

2026 Summary of Benefits

True Blue® Rx 37 (HMO)

H1350-037-000

January 1, 2026 – December 31, 2026

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 1-888-492-2583 (TTY: 711) and request the "Evidence of Coverage" or access it online at ***[bcidaho.com/HMOMemberResources](https://www.bcidaho.com/HMOMemberResources)***.

To join True Blue® Rx 37 (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: Bannock, Bingham, Bonner, Cassia, Elmore, Fremont, Gooding, Jerome, Madison, Minidoka, Power, Shoshone, Valley, Washington.

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](https://www.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](https://www.medicare.bcidaho.com).

Monthly Plan Premium You must continue to pay your Medicare Part B premium	You pay \$153
Medical Deductible[§] The set amount you pay towards certain services before Blue Cross of Idaho helps pay for medical costs. Not all services apply to the medical deductible.	\$900 deductible The deductible applies to these common services: • Outpatient Hospital Surgery • Diagnostic Tests & Radiology (MRI, CT, PET) • Part B Prescription Drugs The deductible <u>does not</u> apply for these common services: • Inpatient Hospital • Doctor Visits (PCP and Specialists) • X-ray/Lab • Physical Therapy • Durable Medical Equipment This is not an inclusive list; for a full list of services see your plan Evidence of Coverage (EOC).
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: 1 - 5 days; \$0 daily: 6 - 90 days
Outpatient Hospital^{°†}	\$500 copay; 20% of cost for orthopedic surgery; \$0 diagnostic colonoscopy
Observation Coverage^{°†}	\$500 copay
Ambulatory Surgery Center^{°†}	\$250 copay; 20% of cost for orthopedic surgery \$0 diagnostic colonoscopy
Doctor Visits Primary Care	\$0: you pay nothing
Specialists[†]	\$40 copay
Preventive Care	\$0: you pay nothing

[§]See the plan Evidence of Coverage (EOC) for the full list of services that apply.

[°]Your provider may need to obtain prior authorization.

[†]This service may require a referral from your primary care physician (PCP).

Emergency Care* Copay waived if admitted to the hospital within 24 hours	\$130 copay
Urgent Care*	\$50 copay
Worldwide Emergency and Urgent Coverage	\$0 copay emergency/urgent/ambulance
Diagnostic Tests and Procedures[†]	\$35 copay
Lab Services[‡]	\$0: you pay nothing
Diagnostic Radiology (MRI, CT, PET)[‡]	\$350 copay in a hospital-based facility; \$175 copay in a non-hospital-based facility; \$0 copay diagnostic mammogram
X-rays[‡]	\$25 copay
Medicare-Covered Hearing Services[†]	\$20 copay
TruHearing® Hearing Exam	\$0: you pay nothing for one exam per year
TruHearing® Hearing Aids	Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to the TruHearing Standard, Advanced and Premium hearing aids with an 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. Standard \$499 copay; Advanced \$699 copay; Premium \$999 copay
Medicare-Covered Dental Services	\$40 copay
Preventive Dental	\$0 copay per visit; • 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

*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.

[†]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 premium • \$1,000 benefit maximum • \$50 deductible • Six-month waiting period Basic: fillings and simple extractions • In-network: 20% of cost after deductible • Out-of-network: 50% 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 • In-network: 50% • Out-of-network: 50% • 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	\$0: you pay nothing; benefit is once per year
VSP[®] Eyewear	\$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 Benefit is for every two years.
Inpatient Mental Health Care^{◊†}	\$425 daily: 1 - 5 days; \$0 daily: 6 - 90 days
Outpatient Mental Health Care[†] Individual and Group therapy	\$35 copay

[◊]Your provider may need to obtain prior authorization.

[†]This service may require a referral from your primary care physician (PCP).

Skilled Nursing Facility (SNF)[†]	\$0 daily: 1 - 20 days; \$218 daily: 21 - 55 days; \$0 daily: 56 - 100 days
Occupational Therapy[†]	\$40 copay
Physical and Speech Therapy[†]	\$40 copay
Ambulance[‡] Ground or air transport Your provider must obtain prior authorization for non-emergency transportation	\$320 copay
Transportation	Not covered
Medicare Part B Prescription Drugs^{‡**} (i.e., chemotherapy, hospital-administered infusions).	0%-20% of the cost. The minimum coinsurance is set at 0% to reflect the lowest possible coinsurance for a Part B rebatable drug.
Part B Insulin	\$35 maximum for insulin 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.

Medicare Part D: Prescription Drugs

Costs may differ based on pharmacy type (standard, preferred, mail-order).

Your provider may need to obtain prior authorization.

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

Annual Deductible

You are responsible for the cost of your prescription drugs until you have met the deductible.

Tiers 1-2 Part D Prescription Drug Deductible; \$0: you pay nothing.

Tiers 3-5 Part D Prescription Drug Deductible; \$150 per year for prescriptions.

Initial Coverage Period

You are responsible for a limited copay or coinsurance. You pay a small amount until you reach \$2,100 in total drug costs. See chart below for exact amounts.

	Part D preferred retail cost:	Part D standard retail cost:	Part D standard mail-order cost:**
Tier 1: Preferred Generic Up to 100-day supply	\$0 copay	\$0 copay	\$0 copay
Tier 2: Generic Up to 30-day supply	\$7 copay	\$15 copay	\$7 copay
Tier 3: Preferred Brand Up to 30-day supply	\$40 copay \$35 copay for insulin	\$47 copay \$35 copay for insulin	\$40 copay \$35 copay for insulin
Tier 4: Non-Preferred Drug Up to 30-day supply	25% of cost \$35 copay for insulin	25% of cost \$35 copay for insulin	25% of cost \$35 copay for insulin
Tier 5: Specialty Tier Up to 30-day supply	28% of cost	28% of cost	28% of cost

Catastrophic Coverage

After you reach \$2,100 in true out-of-pocket costs, you pay nothing for Part D drugs.

You may be eligible for the Medicare Prescription Payment Plan, a 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.

**You have multiple options to fill your drugs using 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 portal at members.bcidaho.com/pharmacy. Contact CarelonRx Pharmacy at 833-396-0309 (TTY: 711) for any additional help or 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 additional questions about setting up an account, call 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	\$0: you pay nothing
Silver&Fit[®] Membership	\$0: you pay nothing for gym memberships at participating locations, on-demand workout videos, and 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

[†]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 مجاناً اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga 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 दनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नम्र्ति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटीवाइ: 711) ।

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For more information, call **1-888-492-2583 (TTY: 711)** 8 a.m. to 6 p.m, Monday - Friday

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

Blue Cross of Idaho Health Service, Inc.'s pharmacy network includes limited lower-cost, preferred pharmacies in Bannock, Bingham, Bonner, Cassia, Elmore, Fremont, Gooding, Jerome, Madison, Minidoka, Power, Shoshone, Valley, Washington counties in Idaho. 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 1-888-494-2583 (TTY: 711) or consult the online pharmacy directory at **bcidaho.com/FindAPharmacy**.

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/noncontracted 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..