2027 Summary of Benefits

True Blue® Rx 36 (HMO)

H1350-036-000
January 1, 2027 – December 31, 2027

Blue Cross of Idaho Health Service, Inc. is a Medicare Advantage HMO 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/HMOMemberResources***.

To join True Blue® Rx 36 (HMO), 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: Kootenai.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these 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***.

Monthly Plan Premium You must continue to pay your Medicare Part B premium	You pay $79
Medical Deductible Medical deductible only applies to some services. For those services, you pay 100% of the cost up to the deductible, then your plan begins to help pay. Other services are covered before you meet your deductible; however, you may still be responsible for a copayment or coinsurance. The Summary of Benefits only lists some common services. For a complete list of services and if they apply to the deductible, refer to the plan's Evidence of Coverage (EOC).	$900 deductible **See below for services where medical deductible applies**
Maximum Out-of-Pocket Responsibility The most you pay for covered Part A and Part B medical services. Doesn't include Part D services or monthly premium.	$5,900
Inpatient Hospital Coverage◊†	$425 daily: days 1 - 5; $0 daily: days 6 - 90
Outpatient Hospital◊†	$500 copay; 20% of cost for orthopedic surgery; $0 diagnostic colonoscopy **Medical deductible applies**
Observation Coverage◊†	$500 copay **Medical deductible applies**
Ambulatory Surgery Center◊†	$250 copay; 20% of cost for orthopedic surgery; $0 diagnostic colonoscopy **Medical deductible applies**
Doctor Visits Primary Care	$0: you pay nothing
Specialists†	$40 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

◊Your provider may need to obtain prior authorization.
†This service may require a referral from your primary care physician (PCP).
*Emergency care or urgently needed services that you get from an out-of-network provider are covered. Your cost is the same as in-network.

Worldwide Emergency and Urgent Coverage	$0 copay for emergency room and urgent care; $0 copay for ambulance **Medical deductible applies**
Diagnostic Tests and Procedures†	$35 copay **Medical deductible applies**
Lab Services◊†	$0: you pay nothing
Diagnostic Radiology (MRI, CT, PET)◊†	$340 copay in a hospital-based facility; $170 copay in a non-hospital-based facility; $0 copay diagnostic mammogram **Medical deductible applies**
X-rays◊†	$25 copay
Medicare-Covered Hearing Services†	$20 copay
TruHearing® Hearing Exam Benefit is once per year	$0: you pay nothing
TruHearing® Hearing Aids Benefit is up to 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 TruHearing® branded 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.
Medicare-Covered Dental Services	$40 copay
Preventive Dental	$0: you pay nothing • Two routine preventive exams per year • Two cleanings per year • One annual emergency exam per year • One bitewing and fluoride application per year • One full mouth X-ray every three years

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

Optional Supplemental Dental Plan◊ **True Dental Enhanced**	**True Dental Enhanced: $26.10 premium** • $1,000 coverage limit • $50 deductible • Six-month waiting period **Basic:** fillings and simple extractions 20% of cost after deductible • Same tooth surface restoration covered once in a two-year period • Scaling and root planing once per quadrant every two years; periodontal maintenance not to exceed four visits per year • Full mouth debridement once every three years **Major:** crowns, root canals and bridge repairs 50% of cost after deductible • Crowns, bridge and bridge repairs once per tooth every seven years • Root canals one per tooth per lifetime
Medicare-Covered Eye Exam◊† Diagnosis and treatment of medical eye diseases and conditions	$0: you pay nothing
VSP® Vision Exam Benefit is once per year	$0: you pay nothing
VSP® Eyewear Benefit is once every two years	$35 copay for one pair of glasses (lenses and frames in the VSP Genesis Collection); $50 allowance for non-Genesis frames $35 copay for medically necessary contacts $100 allowance for elective contacts in lieu of glasses
Inpatient Mental Health Care◊†	$425 daily: days 1 - 5; $0 daily: days 6 - 90
Outpatient Mental Health Care† Individual and Group therapy	$35 copay
Skilled Nursing Facility (SNF)◊†	$0 daily: days 1 - 20; $221 daily: days 21 - 55; $0 daily: days 56 - 100
Occupational Therapy†	$40 copay
Physical and Speech Therapy†	$40 copay
Ground Ambulance◊	$320 copay
Air Ambulance◊	$500 copay

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

Transportation	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 **Medical deductible applies**
Part B Insulin Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost; $35 maximum per month

◊Your provider may need to obtain prior authorization.
**Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

Medicare Part D: Prescription Drugs

Costs may vary based on pharmacy type (standard, preferred, mail-order). Your provider may need to get prior authorization.

ANNUAL DEDUCTIBLE

You are responsible for the full cost of your prescription drugs until you meet the deductible first.

Drug tiers group your prescription drugs into levels that determine your share of the cost	
Tier 1 Part D	$0: you pay nothing
Tier 2 Part D	
Tier 3 Part D	$205 per year for prescriptions
Tier 4 Part D	
Tier 5 Part D	

INITIAL COVERAGE PERIOD

After you meet the deductible, you are then responsible for a limited copay or coinsurance. You pay a small amount until you reach $2,400 in total out-of-pocket drug costs. You can save by visiting a preferred retail pharmacy or using mail order. See the chart below for the cost share amounts per month.

	Preferred retail cost: 30-day supply	Standard retail cost: 30-day supply	Standard mail-order** cost: 30-day supply
Tier 1: Preferred Generic Up to 100-day supply	$0 copay		
Tier 2: Generic Up to 100-day supply	$4 copay	$15 copay	$4 copay
Tier 3: Preferred Brand	22% of cost; $35 copay for insulin		
Tier 4: Non-Preferred Drug	26% of cost; $35 copay for insulin		
Tier 5: Specialty Tier Only available in 30-day supply	31% of cost		

CATASTROPHIC

After you reach $2,400 in out-of-pocket costs, you pay nothing for Part D drugs.

Wondering what your prescriptions will cost? Scan this code with your phone's camera to visit ***bcidaho.com/FindAPharmacy***. Enter your prescriptions to check coverage and tiers, or see if your local pharmacy is covered or considered preferred in order to save money.

Part D drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

**See next page for mail-order options

WHAT IF MY DRUG ISN'T COVERED

If your medication is not covered, you still have options. Your provider may:

- Request a coverage determination
- Prescribe a lower-cost alternative

Visit ***bcidaho.com/pharmacy*** or call 1-855-479-3661 (TTY: 711) for help with next steps.

MEDICARE PRESCRIPTION PAYMENT PLAN

You may be eligible for this voluntary payment option to help you manage your drug costs by spreading them across the calendar year. This program may help you manage your expenses, but it doesn't save you money or lower your drug costs. Visit ***bcidaho.com/pharmacy*** or call 1-855-479-3661 to help you determine if this program is right for you.

MAIL ORDER

**You have choices when it comes to getting your medicines from a mail-order pharmacy.

CarelonRx Pharmacy; Have your provider send your prescription to CarelonRx Pharmacy, or you can set up mail order by logging in to your member account at ***members.bcidaho.com/pharmacy***. Contact CarelonRx Pharmacy at 1-833-396-0309 (TTY: 711) if you need help or have questions.

Amazon Pharmacy; Your provider can send your prescription directly to Amazon Pharmacy, or you can transfer existing prescriptions online. To sign up for an Amazon Pharmacy account visit ***pharmacy.amazon.com***. You will need an Amazon account but do not need an Amazon Prime account. For questions about setting up an account, call 1-855-745-5725 or visit ***amazon.com***.

Additional Benefits

Annual Physical Exam	$0: you pay nothing
Additional Telehealth Services†	Follows your in-office copay for in-network participating providers.
Durable Medical Equipment◊	20% of cost
Prosthetic Medical Devices◊	20% of cost
Diabetic Shoes and Inserts	20% of cost
Diabetic Supplies & Monitors	$0: you pay nothing
Silver&Fit® Membership	$0: you pay nothing for gym memberships at participating Silver&Fit® locations $0: you pay nothing for one Home Fitness Kit
Convenience Care◊ Allowance outside of the Blue Cross of Idaho service area but inside the United States	$2,500 per year **Medical deductible applies**

†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 an HMO 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., American Specialty Health, Inc., TruHearing and VSP Vision Care, independent companies, administer supplemental benefit programs. American Specialty Health, Inc. administers the fitness program, TruHearing administers the hearing aid coverage program and VSP Vision Care administers the vision program to Medicare Advantage plan members.

Amazon Pharmacy is an independent company that contracts with Blue Cross of Idaho Rx's pharmacy benefits manager to offer online pharmacy services. Amazon Pharmacy is solely responsible for its services. Blue Cross of Idaho Rx is not responsible for the provision of, or failure to provide, any services offered by Amazon Pharmacy.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross of Idaho Health Service, Inc. True Blue 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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Form No. 16-2009-R (09-26)

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