True Blue Special Needs Plan (HMO SNP) is a health plan with a Medicare and Idaho Medicaid contract. Enrollment in True Blue Special Needs Plan (HMO SNP) depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Idaho Medicaid pays the Medicare Part B premium for Full-Benefit Dual-Eligible members. Each member’s cost share may vary based on the level of extra help you receive. This plan is available to full-benefit dual-eligible beneficiaries who are at least 21 years of age, live in our service area, and receive medical assistance from Medicare and Idaho Medicaid. Please contact the plan for further details.

Esta información está disponible sin costo alguno en otros idiomas. Para información adicional, por favor marque a nuestro número de servicio al cliente 1-888-495-2583 de 8 a.m. a 8 p.m. Usuarios de TTY llamar al 1-800-377-1363.
Please fill out this page for your reference

Your True Blue membership number ____________________________
(located on your membership card)

Your True Blue Care Coordinator ________________________________

Primary Care Physician (PCP) Name ________________________________

Primary Care Physician Phone Number ________________________________

PCP Clinic Address ________________________________________________

PCP Office Hours ________________________________________________

Questions? Problems? Need help?

Call your Care Coordinator toll free at 1-800-682-9329, or TTY 1-800-377-1363. If your Care Coordinator is not available, please call Customer Service at 1-888-495-2583 or TTY 1-800-377-1363. Our trained customer representatives are available from 8 a.m. to 8 p.m., 7 days a week, every day of the year.

Visit our local office at:

Blue Cross of Idaho
3000 East Pine Avenue
Meridian, ID 83642-5995

Send correspondence mail to:

Blue Cross of Idaho
Medicare Advantage
PO Box 8406
Boise, ID 83707-2406

Get more information online at:

www.truebluesnp.com

Contact the 24-hour Nurse Advice Line at:

1-800-704-0727
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Important Words to Know

Here is a list of words you may need to know that describes terms and services used in this handbook.

**Participant/Beneficiary/Enrollee/Member**
You, the person who is eligible to receive both Medicare and Medicaid services, and is enrolled in the True Blue Special Needs Plan.

**Appeal**
An appeal is something you do if you disagree with a decision we have made. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should get.

**Care Coordinator**
The person assigned as your primary contact that helps coordinate your care and assists in getting you services you may need.

**Centers for Medicare & Medicaid Services (CMS)**
The Federal agency that administers Medicare.

**Cost Sharing**
Cost sharing refers to money that a member has to pay when services or drugs are received. You might also hear terms like “deductible, copayment, or coinsurance” instead of cost sharing. Your Medicaid benefit level determines if you have any cost sharing.

**Coverage Determination**
In some cases, we may decide if a drug prescribed for you is covered by True Blue and how much money you are required to pay for the prescription.

**Covered Drugs**
The term we use to mean all of the prescription drugs covered by our plan. You may find these on the List of Covered Drugs (Formulary or “Drug List”).

**Covered Services**
The general term we use to mean all of the health care services and supplies that are covered by our plan.

**Custodial Care**
Custodial care is personal care provided in a nursing home, hospice, or another place when you do not need skilled medical care or skilled nursing care.

**Disenroll or Disenrollment**
The process of ending your membership in our plan. You can ask to leave the True Blue at any time for any reason.

**Dual Eligible Individual**
A person who qualifies for both Medicare and Medicaid coverage. All members of the True Blue Special Needs Plan are Dual Eligible.
Emergency
A medical emergency is when you believe you require immediate medical help to prevent your loss of life, loss of a limb, or loss of function of a limb. Signs of an emergency may be an illness, injury, or severe pain that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information
A booklet that explains your coverage, your rights, and what you have to do as a member of our plan.

Fee–for–Service
This is the Idaho Medicaid payment and service delivery system.

Grievance
A type of complaint you make about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve any coverage decisions or payment disputes.

Home and Community Based Services (HCBS)
These are supportive services needed to live at home, in a residential assisted living facility (RALF), or certified family home (CFH), instead of living in an institution such as a nursing home or an intermediate care facility (ICF/ID). Consumer-direction or self-direction options are available to all members.

List of Covered Drugs (Formulary or “Drug List”)
A list of prescription drugs covered by True Blue. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes brand name and generic drugs.

Medicaid
A state program that helps with medical costs or social needs like home and community based services. To be a member of True Blue, you must be receiving help from Idaho Medicaid.

Medically Necessary
These are services, supplies, or drugs that you may need for your condition and meet accepted medical rules for their use.
Medicare
A federal health insurance program for people that are over 65, plus others under 65 with certain medical issues or disabilities. To be a member of True Blue, you must be eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C.
A plan offered by a private company, like Blue Cross of Idaho, that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Some Medicare Advantage plans, like True Blue, also provide Medicare Part D prescription drug coverage.

Network Provider
“Provider” is the general term we use for doctors, health care professionals, hospitals, and other health care facilities authorized by Medicare and Idaho Medicaid to provide health care services. We call them “network providers” when they have an agreement with True Blue to provide Covered Services to members of our plan.

Out-of-Network Provider or Out-of-Network Facility
A provider or facility who is not contracted to provide covered services to members of our plan.

Personal Care Services (PCS)
These are Covered Services provided in your home. These services give individuals more independence and a better quality of life in their home or residence.

Post-Stabilization Care Services
These are covered services, related to an emergency medical condition, that are provided after you are stabilized in order to maintain the stabilized condition.

Pregnancy and Family Planning Related Services
These are Covered Services that include family planning counseling, prescriptions and supplies used to prevent pregnancy.
**Primary Care Provider**

Your primary care provider is the doctor or other health provider at the clinic you see for most health problems or preventive services. He or she also may talk with other doctors and health care providers about your care and refer you to them.

**Prior Authorization**

This is an approval to get some services and certain drugs that may or may not be on our List of Covered Drugs (Formulary). Some medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan.

**Summary of Benefits**

The Summary of Benefits is a booklet that tells you some features of True Blue. It does not list every service we cover. To get a complete list of benefits, refer to the Evidence of Coverage (EOC).

**Transportation (Non-Emergency)**

If you have a medical appointment but you don’t have a car, cannot operate a car, or no one is available to take you, you can request a ride from American Medical Response (AMR) at 1-877-503-1261. You need to call at least 48 hours before your appointment.
The First Things You Should Know
How Do I Apply for Health Plan Coverage?

Eligible individuals may enroll in True Blue at any time. To get True Blue Special Needs Plan coverage through Blue Cross of Idaho, you must complete an application. You can do this in several ways:

- Call Customer Service toll free at 1-888-495-2583 or TTY 800-377-1363 to apply over the phone. Our trained customer representatives are available from 8 a.m. to 8 p.m., 7 days a week.
- On the internet, go to www.truebluesnp.com and click on the “Enroll Now” button to enroll online.
- Request a paper application from Customer Service at 1-888-495-2583 or TTY 800-377-1363. Fill out the application and return it in the prepaid envelope provided with your application.
- Visit Blue Cross of Idaho in person at 3000 E. Pine Avenue, Meridian, Idaho.

Help completing your application

- Call Customer Service at 1-888-495-2583 or TTY 800-377-1363 and ask for help to appoint someone to act on your behalf.
- Have a friend or relative help you.
- Ask for the application in English or Spanish.
- Ask for an interpreter to help you. This help is free.

Sometimes more information is needed. You might get a phone call or letter asking for more information, so it’s important for you to tell us if your address or phone number changes.

If you’re eligible, you’ll receive an ID card within 7 to 10 days of enrollment, along with other True Blue Special Needs Plan information.

What about my health condition? Will that be a factor in determining if I can participate in the True Blue Special Needs Plan?

Beneficiaries who are full-benefit, dually eligible Medicare and Medicaid participants cannot be denied membership in True Blue on the basis of health status. Those who meet the below eligibility requirements may voluntarily become members of True Blue:

- You have both Medicare Part A and Medicare Part B
- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- You must be eligible for Full Medicaid Benefits and be at least 21 years of age.

If you are not sure of your level of Medicaid benefits, please call:

- Idaho Department of Health and Welfare Benefits Customer Service Center at 1-877-456-1233
- Blue Cross of Idaho Customer Service at 1-888-495-2583 or TTY 800-377-1363
When does True Blue Coverage Begin?

In general, completed enrollment forms will start to provide coverage for the member on the first day of the next month. For example, if you turned your form in on June 5, your effective coverage date will be July 1.

Starting on your Effective Coverage Date, all True Blue Covered Services must be received from True Blue Network Providers and pharmacies, EXCEPT in the following situations:

- During your first 90 days on the True Blue plan, you can continue receiving services from your current providers for services you are already have in place, even if they are not in the True Blue network. Your provider will need to join the True Blue provider network if you wish to continue receiving services from them after 90 days.

- Emergency care or urgently needed care that you get from an out-of-network provider.

- If you cannot find a True Blue provider to meet a specialized health care need included in your health plan, you can review the service with your Care Coordinator. In this instance, Blue Cross of Idaho will allow a provider who is not in the True Blue provider network to provide your care.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area.

Except for the above situations, if a True Blue member gets services from medical providers who are not part of the True Blue Network without prior authorization (permission), True Blue, Medicare and Idaho Medicaid may not pay for those services.

How do I disenroll, or leave True Blue?

Being a member of the True Blue plan is entirely voluntary. You can ask to leave True Blue at any time for any reason. To request True Blue disenrollment, call customer service at 1-888-495-2583 for help. You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you decide to change to a new plan, you can choose any of the following types of Medicare plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

- Original Medicare with a separate Medicare prescription drug plan. If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Until your membership ends, you are still a member of our plan

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.

- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.

- If you disenroll from True Blue, your True Blue coverage ends on the last day of the month that you disenrolled. All Medicaid services will go back to Fee for Service. Any new Medicare plan you enroll in begins on the first day of the next month.
Involuntary Disenrollment
You Will Have to Leave True Blue if:

- You do not stay continuously enrolled in Medicare Part A and Part B.
- You are no longer eligible for Medicaid.
- You move out of our service area.
- You go to prison.
- You lie about or withhold information about other insurance you have that provides prescription drug coverage.

- You gave True Blue false information when you signed up, we may ask Medicare for permission to have you leave the plan.
- You let someone else use your membership card to get medical care, we may ask Medicare for permission to have you leave the plan. If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- You are supposed to pay the extra Part D prescription drug amount because of your income and you do not pay it, Medicare will disenroll you from our plan.
How True Blue Coverage Works
What if I Need Care Right Away (Urgent and Emergency Services)?

In case of an emergency

Call 911 or go to the nearest emergency room. Here are some examples of emergencies:

- Possible heart attack
- Bleeding that won’t stop
- Trouble breathing
- Poisoning
- You were recently unconscious or “knocked out”

Acting quickly can be very important. Calling an ambulance instead of driving yourself is the right choice when:

- The condition is life-threatening
- Moving could cause more injuries
- Paramedics’ skills or equipment are needed

Prior Authorization for treatment of Emergency Medical Conditions is not required. True Blue will cover Emergency Services whether you are in or out of the True Blue Service Area. Please have someone call your Primary Care Provider (Doctor) or your Care Coordinator on the number listed on the back of your membership card as soon as they can.

We will be financially responsible for Post-Stabilization care services received after an emergency from True Blue Network Providers OR non-True Blue Network Providers without a Prior Authorization, that are needed to stabilize your condition if:

- We do not respond to a request for Prior Authorization within one hour of a request for one;
- True Blue Customer Service or your Care Coordinator cannot be contacted; or
- True Blue and the doctor treating you cannot agree on a decision about your care when a True Blue network doctor is not available for consultation.

If this happens, we must allow the doctor to provide care for you until a True Blue network doctor is consulted or one of the following things occurs:

- A True Blue doctor who works at the hospital you are treated at takes over your care;
- A True Blue doctor takes over your care after a transfer to a True Blue Provider Network facility;
- True Blue or your Care Coordinator decide to allow the doctor treating you to continue your care; or
- You are discharged from the facility where you are receiving Post-Stabilization care.

Important Information to Remember

- The emergency room is not an appropriate place to get routine care. Call your primary care provider first if you need routine care.
Urgent Care

Sometimes you may feel sick or you may have injured yourself and decide it is not an emergency. But you still may need to see a doctor quickly. This is one example of when to use “urgent care.” Call your Primary Care Provider or Care Coordinator if you need urgent care. Clinic staff will help you decide what to do next.

Call the 24-Hour Nurse Advice Line

Nurses can help you 24 hours a day, seven days a week. They will answer your health questions and help you decide what to do if you are sick or injured. Call toll free: 1-800-704-0727

If you have a medical appointment but you don’t have a car, cannot operate a car, or no one is available to take you, you can request a ride from American Medical Response (AMR) at 1-877-503-1261. You need to call at least 48 hours before your appointment.

Developmental Disability (DD) Services

Members receiving DD Services will continue to get these services through Idaho Medicaid. Targeted Service Coordination is provided by the True Blue plan.

Your True Blue Membership Card

Your True Blue Membership Card is your ticket to get all your Covered Services. You will need to show your card to your health care Provider to check your coverage and get services.

- Your card will come in the mail. It’s important that you call Blue Cross of Idaho if you don’t receive your card within 10 days after you get the letter telling you that you’re eligible. Keep your card in your purse or wallet so that you’ll have it with you to show to your doctor, dentist, pharmacy, or other service providers. You might have to show picture ID in addition to your True Blue Membership card.
- Carry your membership card with you all the time.
Your Care Coordinator – an important contact in managing your care
A Care Coordinator is assigned to you when you became a True Blue member.

What does a Care Coordinator do?
A Care Coordinator will help coordinate your care and work with you, your family, doctors and other medical providers to make sure you get the right care. Your Care Coordinator will contact you after you enroll to set up a meeting. At the meeting, you can talk about your health care needs.

Overall, your Care Coordinator will:
• Be your primary contact for coordinating your care.
• Help you plan and schedule your health services.
• Make sure you receive quality care.
• Ensure your needs are provided for in a timely manner.

Call your Care Coordinator when:
• You have questions about your health benefits.
• You are having trouble finding the right doctor or getting an appointment.
• Your service needs or health needs change.
• Your living situation changes or you need assistance in managing your personal care.

Your Primary Care Provider – the first place to go for care
As a member of True Blue, you must have a primary care provider. You choose a primary care provider or one is assigned to you when you become a True Blue member.

Choose a doctor whom you trust and then see the same doctor each time you need routine care like a checkup, screening or other preventive care. Your doctor will have your health history and keep your medical records in one place. When your doctor gets to know you and your family, he or she can best direct you to any specialized care needed.
Making an appointment is easy
- Call your clinic directly for an appointment.
- If you need help, your Care Coordinator will assist you in making your appointment.
- Write down the appointment date and time.
- Show your True Blue member ID card when you get care.

Get the information you need
At each clinic visit, feel comfortable asking for more information if something isn’t clear. If you have a health problem, be sure you get answers to these three questions:
- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Here are some more tips
- Bring a friend or family member to help you at your doctor visit.
- Bring a written list of your health concerns to tell your doctor.
- Bring all of your medicines when you visit your doctor.
- Repeat what the doctor said, in your own words.
- Tell the doctor when you don’t understand something.

Need to See a Specialist?
Surgeons and doctors who treat things like allergies and cancer are examples of specialists.

If you need to see a specialist, there are several ways to find one:
- You can ask your Primary Care Provider or Care Coordinator for help.
- Choose a specialist listed in your Provider Directory.
- You can also visit www.truebluesnp.com and select “Provider Search.”
- Or you can call Customer Service at 1-888-495-2583 or TTY 1-800-377-1363. Our trained customer representatives are available from 8 a.m. to 8 p.m., 7 days a week, every day of the year.
You can choose either a True Blue Network or Non-True Blue Network doctor, clinic, hospital or family planning agency to receive services such as family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases and testing for AIDS and HIV-related conditions.

What is Prior Authorization?

Prior authorization means you or your provider must get approval from True Blue or its representatives before you get a service, or you might have to pay the bill.

Usually your doctor, healthcare provider, or pharmacist will request prior authorization for you.

You or your provider will need to get prior authorization for the following list of services:

- Some medical equipment and supplies.
- Home and Community-Based Waiver Services.
- Some inpatient and outpatient hospitalizations or medical procedures.
- Personal care services.
- Private duty nursing.
- Physical, occupational, and speech therapy – beyond service limits.
- Some medicines and most brand name drugs when generics are available.

There might be other services not listed that need prior authorization. Your doctor or health care provider usually knows when you need prior authorization, but if you have questions call Customer Service at 1-888-495-2583 or TTY 1-800-377-1363. Our trained customer representatives are available from 8 a.m. to 8 p.m., 7 days a week, every day of the year.
This part of the handbook tells you what services True Blue covers, how to access services, and if there are any limits on services.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained here as long as you see True Blue Network Providers. However, you may be responsible for paying a “cost share” for a nursing facility or waiver services that are covered through your Medicaid benefit. The Idaho Department of Health and Welfare will determine if your income and certain expenses require you to have a cost share.

If you need help understanding what services are covered, if there is a cost share, or how to access services, please call Customer Service at 1-888-495-2583 or TTY 1-800-377-1363. Or your Care Coordinator at 1-800-682-9329.

Our plan does not allow providers to charge you for services

Except as indicated above, we do not allow True Blue providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

You should never get a bill from a provider for a covered service. If you do, contact Customer Service at 1-888-495-2583.

About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. Your True Blue coverage includes preventive services that are recommended and appropriate for your age and the condition of your health. For a complete explanation of covered services, how to access the services, and if there are any limits or restrictions on the services, please refer to the True Blue Special Needs Plan (HMO SNP) Evidence of Coverage (EOC) AND Summary of Benefits. If you do not have a copy, please call Customer Service at 1-888-495-2583 or TTY 1-800-377-1363.

If you can’t find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Customer Service or your Care Coordinator.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Idaho Medicaid.

- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

- If True Blue makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, see What do I do if I have a problem or complaint? section of this handbook.

- You get your care from a network provider. A network provider is a provider who works with the True Blue health plan. In most cases, the plan will not pay for care you get from an out-of-network provider.

- You have a primary care provider (PCP) that is providing and managing your care.

- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called Prior Authorization.
### BENEFIT

#### Preventive Covered Services
- Abdominal aortic aneurysm screening
- Annual checkup
- Alcohol misuse screening and counseling
- Bone Mass Measurement
- Breast cancer screening
- Cardiovascular (heart) disease risk reduction visit
- Cardiovascular (heart) disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Counseling to stop smoking or tobacco use
- Depression screening
- Diabetes screening
- Diabetes self-management training, diabetic services and supplies
- Glaucoma screening
- Health and wellness education programs
- HIV screening
- Immunizations
- Medical nutrition therapy
- Obesity screening and therapy to keep weight down
- Prostate cancer screening
- Sexually transmitted infections (STI’s) screening

#### Other Covered Services
- Emergency Ambulance transport
- Cardiac rehabilitation services
- Chiropractic services
- Coordination services for developmental disability
- Waiver – Waiver services remain Fee for Service
- Dental services
- Diabetic service
- Durable medical equipment and related supplies
- Emergency care
- Family planning services
- Hearing services

Services with this symbol ✚ are Covered Services that require Prior Authorization.
### BENEFIT

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and community-based waiver services through A and D Waiver</td>
<td>✫</td>
</tr>
<tr>
<td>Home health services</td>
<td>✫</td>
</tr>
<tr>
<td>Hospice care</td>
<td>✫</td>
</tr>
<tr>
<td>Inpatient behavioral health services</td>
<td>✫</td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>✫</td>
</tr>
<tr>
<td>Inpatient hospital stay that exceeds the Medicare limits</td>
<td>✫</td>
</tr>
<tr>
<td>Inpatient Mental health and substance abuse services at addiction centers</td>
<td>✫</td>
</tr>
<tr>
<td>Inpatient services covered during a non-covered inpatient stay</td>
<td>✫</td>
</tr>
<tr>
<td>Intermediate Care Facility Services</td>
<td>✫</td>
</tr>
<tr>
<td>Kidney disease services and supplies</td>
<td>✫</td>
</tr>
<tr>
<td>Long term care</td>
<td>✫</td>
</tr>
<tr>
<td>Medicaid covered drugs</td>
<td>✫</td>
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<tr>
<td>Medicare Part B prescription drugs</td>
<td>✫</td>
</tr>
<tr>
<td>Medicare Part D prescription drugs</td>
<td>✫</td>
</tr>
<tr>
<td>Mental health and substance abuse services at community mental health centers</td>
<td>✫</td>
</tr>
<tr>
<td>Nursing home custodial care</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient diagnostic test and therapeutic services and supplies</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient mental health care</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient rehabilitation services (Physical therapy, Occupational therapy and Speech therapy)</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient substance abuse services</td>
<td>✫</td>
</tr>
<tr>
<td>Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers</td>
<td>✫</td>
</tr>
<tr>
<td>Physician/provider services including doctor office visits</td>
<td>✫</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>✫</td>
</tr>
<tr>
<td>Prosthetic devices and related supplies</td>
<td>✫</td>
</tr>
<tr>
<td>Skilled nursing facility care (100 Days or less)</td>
<td>✫</td>
</tr>
<tr>
<td>Urgently needed care</td>
<td>✫</td>
</tr>
<tr>
<td>Vision care</td>
<td>✫</td>
</tr>
</tbody>
</table>

Services with this symbol ✫ are Covered Services that require Prior Authorization.
You have some responsibilities as a member of the plan

There are some things you need to do as a True Blue member. If you have any questions, please call Customer Service. We’re here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services.
- Your care team, which includes your Primary Care Provider and Care Coordinator, will help you establish a care plan. Make sure to follow your care plan and use any Preventive Services your care team asks you to use.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- Tell us if you move or if you are going to move.
  - If you move outside of our plan service area, you cannot remain a member of our plan. We can help you figure out whether you are moving outside our service area.
  - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

Call Customer Service or your Care Coordinator for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Pay what you owe. As a plan member, you are responsible for these payments:
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see page 25 of this booklet for information about how to make an appeal.
You have a right to get information in a way that meets your needs

Each year you are in our plan, we must tell you about the plan’s benefits and your rights in a way that you can understand.

• To get information in a way that you can understand, call Customer Service. Our plan has people who can answer questions in different languages.

• Esta información está disponible sin costo alguno en otros idiomas. Para información adicional, por favor marque a nuestro número de servicio al cliente 1-888-495-2583 de 8 a.m. a 8 p.m. Usuarios de TTY llamar al 1-800-377-1363.

• We can also give you information in Braille or large print. This information is free to you.

If you are having trouble getting information from our plan because of language barriers or the need for other accommodations and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also contact Idaho Department of Health and Welfare Administrative Procedures at 208-334-5564, Monday through Friday from 8:00 a.m. to 5:00 p.m.

We must treat you with respect, fairness, and dignity at all times. We do not discriminate based on a person’s:

• Race
• Ethnicity
• National origin
• Ancestry
• Religion
• Gender
• Sexual orientation
• Age
• Veteran’s status
• Mental ability
• Behavior
• Color
• Need for health services
• Mental or physical disability
• Health status
• Receipt of health care
• Use of services
• Claims experience
• Appeals
• Medical history
• Genetic information
• Evidence of insurability
• Geographic location within the service area
• You have the right to be treated with respect and with regard for your dignity and privacy.

We cannot deny services to you or punish you for exercising your rights. Exercising your rights will not affect the way our plan, our network providers, or the Idaho Department of Health and Welfare treats you.

If you have a health condition that requires an accommodation to help you access care, call your Care Coordinator. If you have a complaint, such as a problem with accessing health care buildings, your Care Coordinator can help you.
• If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

• For your convenience, we have attached a copy of the Civil Rights Complaint Form in the back of the Member Handbook on page 31 that you can fill out and return to the appropriate office.

We must ensure you get timely access to covered services

As a member of our plan:

• You have the right to receive all services that True Blue must provide and to choose the provider that gives you care whenever possible and appropriate.

• You have the right to be sure that others cannot hear or see you when you are getting medical care.

• You have the right to choose a primary care provider (PCP) in the plan’s network. A network provider is a provider who works with the health plan.

• You have the right to go to a network gynecologist or another network women’s health specialist for covered women’s health services without getting a referral. A referral is a written order from your primary care provider.

• You have the right to get covered services from network providers within a reasonable amount of time. This includes the right to get timely services from specialists.

• You have the right to get emergency services or care that is urgently needed without prior approval.

• You have the right to get your prescriptions filled at any of our network pharmacies without long delays.

• You have the right to know when you can see an out-of-network provider.

• Chapter 9 of the Evidence of Coverage (EOC) tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

We must protect your personal health information

We protect your personal health information as required by federal and state laws.

• Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

• You have the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.

• You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the “Notice of Privacy Practice.” The notice also explains how we protect the privacy of your health information.
You have a right to see your medical records

• You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records if it isn’t to transfer the records to a new provider.

• You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

• You have the right to know if and how your health information has been shared with others.

We must give you information about the plan

If you want any of the following, please call Customer Service:

• Information about how to choose or change plans

• Information about our plan, including but not limited to:
  o Financial information
  o How the plan has been rated by plan members
  o The number of appeals made by members
  o How to leave the plan

• Information about our network providers and our network pharmacies, including:
  o How to choose or change primary care providers (PCP)
  o The skills of our network providers and pharmacies
  o How we pay the providers in the True Blue network
  o For a list of providers and pharmacies in the True Blue network, see the Provider Directory, or for the most updated listing, visit our website at www.truebluesnp.com.

• Information about covered services and drugs and about rules you must follow, including:
  o Services and drugs covered by the plan
  o Limits to your coverage and drugs
  o Rules you must follow to get covered services and drugs

• Information about why something is not covered and what you can do about it, including:
  o Asking us to put in writing why something is not covered
  o Asking us to change a decision we made
  o Asking us to pay for a bill you have received

Network Providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us.

You have the right to get your Medicare and Part D coverage from original Medicare or another Medicare plan at any time by asking for a change

You simply must request to be disenrolled from True Blue.
You have a right to make decisions about your health care (self-direction of services)

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care.

- **The right to say “no.”** You have the right to refuse any recommended treatment.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. For more information, please review the next section of the handbook called What to do if you have a problem or complaint.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** You can contact your Care Coordinator to ask for the forms.

- **Fill it out and sign it.**

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.
If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

What to do if I have a problem or complaint?

This section briefly explains the processes for handling problems and concerns. For complete instructions on how to file appeals and making complaints, please read Chapter 9 of the Evidence of Coverage. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by Medicare or Idaho Medicaid. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Customer Service.

2. The type of problem you are having:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

How to contact us when you are making an appeal or complaint about your medical care

CALL 1-888-495-2583
Calls to this number are free. We are available from 8 a.m. to 8 p.m., seven days a week. After 8 p.m. please leave a message and we will return your call the following day.

TTY 1-800-377-1363
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. We are available from 8 a.m. to 8 p.m., seven days a week.

FAX 1-208-387-6811

WRITE
Blue Cross of Idaho
P.O. Box 8406
Boise, ID 83707
You can get help from government organizations that are not connected with us.
You can always contact your **Senior Health Insurance Benefits Advisors (SHIBA).**
The services of SHIBA counselors are free. Call 1-800-247-4422. TTY 1-800-377-1363.

You can also get help and information from Medicare.
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare.

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare Web site (http://www.medicare.gov).

You can also get help and information from Medicaid.
For more information and help in handling a problem, you can also contact Medicaid. Here are two ways to get information directly from Medicaid.

- You can call the Idaho Department of Health and Welfare at 1-877-456-1233. TTY users should call 1-800-377-1363.
- You can visit the Idaho Department of Health and Welfare web site at www.healthandwelfare.idaho.gov.

To deal with my problem, which process should I use?
Always contact True Blue first if you have a problem, complaint or want to request an appeal.

**CALL 1-888-495-2583**
Calls to this number are free. We are available from 8 a.m. to 8 p.m., seven days a week. After 8 p.m. please leave a message and we will return your call the following day.

**TTY 1-800-377-1363**
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. We are available from 8 a.m. to 8 p.m., seven days a week.

**FAX 1-208-387-6811**

**WRITE**
Blue Cross of Idaho
P.O. Box 8406
Boise, ID 83707
If you do not accept True Blue’s response as fair and reasonable, you can still get help. Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Customer Service. The Medicare process and Medicaid process are described in different parts of the Evidence of Coverage. To find out which part you should read, use the chart below.

<table>
<thead>
<tr>
<th>Is your problem about Medicare benefits or Medicaid benefits?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you need help deciding whether your problem is about Medicare or Medicaid benefits, please contact Customer Service. Phone numbers are listed on the next page.)</td>
<td></td>
</tr>
<tr>
<td>My problem is about <strong>Medicare</strong> benefits.</td>
<td>My problem is about <strong>Medicaid</strong> benefits.</td>
</tr>
<tr>
<td>In the Evidence of Coverage go to Chapter 9, Section 4, “Handling problems about Medicare your benefits.”</td>
<td>In the Evidence of Coverage go to Chapter 9, Section 12, “Handling problems about your Medicaid benefits.”</td>
</tr>
<tr>
<td>My problem is about <strong>Medicare Part D</strong> prescription drug benefits.</td>
<td></td>
</tr>
<tr>
<td>In the Evidence of Coverage go to Chapter 9, Section 7 “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.”</td>
<td></td>
</tr>
</tbody>
</table>
You have the right to appeal our decision

You have the right to ask Blue Cross of Idaho to review a claim decision you do not agree with by asking us for an appeal.

How to ask for an appeal:

First, you should determine if the decision you are appealing is a Medicare or Idaho Medicaid service. If you need help, please call us at 1-888-495-2583 or TTY 1-800-377-1363. We are available from 8 a.m. to 8 p.m. seven days a week.

For Medicare Services

- You, your representative, or your provider must ask Blue Cross of Idaho for an appeal within 60 days of the date of this letter. You may request an appeal by phone. You must follow-up your phone request by writing a letter to us.
- We can give you more time if you have a good reason for missing the 60-day deadline.
- If you lose your appeal, you may have to pay for the services you received during your appeal.

For Medicaid Services

- You, your representative, or your provider must ask Blue Cross of Idaho for an appeal within 28 days of the date of this letter. You may request an appeal by phone. You must follow-up your phone request by writing a letter to us.
- We can give you more time if you have a good reason for missing the 28-day deadline.
- You can ask that services continue while we review your appeal.
- If you lose your appeal, you may have to pay for the services you received during your appeal.

State Fair Hearing:

- If you lose the Medicaid services appeal with Blue Cross of Idaho, you can ask for a State Fair Hearing.
- You can ask for a State Fair Hearing only after losing your appeal with Blue Cross of Idaho.
- You must ask for a State Fair Hearing within 28 days of losing the appeal with Blue Cross of Idaho.
- You can ask that services continue while you are waiting for your State Fair Hearing.
- If you lose your State Fair Hearing appeal, you may have to pay for the services you received while waiting for your State Fair Hearing.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-495-2583 to learn how to name your representative. TTY users call 1-800-377-1363. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.
Important Information About Your Appeal Rights

We will mail you our decision within 60 days of getting your appeal request. Our decision might take longer if you ask for more time, or if we need more information about your case. We will tell you if we are taking extra time, and tell you why more time is needed.

How to ask for an appeal with Blue Cross of Idaho

Step 1: You, your representative, or your provider must ask us for an appeal. Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your provider if you need this information.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal.

Mailing Address: Blue Cross of Idaho
Medicare Advantage Plans
PO Box 8406
Boise, ID 83707
Fax: 208-331-8829
Physical Address: 3000 E. Pine Avenue
Meridian, ID 83642

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a service, we’ll send you a written decision. If we deny your appeal for Medicare Services, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

How to ask for a Medicaid State Fair Hearing

Step 1: If you lose the appeal with Blue Cross of Idaho you can ask for a State Fair Hearing;

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Send your request to:
Department of Health and Welfare
Administrative Procedures Section
PO Box 83720
Boise, ID 83720-0036
Phone: 208-334-5564
Fax: 208-332-7347

What happens next?

The State will hold a hearing. You may go to the hearing in person or participate by phone. You’ll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You will get a written decision within 30 days. The written decision will explain if you have additional appeal rights.
How to access rules governing contested case proceedings and declaratory rulings

The Idaho Legislature has granted the Director of the Department of Health and Welfare and the Board of Health and Welfare the power and authority to conduct contested case proceedings and issue declaratory rulings, and to adopt rules governing such proceedings.

You have the right to access this information online or from the Idaho Department of Health and Welfare office.

To access this information online:

Please visit http://adminrules.idaho.gov/rules/current/16/0503.pdf

To access this information in person:

Idaho Department of Health and Welfare
450 West State Street
Boise, ID 83702

To request information by mail:

Idaho Department of Health and Welfare
P.O. Box 83720
Boise, Idaho 83720-0036
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME
YOUR LAST NAME

HOME PHONE (Please include area code)
WORK PHONE (Please include area code)

STREET ADDRESS
CITY

STATE
ZIP

E-MAIL ADDRESS (If available)

Are you filing this complaint for someone else? [ ] Yes [ ] No

If Yes, whose civil rights do you believe were violated?

FIRST NAME
LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of:

[ ] Race / Color / National Origin [ ] Age
[ ] Religion [ ] Sex
[ ] Disability [ ] Other (specify):

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/TITLE/AGENCY/ORGANIZATION

STREET ADDRESS
CITY

STATE
ZIP

PHONE (Please include area code)

When do you believe that the civil right discrimination occurred?

LIST DATE(S)

Describe briefly what happened. How and why do you believe that you have been (or someone else has been) discriminated against? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE
DATE (mm/dd/yyyy)

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR’s web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To mail a complaint see reverse page for OCR Regional addresses.
The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

- [ ] Braille
- [ ] Large Print
- [ ] Cassette tape
- [ ] Computer diskette
- [ ] Electronic mail
- [ ] TDD

- [ ] Sign language interpreter (specify language): __________________________
- [ ] Foreign language interpreter (specify language): __________________________
- [ ] Other: __________________________

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME ____________________________________________

LAST NAME ____________________________________________

HOME PHONE (Please include area code) ____________________________

WORK PHONE (Please include area code) ____________________________

STREET ADDRESS ____________________________________________

CITY ____________________________________________

STATE ________ ZIP ________

E-MAIL ADDRESS (If available) ____________________________________________

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S) ____________________________________________

DATE(S) FILED ____________________________________________

CASE NUMBER(S) (If known) ____________________________________________

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

- Hispanic or Latino
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Not Hispanic or Latino
- Black or African American
- White
- Other (specify): __________________________

RACE (select one or more)

- Hispanic or Latino
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Not Hispanic or Latino
- Black or African American
- White
- Other (specify): __________________________

PRIMARY LANGUAGE SPOKEN (if other than English) __________________________

How did you learn about the Office for Civil Rights?

- [ ] HHS Website/Internet Search
- [ ] Family/Friend/Associate
- [ ] Religious/Community Org
- [ ] Lawyer/Legal Org
- [ ] Phone Directory
- [ ] Employer
- [ ] Fed/State/Local Gov
- [ ] Healthcare Provider/Health Plan
- [ ] Conference/OCR Brochure
- [ ] Other (specify): __________________________

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.

Region I - CT, ME, MA, NH, RI, VT

Office for Civil Rights, DHHS

JFK Federal Building - Room 1875

Boston, MA 02203

(617) 565-1340; (617) 565-1343 (TDD)

(617) 565-3809 FAX

Region II - NJ, NY, PR, VI

Office for Civil Rights, DHHS

26 Federal Plaza - Suite 3312

New York, NY 10278

(212) 264-3313; (212) 264-2355 (TDD)

(212) 264-3039 FAX

Region III - DE, DC, MD, PA, VA, WV

Office for Civil Rights, DHHS

150 S. Independence Mall West - Suite 372

Philadelphia, PA 19106-3499

(215) 861-4441; (215) 861-4440 (TDD)

(215) 861-4431 FAX

Region IV - AL, FL, GA, KY, MS, NC, SC, TN

Office for Civil Rights, DHHS

61 Forsyth Street, SW. - Suite 16770

Atlanta, GA 30303-8909

(404) 562-7886; (404) 562-7884 (TDD)

(404) 562-7881 FAX

Region V - IL, IN, MI, MN, OH, WI

Office for Civil Rights, DHHS

233 N. Michigan Ave. - Suite 240

Chicago, IL 60601

(312) 866-2359; (312) 353-5693 (TDD)

(312) 866-1807 FAX

Region VI - AR, LA, NM, OK, TX

Office for Civil Rights, DHHS

1301 Young Street - Suite 1169

Dallas, TX 75202

(214) 767-4056; (214) 767-8940 (TDD)

(214) 767-0432 FAX

Region VII - IA, KS, MO, NE

Office for Civil Rights, DHHS

601 East 12th Street - Room 248

Kansas City, MO 64106

(816) 426-7277; (816) 426-7065 (TDD)

(816) 426-3686 FAX

Region VIII - CO, MT, ND, SD, UT, WY

Office for Civil Rights, DHHS

999 18th Street, Suite 417

Denver, CO 80202

(303) 844-2024; (303) 844-3439 (TDD)

(303) 844-2025 FAX

Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions

Office for Civil Rights, DHHS

90 7th Street, Suite 4-100

San Francisco, CA 94103

(415) 437-8310; (415) 437-8311 (TDD)

(415) 437-8329 FAX

Region X - AK, ID, OR, WA

Office for Civil Rights, DHHS

2201 Sixth Avenue - Mail Stop RX-11

Seattle, WA 98121

(206) 615-2290; (206) 615-2296 (TDD)

(206) 615-2297 FAX

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. Please do not mail complaint form to this address.

HHS-699 (7/09) (BACK)
COMPLAINANT CONSENT FORM

The Department of Health and Human Services’ (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.
I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

In addition, I understand that as a complainant I am covered by the Department of Health and Human Services’ (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS’ investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

☐ CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS’ investigation, conciliation, or enforcement process.

☐ CONSENT DENIED: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: __________________________ Date: __________________________

*Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

Name (Please print): __________________________

Address: __________________________

Telephone Number: __________________________
NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act
The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
  (i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
  (ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
  (iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
  (iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.
OCR has the authority to disclose personal information collected during an investigation without the individual’s consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**
A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**
Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".
PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services’ (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual’s medical history, education, financial transactions, and criminal or employment history that contains an individual’s name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR’s files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,
as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package, Please contact OCR at [http://www.hhs.gov/ocr/office/about/contactus/index.html](http://www.hhs.gov/ocr/office/about/contactus/index.html)

OR

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)
Medicare Advantage Plans
True Blue® Special Needs Plan (HMO SNP)

Feel free to contact Blue Cross of Idaho at

1-888-495-2583 or
TTY 800-377-1363
On our website www.truebluesnp.com

Visit our local office at:
MERIDIAN
3000 East Pine Avenue
Meridian, ID 83642-5995