



True Blue *Rx Option I & II* HMO

2012 Summary of Benefits

You think about finding
the perfect health
insurance plan.

We think about providing
you with seamless service
and affordable benefits.

True Blue[®] HMO

Medicare^{Rx}
Prescription Drug Coverage ^{Rx}

Serving Select Counties in Idaho

SECTION 1

Introduction to the Summary of Benefits

Thank you for your interest in True Blue Rx *Option I and II* (HMO). Our plan is offered by BLUE CROSS OF IDAHO HEALTH SERVICE, INC/Blue Cross of Idaho, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call True Blue Rx *Option I and II* (HMO) and ask for the "Evidence of Coverage".

You Have Choices In Your Healthcare

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like True Blue Rx *Option I and II* (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call True Blue Rx *Option I and II* (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare True Blue Rx *Option I and II* (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For

each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where Is True Blue Rx *Option I And II* (HMO) Available?

The service area for this plan includes: Ada, Adams, Bannock, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley, and Washington counties, Idaho. You must live in one of these areas to join the plan.

Who Is Eligible To Join True Blue Rx *Option I And II* (HMO)?

You can join True Blue Rx *Option I and II* (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in True Blue Rx *Option I and II* (HMO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

True Blue *Rx Option I and II* (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at <http://www.bcidaho.com/medicare>. Our customer service number is listed at the end of this introduction.

What Happens If I Go To A Doctor Who's Not In Your Network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Where Can I Get My Prescriptions If I Join This Plan?

True Blue *Rx Option I and II* (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at http://www.bcidaho.com/ma_formulary. Our customer service number is listed at the end of this introduction.

True Blue *Rx Option I and II* (HMO) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copayment or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

Does My Plan Cover Medicare Part B Or Part D Drugs?

True Blue *Rx Option I and II* (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?

True Blue *Rx Option I and II* (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at http://www.bcidaho.com/ma_formulary.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With My Prescription Drug Plan Costs Or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24

hours a day/7 days a week; and see <http://www.medicare.gov> 'Programs for People with Limited Income and Resources' in the publication *Medicare & You*.

- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

What Are My Protections In This Plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of True Blue Rx Option I and II (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and

ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of True Blue Rx Option I and II (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance

if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact *True Blue Rx Option I and II* (HMO) for more details.

What Types Of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact *True Blue Rx Option I and II* (HMO) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring

either dialysis or transplantation) and need this drug to treat anemia.

- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs** administered through DME.

Where Can I Find Information On Plan Ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on <http://www.medicare.gov> and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed next.

Please call Blue Cross of Idaho for more information about True Blue *Rx Option I and II* (HMO).

Visit us at <http://www.bcidaho.com/medicare> or, call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. - 8 p.m.

Current members

should call toll-free 1-888-494-2583 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.
TTY 1-800-377-1363

Prospective members

should call toll-free 1-888-492-2583 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.
TTY 1-800-377-1363

Current members

should call locally 1-208-395-8200 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program.
TTY 1-800-377-1363

Prospective members

should call locally 1-208-387-6673 for questions related to the Medicare Advantage Program. and the Medicare Part D Prescription Drug program.
TTY 1-800-377-1363

For more information about Medicare,
please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit <http://www.medicare.gov> on the web.

This document may be available in other formats such as braille, large print or other alternate formats.

For additional information, call customer service at the phone number listed above.

Summary of Benefits Report

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
Important Information			
<p>1 – Premium and Other Important Information</p>	<p>In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples).</p> <p>For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$135 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples).</p> <p>For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$3,000 out-of-pocket limit. All plan services included. \$3,000 plan coverage limit every year for Non-Medicare Supplemental benefits.</p> <p>Contact the plan for services that apply.</p>	<p>General \$116 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples).</p> <p>For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$3,000 out-of-pocket limit. All plan services included. \$3,000 plan coverage limit every year for Non-Medicare Supplemental benefits.</p> <p>Contact the plan for services that apply</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>2 – Doctor and Hospital Choice</p> <p><i>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</i></p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>

Inpatient Care

<p>3 – Inpatient Hospital Care</p> <p><i>(Includes Substance Abuse and Rehabilitation Services.)</i></p>	<p>In 2011 the amounts for each benefit period were: Days 1 - 60: \$1132 deductible Days 61 - 90: \$283 per day Days 91 - 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$100 copayment for each Medicare-covered hospital stay \$0 copayment for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$100 copayment for each Medicare-covered hospital stay \$0 copayment for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
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Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>4 – Inpatient Mental Healthcare</p>	<p>In 2011 the amounts for each benefit period were: Days 1 - 60: \$1132 deductible Days 61 - 90: \$283 per day Days 91 - 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days if inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>\$100 copayment for Medicare-covered hospital stay.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>\$100 copayment for Medicare-covered hospital stay.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>5 – Skilled Nursing Facility (SNF) <i>(In a Medicare-certified skilled nursing facility.)</i></p>	<p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$ 0 per day Days 21 - 100: \$141.50 per day</p> <p>These amounts may change for 2012.</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays: Days 1 - 20: \$50 copayment per day Days 21 - 100: \$ 0 copayment per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays: Days 1 - 20: \$50 copayment per day Days 21 - 100: \$ 0 copayment per day</p>
<p>6 – Home Healthcare <i>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i></p>	<p>\$ 0 copayment</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copayment for Medicare-covered home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copayment for Medicare-covered home health visits</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Outpatient Care

8 – Doctor Office Visits	20% coinsurance	In-Network \$15 copayment for each primary care doctor visit for Medicare-covered benefits. \$25 copayment for each in-area, network urgent care visit for Medicare-covered visit. \$25 copayment for each specialist visit for Medicare-covered benefits.	In-Network \$15 copayment for each primary care doctor visit for Medicare-covered benefits. \$25 copayment for each in-area, network urgent care visit for Medicare-covered visit. \$25 copayment for each specialist visit for Medicare-covered benefits.
9 – Chiropractic Services	Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	In-Network \$20 copayment for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	In-Network \$20 copayment for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10 – Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network \$25 copayment for each Medicare-covered visit Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network \$25 copayment for each Medicare-covered visit Medicare-covered podiatry benefits are for medically-necessary foot care.

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
11 – Outpatient Mental Healthcare	<p>40% coinsurance for most outpatient mental health services.</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copayment cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copayment for each Medicare-covered individual therapy visit \$25 copayment for each Medicare-covered group therapy visit \$25 copayment for each Medicare-covered individual therapy visit with a psychiatrist \$25 copayment for each Medicare-covered group therapy visit with a psychiatrist \$25 for Medicare-covered partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copayment for each Medicare-covered individual therapy visit \$25 copayment for each Medicare-covered group therapy visit \$25 copayment for each Medicare-covered individual therapy visit with a psychiatrist \$25 copayment for each Medicare-covered group therapy visit with a psychiatrist \$25 for Medicare-covered partial hospitalization program services</p>
12 – Outpatient Substance Abuse Care	20% coinsurance	<p>In-Network \$25 copayment for Medicare-covered individual visits \$25 copayment for Medicare-covered group visits</p>	<p>In-Network \$25 copayment for Medicare-covered individual visits \$25 copayment for Medicare-covered group visits</p>
13 – Outpatient Services/ Surgery	<p>20% coinsurance for the doctor’s services.</p> <p>Specified copayment for outpatient hospital facility services. Copayment cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$175 copayment for each Medicare-covered ambulatory surgical center visit \$175 copayment for each Medicare-covered outpatient hospital facility visit</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$175 copayment for each Medicare-covered ambulatory surgical center visit \$175 copayment for each Medicare-covered outpatient hospital facility visit</p>
14 – Ambulance Services <i>(Medically necessary ambulance services.)</i>	20% coinsurance.	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copayment for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copayment for Medicare-covered ambulance benefits.</p>

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<p>15 – Emergency Care</p> <p><i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i></p>	<p>20% coinsurance for the doctor's services.</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copayment cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copayment if you are admitted to the hospital as an inpatient for the same emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$60 copayment for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$ 0 for the emergency room visit.</p>	<p>General</p> <p>\$60 copayment for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$ 0 for the emergency room visit.</p>
<p>16 – Urgently Needed Care</p> <p><i>(This is NOT emergency care, and in most cases, is out of the service area.)</i></p>	<p>20% coinsurance, or a set copayment.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$25 copayment for Medicare-covered urgently-needed-care visits</p>	<p>General</p> <p>\$25 copayment for Medicare-covered urgently-needed-care visits</p>
<p>17 – Outpatient Rehabilitation Services</p> <p><i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy.)</i></p>	<p>20% coinsurance</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$15 copayment for Medicare-covered Occupational Therapy visits</p> <p>\$15 copayment for Medicare-covered Physical and/or Speech and Language Therapy visits</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$15 copayment for Medicare-covered Occupational Therapy visits</p> <p>\$15 copayment for Medicare-covered Physical and/or Speech and Language Therapy visits</p>

Outpatient Medical Services And Supplies

<p>18 – Durable Medical Equipment</p> <p><i>(Includes wheelchairs, oxygen, etc.)</i></p>	<p>20% coinsurance</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$ 0 copayment for Medicare-covered items</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$ 0 copayment for Medicare-covered items</p>
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Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
19 – Prosthetic Devices <i>(Includes braces, artificial limbs and eyes, etc.)</i>	20% coinsurance	General Authorization rules may apply. In-Network \$0 copayment for Medicare-covered items	General Authorization rules may apply. In-Network \$0 copayment for Medicare-covered items
20 – Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	In-Network \$0 copayment for Diabetes self-management training \$0 copayment for: <ul style="list-style-type: none"> ● Diabetes monitoring supplies ● Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$15 to \$25 may apply	In-Network \$0 copayment for Diabetes self-management training \$0 copayment for: <ul style="list-style-type: none"> ● Diabetes monitoring supplies ● Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$15 to \$25 may apply
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays \$ 0 copayment for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	General Authorization rules may apply. In-Network \$0 copayment for the cost for Medicare-covered: <ul style="list-style-type: none"> ● X-rays ● diagnostic radiology services (not including X-rays) ● therapeutic radiology services \$0 copayment for Medicare-covered lab services \$0 copayment for Medicare-covered diagnostic procedures and tests If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$15 to \$25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$15 to \$25 may apply	General Authorization rules may apply. In-Network \$0 copayment for the cost for Medicare-covered: <ul style="list-style-type: none"> ● X-rays ● diagnostic radiology services (not including X-rays) ● therapeutic radiology services \$0 copayment for Medicare-covered lab services \$0 copayment for Medicare-covered diagnostic procedures and tests If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$15 to \$25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$15 to \$25 may apply

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
Preventive Services			
22 – Cardiac and Pulmonary Rehabilitation Services	<p>20% coinsurance Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copayment for Medicare-covered Cardiac Rehabilitation Services \$15 copayment for Medicare-covered Intensive Cardiac Rehabilitation Services \$15 copayment for Medicare-covered Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copayment for Medicare-covered Cardiac Rehabilitation Services \$15 copayment for Medicare-covered Intensive Cardiac Rehabilitation Services \$15 copayment for Medicare-covered Pulmonary Rehabilitation Services</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
23 – Preventive Services and Wellness/ Education Programs	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> ● Abdominal Aortic Aneurysm Screening ● Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. ● Cardiovascular Screening ● Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. ● Colorectal Cancer Screening ● Diabetes Screening ● Influenza Vaccine ● Hepatitis B Vaccine for people with Medicare who are at risk ● HIV Screening. \$ 0 copayment for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. 	<p>General</p> <p>\$0 copayment for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> ● Abdominal Aortic Aneurysm screening ● Bone Mass Measurement ● Cardiovascular Screening ● Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ● Colorectal Cancer Screening ● Diabetes Screening ● Influenza Vaccine ● Hepatitis B Vaccine ● HIV Screening ● Breast Cancer Screening (Mammogram) ● Medical Nutrition Therapy Services ● Personalized Prevention Plan Services (Annual Wellness Visits) ● Pneumococcal Vaccine ● Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ● Smoking Cessation (Counseling to stop smoking) ● Welcome to Medicare Physical Exam (initial preventive physical exam) 	<p>General</p> <p>\$0 copayment for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> ● Abdominal Aortic Aneurysm screening ● Bone Mass Measurement ● Cardiovascular Screening ● Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ● Colorectal Cancer Screening ● Diabetes Screening ● Influenza Vaccine ● Hepatitis B Vaccine ● HIV Screening ● Breast Cancer Screening (Mammogram) ● Medical Nutrition Therapy Services ● Personalized Prevention Plan Services (Annual Wellness Visits) ● Pneumococcal Vaccine ● Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ● Smoking Cessation (Counseling to stop smoking) ● Welcome to Medicare Physical Exam (initial preventive physical exam)

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
<p>23 – Preventive Services and Wellness/ Education Programs</p> <p><i>(Continued)</i></p>	<ul style="list-style-type: none"> ● Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. ● Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease ● Personalized Prevention Plan Services (Annual Wellness Visits) ● Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. ● Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50 ● Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. 	<ul style="list-style-type: none"> ● HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ● Written health education materials, including newsletters ● Nursing Hotline 	<ul style="list-style-type: none"> ● HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ● Written health education materials, including newsletters ● Nursing Hotline

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
23 – Preventive Services and Wellness/ Education Programs <i>(Continued)</i>	<ul style="list-style-type: none"> Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 		
24 – Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	In-Network \$0 copayment for renal dialysis \$0 copayment for kidney disease education services	In-Network \$0 copayment for renal dialysis \$0 copayment for kidney disease education services

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>25 – Outpatient Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.bcidaho.com/ma_formulary on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.bcidaho.com/ma_formulary on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
<p>25 – Outpatient Prescription Drugs</p> <p><i>(Continued)</i></p>		<p>Your provider must get prior authorization from True Blue <i>Rx Option I</i> (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on http://www.medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and True Blue <i>Rx Option I</i> (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy <i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy 	<p>Your provider must get prior authorization from True Blue <i>Rx Option II</i> (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on http://www.medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and True Blue <i>Rx Option II</i> (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p> <p>In-Network \$260 deductible.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy <i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>25 – Outpatient Prescription Drugs <i>(Continued)</i></p>		<ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$8 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$24 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$31 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$93 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$33 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$99 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$41 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$123 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy 	<ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$8 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$24 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$31 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$93 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$33 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$99 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$41 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$123 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>25 – Outpatient Prescription Drugs <i>(Continued)</i></p>		<ul style="list-style-type: none"> - \$43 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$129 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p>Long Term Care Pharmacy</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (31-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$31 copayment for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$41 copayment for a one-month (31-day) supply of drugs in this tier 	<ul style="list-style-type: none"> - \$43 copayment for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - \$129 copayment for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy - 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p>Long Term Care Pharmacy</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (31-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$31 copayment for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$41 copayment for a one-month (31-day) supply of drugs in this tier

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>25 – Outpatient Prescription Drugs <i>(Continued)</i></p>		<p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$93 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$123 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Additional Coverage Gap You pay the following:</p> <p>Retail Pharmacy</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (30-day) supply of all drugs covered in this tier from a preferred pharmacy 	<p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$93 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$123 copayment for a three-month (90-day) supply of drugs in this tier <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Coverage Gap After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay [XXX]% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
<p>25 – Outpatient Prescription Drugs</p> <p><i>(Continued)</i></p>		<ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy - \$8 copayment for a one-month (30-day) supply of all drugs covered in this tier at a non-preferred pharmacy - \$24 copayment for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$6 copayment for a one-month (31-day) supply of all drugs covered in this tier <p>Mail Order</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$18 copayment for a three-month (90-day) supply of all drugs covered in this tier <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>	

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
<p>25 – Outpatient Prescription Drugs <i>(Continued)</i></p>		<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copayment for generic (including brand drugs treated as generic) and a \$6.50 copayment for all other drugs. <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from True Blue <i>Rx Option I</i> (HMO).</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$8 copayment for a one-month (30-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$33 copayment for a one-month (30-day) supply of drugs in this tier 	<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copayment for generic (including brand drugs treated as generic) and a \$6.50 copayment for all other drugs. <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from True Blue <i>Rx Option II</i> (HMO).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$8 copayment for a one-month (30-day) supply of drugs in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$33 copayment for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue <i>Rx Option I</i> (HMO)	For Contract H1350, Plan 010 True Blue <i>Rx Option II</i> (HMO)
<p>25 – Outpatient Prescription Drugs</p> <p><i>(Continued)</i></p>		<p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$43 copayment for a one-month (30-day) supply of drugs in this tier <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (30-day) supply of drugs in this tier <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Additional Out-of-Network Coverage Gap</p> <p>You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p><i>Tier 1: Preferred Generic Drugs</i></p> <ul style="list-style-type: none"> - \$8 for a one-month (30-day) supply of all drugs covered in this tier <p><i>Tier 2: Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. 	<p><i>Tier 3: Non-Preferred Brand Drugs</i></p> <ul style="list-style-type: none"> - \$43 copayment for a one-month (30-day) supply of drugs in this tier <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (30-day) supply of drugs in this tier <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Additional Out-of-Network Coverage Gap</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
<p>25 – Outpatient Prescription Drugs <i>(Continued)</i></p>		<p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> <p><i>Tier 4: Specialty Tier Drugs</i></p> <ul style="list-style-type: none"> - You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copayment for generic (including brand drugs treated as generic) and a \$6.50 copayment for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copayment for generic (including brand drugs treated as generic) and a \$6.50 copayment for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

Benefit Category	Original Medicare	For Contract H1350, Plan 001 True Blue Rx Option I (HMO)	For Contract H1350, Plan 010 True Blue Rx Option II (HMO)
26 – Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network \$0 copayment for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered.	In-Network \$0 copayment for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered.
27 – Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network In general, supplemental routine hearing exams and hearing aids not covered. \$25 copayment for Medicare-covered diagnostic hearing exams	In-Network In general, supplemental routine hearing exams and hearing aids not covered. \$25 copayment for Medicare-covered diagnostic hearing exams
28 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network \$0 copayment for one pair of eyeglasses or contact lenses after cataract surgery <ul style="list-style-type: none"> • glasses • contacts • lenses • frames \$0 to \$25 copayment for exams to diagnose and treat diseases and conditions of the eye. \$25 copayment for up to 1 supplemental routine eye exam every year \$100 plan coverage limit for eye wear every year. Plan offers additional vision benefits. Contact plan for details.	In-Network \$0 copayment for one pair of eyeglasses or contact lenses after cataract surgery <ul style="list-style-type: none"> • glasses • contacts • lenses • frames \$0 to \$25 copayment for exams to diagnose and treat diseases and conditions of the eye. \$25 copayment for up to 1 supplemental routine eye exam every year \$100 plan coverage limit for eye wear every year. Plan offers additional vision benefits. Contact plan for details.
Over-the-Counter Items	Not covered.	General The plan does not cover Over-the-Counter items.	General The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	In-Network This plan does not cover supplemental routine transportation.	In-Network This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.

SECTION 3

How to use your plan

This section further explains some of the plan benefits. To get a complete list of benefits, limitations and exclusions, call Customer Service and ask for the “Evidence of Coverage”.

1 Premium and Other Important Information

Maximum out-of-pocket limit

\$3,000 maximum. While most expenses apply to the maximum, the following do not:

- Your monthly plan premium
- [Outpatient Part D prescription drugs]

2 Doctor and Hospital Choice

True Blue (HMO) has a network of doctors, specialists, and hospitals who agree to provide you, as a member of our plan, with your healthcare and vision coverage. You may go to any of our network providers.

If you need treatment from an out-of-network provider, call for prior authorization. The plan covers emergency services and urgent care. You must visit network providers except in emergency or urgent care situations or if you are receiving renal dialysis.

Visitor/Traveler Program

Under our visitor/traveler benefit, all plan services are available for your in-network cost sharing amount. These services must be provided outside the state of Idaho but within the U.S.

The benefit has a **maximum coverage limit of \$3,000 each calendar year.**

INPATIENT CARE

3 Inpatient Hospital Care

True Blue (HMO) requires prior authorization for inpatient hospital, except in the case of emergencies or urgently needed care. There is no limit to the number of days covered by the plan each benefit period for Medicare covered services.

You pay:

\$100 cost-sharing for each admission

\$15-25 cost-sharing for physician services

\$0 cost-sharing for additional hospital days

4 Inpatient Mental Healthcare

True Blue (HMO) requires prior authorization for inpatient hospital mental healthcare admissions, except in the case of emergencies or urgently needed care. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. This limit does not apply to mental health services provided in a psychiatric unit of a general hospital.

You pay:

\$100 cost-sharing for each admission

\$15-\$25 cost-sharing for physician services

5 Skilled Nursing Facility (SNF)

Skilled nursing facility admissions do not require a prior hospital stay. You are covered for 100 days each benefit period, as medically necessary, per Original Medicare coverage criteria. The plan requires prior authorization for skilled nursing facility admissions.

You pay:

\$50 cost-sharing per day for days 1 to 20

\$0 cost-sharing per day for days 21 to 100

\$15-\$25 cost-sharing for physician services

OUTPATIENT CARE

8 Doctor Office Visits

You pay:

\$15 cost-sharing at your primary care provider's office

\$25 cost-sharing at a specialist's office

\$25 cost-sharing at an immediate care facility

\$20 cost-sharing for chiropractic visits

12 Outpatient Substance Abuse

You pay:

\$25 cost-sharing for each individual or group therapy visit

\$25 cost-sharing for each individual therapy visit with a psychiatrist

13 Outpatient Services/Surgery

For services you receive at a hospital facility as an outpatient, including ambulatory surgical centers,

You pay:

\$175 cost-sharing for Hospital Observation

\$15 cost-sharing for Cardiac Rehabilitation

\$15 cost-sharing for Physical, Occupational, or Speech Language Therapy

\$0 cost-sharing for Radiation Therapy

\$0 cost-sharing for Renal Dialysis

10% cost-sharing for Chemotherapy

\$0 cost-sharing for Laboratory Services

\$0 cost-sharing for Nuclear Medicine

\$0 cost-sharing for Advanced Imaging such as MRI, MRA and PET

\$0 cost-sharing for X-rays

\$0 cost-sharing for Diagnostic Services

\$175 cost-sharing for Surgical Services

\$175 cost-sharing for Pain Injections

15 Emergency Care

The emergency room copayment covers all services provided and billed by the hospital. Additional cost sharing applies to separately billed physician services. Emergency coverage is available worldwide.

\$60 cost-sharing for Medicare-covered emergency room visits. This covers all emergency room facility services, such as X-rays and laboratory services

\$0 cost-sharing for emergency room when you are admitted to the hospital within 3-days for the same condition

\$15-\$25 cost-sharing, physician services are billed separately

17 Outpatient Rehabilitation Services

You pay:

\$15 cost-sharing at a specialist's office for all therapy and rehabilitation services

\$15 cost-sharing at a hospital facility as an outpatient for audiology, occupational, physical and speech therapy services

\$15 cost-sharing at a hospital facility as an outpatient for cardiac rehabilitation services

\$15 cost-sharing at a hospital facility as an outpatient for respiratory therapy services

18 Durable Medical Equipment

Durable medical equipment is ordered by your doctor for use at home. Examples include wheelchairs, oxygen, nebulizers, walkers, crutches and hospital beds.

You pay:

\$0 cost-sharing insurance for Medicare-covered items

19 Prosthetic Devices

Prosthetic devices (other than dental) replace a body part or function. Examples include pacemakers, braces, prosthetic shoes, artificial limbs, breast prosthesis and lenses implanted during cataract surgery.

You pay:

\$0 cost-sharing for Medicare-covered items

20 Diabetes Self- Monitoring Training, Nutrition Therapy and Supplies

Monitoring supplies include glucose monitors, test strips, lancets. Includes nutrition therapy when ordered by a physician.

You pay:

\$0 cost-sharing for monitoring supplies

\$0 cost-sharing for diabetes self-monitoring training

\$0 cost-sharing for nutritional therapy

\$15-25 cost-sharing for office visits may apply

\$0 cost-sharing for an annual diabetes screening at all places of service

21 Diagnostic Tests, X-rays, Lab Services and Radiology Services

The plan covers diagnostic lab services which are used by your doctor to diagnose or rule out a suspected illness or condition. Most routine screenings, like cholesterol checks, are not diagnostic and therefore not covered.

Be aware that if you have diagnostic tests at an ambulatory surgical center you may receive two bills, one for the diagnostic testing and one from the ambulatory surgical center.

You pay the following for:

Laboratory Services

- \$0 cost-sharing at your primary care doctor's office
- \$0 cost-sharing at a specialist office or immediate care facility
- \$0 cost-sharing at a freestanding lab
- \$0 cost-sharing at a hospital facility as an outpatient

Diagnostic Procedures and Tests

- \$0 cost-sharing at your primary care doctor's office
- \$0 cost-sharing at a specialist office or immediate care facility
- \$175 cost-sharing at an ambulatory surgery center
- \$175 cost-sharing at a hospital facility as an outpatient

X-rays and Diagnostic Radiology Services

- \$0 cost-sharing at your primary care doctor's office
- \$0 cost-sharing at a specialist office or immediate care facility
- \$0 cost-sharing at a freestanding radiology facility
- \$0 cost-sharing at a hospital facility as an outpatient

For Advanced Imaging (MRI, MRA, PET, or CT Scan) Services, in addition to the office visit you pay:

- \$0 cost-sharing at your primary care doctor's office
- \$0 cost-sharing at a specialist office or immediate care facility
- \$0 cost-sharing at a freestanding facility
- \$0 cost-sharing at a hospital facility as an outpatient

For Nuclear Medicine Services, you pay:

- \$0 cost-sharing at a freestanding radiology facility
- \$0 cost-sharing at a hospital facility as an outpatient

For Therapeutic Radiology Services (radiation therapy) you pay:

- \$0 cost-sharing at a specialist office
- \$0 cost-sharing at a freestanding radiology facility
- \$0 cost-sharing at a hospital facility as an outpatient

23 Preventive Services and Wellness Programs:

Wellness programs include a nursing hotline to help with any of your health questions. As well as supplemental education to help you manage specific health issues related to diabetes, depression, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and asthma. You pay \$ [XXX] cost-sharing for all preventive services covered under Original Medicare. Separate office visit cost-sharing applies only when you see the provider for services in addition to the following:

- Annual wellness exam that include a personalized prevention plan
- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Screening
- Pap Tests and Pelvic Exams
- Colorectal Cancer Screening
- Diabetes Screening
- Flu Vaccine
- Hepatitis B Vaccine
- Pneumonia Vaccine
- HIV Screening
- Mammograms
- Medical Nutrition Therapy Services
- Prostate Cancer Screening
- PSA Test
- Counseling to Stop Smoking

28 Vision Services

You pay:

\$0 cost-sharing for one pair of eyeglasses or contact lenses after cataract surgery

\$0 cost-sharing for annual glaucoma screenings

\$25 cost-sharing for exams to diagnose and to treat diseases and conditions of the eye

\$25 cost-sharing for a routine eye exam every year

\$100 Plan coverage limit for eyewear every year

Additional Benefits:

- Visitor/Travel Program
- Worldwide Emergency Coverage
- Unlimited covered days for inpatient stays
- Disease management programs
- Medication therapy management
- Wellness education programs
- Health and wellness education including:
 - WalkingWorks® – your next adventure is only a step away
 - 24/7 Nurse Advice Line – around the-clock guidance on general health matters
 - One to One Magazine – valuable health, education and benefit information
 - WellConnected – an online resource offering extensive wellness tools and information to aid in your healthcare decisions

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