Blue Cross of Idaho

True Blue Rx 33 (HMO)

Plan type: Medicare Advantage with drug coverage

Plan ID: H1350-033-0

Plan website | **Non-members:** 1-888-492-2583 | **Members:** 1-888-494-2583

What you'll pay

Total monthly premium	Health deductible	Primary doctor
$59.00	$900 In-network	$0 copay

Overview

PREMIUMS

Total monthly premium	$59.00
Health premium	$43.30
Drug premium	$15.70
Standard Part B premium What's the standard Part B premium?	$202.90
Part B premium reduction What's the Part B premium reduction?	Not offered

DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Health deductible	$900 In-network
Drug deductible	$175.00

MAXIMUM YOU PAY FOR HEALTH SERVICES

Maximum you pay for health services Once you spend this amount for covered services in a year, your plan pays 100% for your care.	$5,900 In-network

CONTACT INFORMATION

Plan address	P.O. Box 8406 Boise, ID 83707

Benefits & Costs

DOCTOR SERVICES

View Provider Network Directory

Primary doctor visit	In-network: $0 copay	
Specialist visit	In-network: $40 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

TESTS, LABS, & IMAGING

Diagnostic tests & procedures Tests done to confirm or uncover the presence of an illness or disease.	In-network: $35 copay	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Lab services	In-network: $0 copay	

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Diagnostic radiology services (like MRI)	In-network: $0-$350 copay	

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Outpatient x-rays	In-network: $25 copay	

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Emergency care	$130 copay	
Urgent care	$50 copay	

HOSPITAL SERVICES

Inpatient hospital coverage	Tier 1 $425 per day for days 1-5 $0 per day for days 6-90 $0 per stay	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Outpatient hospital coverage	In-network: $0-$500 copay, 20% coinsurance	

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SKILLED NURSING FACILITY

Skilled nursing facility	Tier 1 $0 per day for days 1-20 $218 per day for days 21-55 $0 per day for days 56-100	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

PREVENTIVE SERVICES

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (like Pap tests, flu shots, and screening mammograms).

Learn more about your costs for preventive services

Preventive services	In-network: $0 copay	

AMBULANCE

Ground ambulance	In-network: $320 copy	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.

THERAPY SERVICES

Occupational therapy visit	In-network: $40 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Physical therapy & speech & language therapy visit	In-network: $40 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

MENTAL HEALTH SERVICES

Outpatient group therapy with a psychiatrist	In-network: $40 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Outpatient individual therapy with a psychiatrist	In-network: $40 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Outpatient group therapy visit	In-network: $35 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

Outpatient individual therapy visit	In-network: $35 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

OPIOID TREATMENT PROGRAM SERVICES

Opioid treatment program services	In-network: $0 copay	Limits apply ^ **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

OTHER SERVICES

Durable medical equipment (like wheelchairs & oxygen)	In-network: 20% coinsurance	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Prosthetics (like braces, artificial limbs)	In-network: 20% coinsurance	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Dialysis	In-network: 20% coinsurance	

		Limits apply **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Diabetes supplies	In-network: $0 copay	

Drug Coverage

See if there's help to lower costs for drugs you take.

PHARMACIES

Add Pharmacies

Add pharmacies to get better cost estimates

Your drug costs can change depending on your plan and pharmacy. Adding pharmacies to your account can give you better out-of-pocket cost estimates when comparing plans.

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

COSTS BY DRUG TIER

Each plan has a list of drugs they cover (called a “formulary”). Drugs on the list can be grouped into tiers with different cost levels. Some plans don’t use tiers. Below is what you’ll pay for drugs in each tier, based on your coverage phase.

Learn more about drug tiers.

	Initial coverage phase	Catastrophic coverage phase
Preferred Generic	$0.00 copay	$0 copay
Generic	$6.00 copay	$0 copay
Preferred Brand	$40.00 copay	$0 copay
Non-Preferred Drug	25% coinsurance	$0 copay
Specialty Tier	28% coinsurance	$0 copay

PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Part B insulin	In-network: 0%-20% coinsurance	Limits apply ^ **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Chemotherapy drugs	In-network: 0%-20% coinsurance	Limits apply ^ **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Other Part B drugs	In-network: 0%-20% coinsurance	

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

		Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.

Extra Benefits

HEARING

Hearing exam	In-network: $0 copay	Limits apply **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type. **Plan limits** - There may be limits on how much the plan will provide.
Fitting/evaluation	In-network: $0 copay	Limits apply **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Hearing aids - prescription	In-network: $499-$999 copay	Limits apply **Plan limits** - There may be limits on how much the plan will provide.
Hearing aids - over the counter	Not covered	

PREVENTIVE DENTAL

Care to prevent or find problems with your teeth and gums.

Oral exam	In-network: $0 copay	Limits apply ^ **Plan limits** - There may be limits on how much the plan will provide.
Cleaning	In-network: $0 copay	Limits apply ^ **Plan limits** - There may be limits on how much the plan will provide.
Fluoride treatment	In-network: $0 copay	Limits apply ^ **Plan limits** - There may be limits on how much the plan will provide.
Dental x-rays	In-network: $0 copay	Limits apply ^ **Plan limits** - There may be limits on how much the plan will provide.

COMPREHENSIVE DENTAL

Care to maintain or treat problems with your teeth and gums.

Restorative services	Not covered	
Endodontics	Not covered	
Periodontics	Not covered	
Prosthodontics, removable	Not covered	
Prosthodontics, fixed	Not covered	
Maxillofacial prosthetics	Not covered	
Implant services	Not covered	
Oral and maxillofacial surgery	Not covered	
Orthodontics	Not covered	
Adjunctive general services	Not covered	

VISION

Routine eye exam	In-network: $0 copay	Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type. **Plan limits** - There may be limits on how much the plan will provide.
Contact lenses	In-network: $0-$35 copay	

		Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type. **Plan limits** - There may be limits on how much the plan will provide.
Eyeglasses (frames & lenses)	In-network: $35 copay	

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Eyeglass frames only	Not covered	
Eyeglass lenses only	Not covered	
Upgrades	In-network: $0 copay	

		Limits apply **Advanced Plan Approval Required** - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization. **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

MEDICALLY-APPROVED NON-OPIOID PAIN MANAGEMENT SERVICES

Chiropractic services	Not covered	
Acupuncture	Not covered	
Massage therapy	Not covered	
Alternative therapies	Not covered	

MORE BENEFITS

Health Education	Not covered	
Counseling Services	Not covered	
Support for Caregivers of Enrollees	Not covered	
Personal Emergency Response System (PERS)	Not covered	
Fitness benefit	In-network: $0 copay	Limits apply **Plan limits** - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Transportation services for non-emergency care: Any health-related locations	Not covered	
Transportation services for non-emergency care: Plan-approved locations	Not covered	
Over the counter drug benefits	Not covered	
In-home support services	Not covered	
Home and bathroom safety devices	Not covered	
Meals for short duration	Not covered	

Annual physical exams	In-network: $0 copay	Limits apply **Plan limits** - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Telehealth	In-network: $0-$40 copay	Limits apply **Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type. **Plan limits** - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Worldwide emergency	$0 copay	Limits apply **Plan limits** - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Post discharge in-home medication reconciliation	Not covered	
Re-admission prevention	Not covered	

Wigs for hair loss related to chemotherapy	Not covered	
Weight management programs	Not covered	
Adult day health services	Not covered	
Home-based palliative care	Not covered	

Optional Packages

This plan includes optional benefits you can add to your coverage at an additional cost.

Package #1 Includes comprehensive dental services	**Monthly premium**: $26.00 **Deductible**: $50.00

Star Ratings

+ Expand All Ratings

Overall star rating

Overall rating is based on the categories below.

+ **Health plan star rating**

Summary rating of health plan quality

+ **Drug plan star rating**

Summary rating of drug plan quality

Providers

View Provider Network Directory

Add Provider

Find in-network providers

Add your providers to find out if they're in this plan's network.