provider may need to obtain prior authorization.
[†]This service may require a referral from your primary care physician (PCP).

	IN-NETWORK	OUT-OF-NETWORK
TruHearing® Hearing Aids Benefit is two per year (one per ear per year)	$499 copay per Standard aid; $699 copay per Advanced aid; $999 copay per Premium aid Benefit is limited to the TruHearing Standard, Advanced, and Premium hearing aids Optional $50 additional cost per rechargeable aid on select models. First year of follow-up provider visits for fitting/evaluation of hearing aid and adjustments are covered.	90% of cost from providers whose primary business is hearing care services after $1,000 out-of-network hearing aid deductible
Medicare-Covered Dental Services	10% of cost	25% of cost
Preventive Dental	$0 copay per visit • Two routine preventive exams per year • Two cleanings per year • One emergency exam per year • One bitewing and fluoride application per year • One full mouth X-ray every three years	50% of cost after $100 combined preventive and comprehensive out-of-network dental deductible
	$500 combined in- and out-of-network preventive dental coverage limit	

	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Dental[◊]	$0 copay per visit; • Fillings once per tooth every two years and simple extractions • Scaling, root planing once per quadrant every two years • Full mouth debridement once every three years • Periodontal maintenance up to four visits per year 50% of cost; • Crowns: once per tooth every seven years, one tooth per year • Root canals: one per tooth per lifetime • Implants once per tooth every seven years • Bridge/bridge repairs: once per tooth every seven years • Dentures one set every seven years	50% of cost after $100 combined preventive and comprehensive out-of-network dental deductible
	$1,500 combined in- and out-of-network comprehensive dental coverage limit	
Medicare-Covered Eye Exam[◊†] Diagnosis and treatment of medical eye diseases and conditions	$0: you pay nothing	$0: you pay nothing
VSP® Vision Exam Benefit is for one per year	$20 copay	50% of cost

[◊]Your provider may need to obtain prior authorization.
[†]This service may require a referral from your primary care physician (PCP).

	IN-NETWORK	OUT-OF-NETWORK
VSP® Eyewear Benefit is for every two years	$35 copay for one pair of glasses (frames in the VSP Genesis Collection); $50 allowance for non-Genesis frames $35 copay for medically necessary contacts $100 allowance towards contacts in lieu of glasses	$50 frame allowance 50% of cost for single vision lenses 50% of cost for Standard Progressive lenses, UV Coating, and Scratch Resistance Coating $100 allowance towards contacts in lieu of glasses $35 copay for medically necessary contacts
Inpatient Mental Health Care◊†	$350 daily: days 1 - 5; $0 daily: days 6 - 90	$350 daily: days 1 - 10; $0 daily: days 11 - 90
Outpatient Mental Health Care† Individual and Group therapy	$0: you pay nothing	25% of cost
Skilled Nursing Facility (SNF)◊†	$0 daily: days 1 - 20; $221 daily: days 21 - 55; $0 daily: days 56 - 100	$100 daily: days 1 - 12; $221 daily: days 13 - 100
Occupational Therapy†	$40 copay	$45 copay
Physical and Speech Therapy†	$40 copay	$45 copay
Ground Ambulance◊	$275 copay	$275 copay
Air Ambulance◊	$275 copay	$275 copay
Transportation	Not covered	Not covered
Medicare Part B Prescription Drugs◊** (i.e., chemotherapy, hospital-administered infusions) Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost	30% of cost
Part B Insulin Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost; $35 maximum per month	30% of cost; $35 maximum per month

◊Your provider may need to obtain prior authorization.
†This service may require a referral from your primary care physician (PCP).
**Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Annual Physical Exam	$0: you pay nothing	25% of cost
Additional Telehealth Services†	Follows your in-network copay for participating providers	Not covered
Durable Medical Equipment◊	20% of cost	30% of cost
Prosthetic Medical Devices◊	20% of cost	30% of cost
Diabetic Shoes and Inserts	20% of cost	30% of cost
Diabetic Supplies Glucose monitors, test strips, and lancets	$0: you pay nothing	30% of cost
Silver&Fit® Membership	$0: you pay nothing for gym memberships at participating Silver&Fit® locations	90% of cost at a gym whose primary function is fitness services after $600 out-of-network fitness deductible

†This service may require a referral from your primary care physician (PCP).
◊Your provider may need to obtain prior authorization.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***https://www.hhs.gov/ocr/complaints/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-800-627-1188 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimbauvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188（TTY：711）.

Farsi: توجه: اگر به زبان فارسی صحبت می کن د، خدمات را گان پشت بانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्तर्ि भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-627-1188 (टटिवाइ: 711)।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

For more information, call **1-888-492-2583 (TTY: 711)**.

8 a.m. to 6 p.m, Monday - Friday

Blue Cross of Idaho Health Service, Inc. is a PPO Medicare Advantage plan with a Medicare contract. Enrollment in Blue Cross of Idaho Health Service, Inc. depends on contract renewal.

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On behalf of Blue Cross of Idaho Health Service, Inc., TruHearing, VSP Vision Care, and American Specialty Health, independent companies, administer supplemental benefit programs. VSP Vision Care administers the vision program, TruHearing administers the hearing aid coverage program, and American Specialty Health administers the fitness program to Medicare Advantage plan members.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross of Idaho Health Service, Inc. Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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